Wandsworth Safeguarding Children Board
Annual Report 2016-2017
As the Independent Chair of the Wandsworth Safeguarding Children Board (WSCB) I am pleased to present the annual report for the period April 2016 to March 2017. Local Safeguarding Children Boards (LSCB) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children’s lives. The WSCB has a really important role in coordinating and ensuring the effectiveness of what is done by each and every person involved in protecting children and it carries statutory responsibilities for safeguarding children in Wandsworth. It is made up of senior managers within organisations in Wandsworth who hold responsibility for safeguarding children in their agencies, such as children’s social care, police, health, schools and other services including voluntary bodies. The WSCB monitors how they all work together to provide services for children and ensure children are protected.

This year has been a significant one for the Board, as following the inspection of Children’s Service by OFSTED at the end of 2015, the focus has been on improving services for children during this period. The Board has been a significant partner in supporting and challenging the changes being made. It is of note that OFSTED have visited on a regular basis and they have commented positively on the changes being made in Children’s Services.

The national review into LSCBs has also been published this year, the recommendations of which were accepted in full by Government. The changes to safeguarding boards and the functions they carry out will form part of the Children and Social Work Bill progressing through parliament. This will make significant changes to the organisation of the safeguarding partnerships and a number of functions that Boards currently fulfil. Our challenge over the next year will be to ensure that we replace the LSCBs with something better. This will need to be done carefully and building on what we know works well. There will be key principles we must still adhere to when deciding the structure and form of local arrangements and agreement on the core functions of multi-agency partnership. The next year will also see significant changes in the delivery models within police and health which need to be carefully monitored to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.
Lastly, I would like to thank all the Board staff, for their continued support in the smooth functioning and promotion of the WSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Wandsworth.

WSCB Independent Chair

Nicky Pace
WSCB Independent Chair
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1. How effective is the WSCB in improving the safety of children in Wandsworth?

This Annual report highlights progress and improvements across the partnership over the past year and evidences both joint working and single agency focus on safeguarding and promoting the welfare of our children and young people in Wandsworth. The report comments on the key areas of statutory responsibility of the Board, such as the work of the Child Death Overview Panel (CDOP), multi-agency training, Private Fostering and allegations against professionals and the work of the LADO (Local Authority Designated Officer).

The Board has regularly reviewed the performance of professionals working with children through its programme of multi-agency audits and by examining the results of single agency audit work. During the last year, multi-agency audits have examined progress on cases:

- Step Up/Down audit - commissioned in February 2016
- Child Protection – Initial conferences effectiveness
- Self-Harm

In addition to its audit work, the Board identifies ways to improve through its reviews of individual cases, including Serious Case Reviews (SCRs). A Serious Case Review was initiated by the Board in July 2016 and a report completed in April 2017. For legal reasons it cannot yet be published, but the WSCB is already taking forward the learning identified with partners and this work will continue in 2017-2018.

The Board has continued to review its processes for undertaking Section 11 audits in the last year. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. The S11 self-assessment questionnaire designed by the WSCB is one of the key tools being used by the Board to assess and monitor whether staff in all agencies are able to properly identify and safeguard children. It gives the board the opportunity to understand how well front line staff understand safeguarding across the partnership.
The Board has worked on developing and confirming its dataset over the last year to ensure we have the right information and data to measure activity, but more importantly identify where there are areas of concern about performance or practice in individual agencies. The data has enabled the board to focus on areas of multi-agency practice and the impact on safeguarding children. The WSCB dataset has been under revision, with the aim of streamlining the number of indicators and enabling more emphasis on commentary, analysis and narrative.

This Annual report covers the work of all the sub-committees of the Board and the activity over the last year. The report comments on the key areas of statutory responsibility of the Board, such as the work of the Child Death Overview Panel (CDOP), multi-agency training, Private Fostering and allegations against professionals and the work of the LADO (Local Authority Designated Officer).

2. Snapshot of Safeguarding in Wandsworth 2016-2017

**Safeguarding Training Highlights:**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>Change</th>
</tr>
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<tbody>
<tr>
<td>Total number of events offered</td>
<td>276</td>
<td>338</td>
<td>+</td>
</tr>
<tr>
<td>Total number of events delivered</td>
<td>245</td>
<td>317</td>
<td>+29%</td>
</tr>
<tr>
<td>Total number of events cancelled due to low numbers</td>
<td>14</td>
<td>5</td>
<td>-65%</td>
</tr>
</tbody>
</table>
65,922 children live in Wandsworth (including 18 year olds)

1295 families received early help support below the threshold for social care

289 children were looked after at March 2017, compared to 235 at March 2016

4,803 individual practitioners completed S11 self-assessment questionnaire

The average caseload for Children Service social workers is 19 across all teams

There were 258 S47 assessments per 10,000 population - an increase of over 20% from 2015-16

There were 403 children on Child Protection Plans at March 2017 - an increase of over 70% on 2015-16

8% vacancy rate for health visitors & 4% for school nurses at end of 2015-16

There were 50 children missing from education at March 2017

There were 403 children on Child Protection Plans at March 2017 - an increase of over 70% on 2015-16

There were five Privately fostered children at 31st March 2017 - two less than at 31st March 2016

The average time for a child to be placed for adoption was 624 days at March 2017

145 referrals to MARAC had children in the family; 52 re-referrals involved children

There were 403 children on Child Protection Plans at March 2017 - an increase of over 70% on 2015-16

There were 65 referrals made to SEMAP during 2016-17, three more than in 2015-16

97.1% of all missing children were offered a return home interview

9.8% of children looked after were reported as missing

8% vacancy rate for health visitors & 4% for school nurses at end of 2015-16

9340 contacts were received in Children’s Services

65 referrals made to SEMAP during 2016-17, three more than in 2015-16
Wandsworth is one of the largest inner London boroughs, with an estimated population of 318,906 in 2017\(^1\). This indicates a pattern of continuous growth.

The total child population (those aged 0-18, including 18 year olds) is 65,922. Over 20% of children are living in poverty (based on school aged children eligible for free school meals).

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>58855</td>
</tr>
<tr>
<td>2012</td>
<td>59913</td>
</tr>
<tr>
<td>2013</td>
<td>61148</td>
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<tr>
<td>2014</td>
<td>62618</td>
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<tr>
<td>2015</td>
<td>63967</td>
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<td>2016</td>
<td>65080</td>
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<tr>
<td>2018</td>
<td>66688</td>
</tr>
<tr>
<td>2019</td>
<td>67486</td>
</tr>
<tr>
<td>2020</td>
<td>68171</td>
</tr>
<tr>
<td>2021</td>
<td>68903</td>
</tr>
<tr>
<td>2022</td>
<td>69509</td>
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<tr>
<td>2023</td>
<td>70026</td>
</tr>
<tr>
<td>2024</td>
<td>70531</td>
</tr>
<tr>
<td>2025</td>
<td>70812</td>
</tr>
</tbody>
</table>

**Population growth projections 0-18 years 2011-2025\(^2\)**

\(^1\) Source: https://data.london.gov.uk/dataset/2016-based-population-projections

The JSNA for the Wandsworth Health and Wellbeing Board has produced a very useful graphic (based on mainly 2015 data):
3. SCB Priorities 2016-2017 - progress

The Board is required to report on progress against its priorities, look forward and plan any changes to the safeguarding priorities for the local area for the next year. We have taken into account national priorities and local needs, findings and recommendations from the inspection and any issues arising from SCRs and multi-agency audits. When deciding our priorities, we acknowledge that our core business of safeguarding children is ongoing, including identifying, assessing and provided services and help to those children who need protection. In deciding the Board’s improvement priorities, we consider how well we have delivered our priorities from the previous year and if further work is needed. When deciding priorities the Board recognised that the areas identified would require a two year work plan at least to make the necessary improvements.
The Board recognises that continues to use opportunities to meet with and hear from young people through other mechanisms such as the Children in Care council (CLICK). It is therefore felt that this priority area needs to be embedded as a golden thread into all future work of the board and is part of our core values into next year.

The key priority areas were agreed for 2016-2017 as:

- Early help
- Children and Young People
- Neglect
- Children living away from their parents

The Board previously decided to add some overarching core values that sit over our key priority areas for 2016-18. These are a direct result of the inspection of children’s services and capture some of our key areas for continuing development. Safeguarding children and young people are at the heart of what we do and our core values are:

There is a strong focus on improving practice to reduce risk and secure better outcomes for children. Agencies are not complacent and recognise where there is a need to improve systems and processes to ensure more consistent, safer and effective practice. The full report gives a detailed picture of how all partner agencies have worked together in the last year.
3.1 WSCB Activity
The WSCB has undertaken development work, encouraged and monitored partners under the range of agreed priority headings below, led by the Monitoring Sub-Committee and the Independent Chair.

WSCB's key priority areas for 2016-18:

1. Early help
2. Children and Young People
3. Neglect
4. Children living away from their parents

Early Help
Ensure services provide appropriate early help and intervention, consistent application of thresholds between preventative, targeted and specialist services and monitor the effectiveness of the Multi-agency Safeguarding Hub (MASH).

Children and Young People
Address the challenges and risks faced by vulnerable children and young people, in particular:
- Going missing from care, education and home
- Child Sexual Exploitation
- Radicalisation
- Self-harming behaviour
- Involvement in gangs
- Children with disabilities and special educational needs
- Female genital mutilation
- Honour Based Violence
- Substance misuse

Neglect
Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work especially where there are concerns of:
- Domestic abuse,
- Parental mental health
- Substance misuse

Children living away from their parents
Ensure children not living at home are safe, receive high quality support to achieve better outcomes, which includes:
- Children Looked After
- Privately fostered children,
- 'Sofa surfing’
- Unaccompanied minors
- Young people in custody
Priority [1]. Early Help: Ensure services provide appropriate early help and intervention, consistent application of thresholds between preventative, targeted and specialist services and monitor the effectiveness of the Multi-agency Safeguarding Hub (MASH).

Early Help/ MASH:
The Multi Agency Safeguarding Hub (MASH) is the Local Authority's first point of contact for safeguarding concerns. The model brings together a range of partners into a multi-agency team that is able to share information quickly and efficiently as soon as notification of possible harm to a child is received. Risk is assessed by making evidence-based decisions that take into account the information gathered and the risk assessment of each agency. The MASH Service is located in the Referrals and Assessment Service (RAS) alongside the Assessment Teams. The MASH is the ‘Front Door’ to Children’s Social Care.

Following the Ofsted Inspection and acknowledgement of the issues raised there concerning MASH and RAS, Children’s Services completed their own diagnostic and identified some changes which were required immediately to manage the risk and increased demand. There are other changes which were carried out in 2016-2017, linked with the End to End Review of all Children’s Services, which was agreed at Committee on 9 February 2017.

The learning from the GSCB MASH audit in 2016 and Step Up/ Step Down audits has contributed to the changes and improvements made. The MASH audit will be repeated to benchmark improvement in the Spring of 2018, and will be reported in 2017-2018. See also under 8. Learning and Improvement – audit and reviews
Early Help

The number of Early Help Assessments (EHAs) has increased slightly this year. An EHA will be started with a family if a service has identified concerns and worries that would require more than one than one agency to help improve outcomes. In Wandsworth there is a family EHA so one EHA could be cover the needs of one or more children in a family.

Most EHAs are open for around two years, but there are quite a number that remain open during a child’s school life, in this case the presenting issues will be due to a child’s ongoing SEND needs or because of a long term need of a parent e.g. mental health or learning need. For more information see Appendix 15.

For the initial EHA the main generators are universal services, schools, children’s centres and health visitors. Of this group, primary schools have undertaken the most, given most children will have an EHA started between the ages of 3 and 5.

Further changes to improve early help are planned for 2017.

For more information see Appendix 15.
Priority [2]. Children and young people: Address the challenges and risks faced by vulnerable children and young people

Going missing from care, education and home:
Children who go missing from home, care and those missing from education continue to be a key priority area for the WSCB – see Section 8. below. We also recognise the increased vulnerability that children face when they go missing to issues such as child sexual exploitation, involvement in gangs and possible risk to radicalisation. As this is recognised across the board, mapping takes place at meetings such as SEMAP and GMAP and consideration also is given to whether the young person has been reported missing in the past, whether they are known to go missing frequently, etc. The Missing Sub-Group is facilitated by the WSCB.

For more detail see 8. Statutory reporting

Child Sexual Exploitation:
The learning from national serious case reviews concerned with Child Sexual Exploitation (CSE) has informed the development of multi-agency arrangements to tackle CSE in Wandsworth. The use of the play in schools - Chelsea’s Choice in May and September 2016 and funded by the WSCB, supported this process to raise awareness with young people at risk of exploitation. The play will be commissioned for further productions in 2017. Links with young people going missing are clearly known and recognised across the partnership and there is good information sharing. There has been a considerable amount of work focusing on young people at risk of CSE and missing in the last year including addressing the offer and take up of return home interviews. This is covered in more details in this report on Child Sexual Exploitation (CSE) and evidences the intervention by agencies to make children and young people safer. As this was an area identified by the inspectors as needing improvement, this remains an area of focus for the WSCB – a final draft revised CSE Strategy and Action Plan was presented to the Executive Board in March 2017.

For more detail see 8. Statutory reporting – below.

Radicalisation/ Prevent:
Wandsworth has had an active Prevent (the government anti extremism strategy) programme for the last few years. There is a clear delivery plan which aims to identify, prioritise and facilitate the delivery of projects, activities and interventions to reduce the risk of people being drawn into terrorism. It is divided into three areas of focus:

1. Work streams - institutions – working with sectors and institutions where there is a risk to radicalisation.
2. Individuals – preventing people being drawn into terrorism and ensure that they are given appropriate advice and support.
3. Ideologies – responding to the ideological challenge of terrorism and threat we face from those that promote it.

This plan is subject to on-going review and activities include:

- Workshop to Raise Awareness about Prevent’ (WRAP) to key partners in the Borough. This includes Council staff, schools, early years settings, safeguarding leads, police etc.
- Working in partnership with HE/ FE Prevent coordinators to report on action plans at St George’s University, Roehampton University & South Thames College.
- Identifying reference networks.
- Building capacity in vulnerable groups to deliver interventions.
- Maintaining and developing Channel Panel meetings (a multi-agency approach to safeguard vulnerable people by identifying individuals at risk, assessing the nature of risk and developing the most appropriate support plan for that individual).

Eighty six practitioners attended a Workshop to Raise Awareness about Prevent (WRAP).

**Self-Harming Behaviour:**

**Self-harm** – Ongoing concerns were raised nationally and by schools, the local hospital and Child and Adolescent Mental Health Services (CAMHS) that there appeared to be a rise in children displaying and presenting for services in relation to self-harming behaviour. This matter was also recognised by the Health and Wellbeing Board (HWBB) which is leading on the CAMHS Transformation Plan. This Plan outlines the strategic priorities for Wandsworth to 2020. This has led to increased capacity and capability for the local CAMHS. The WSCB also agreed to undertake a multi-agency audit on self-harm, which was commissioned within the 2016-17 audit programme, to understand the impact of intervention on reducing deliberate self-harm. Initial findings from the audit were:

Children are helped by interventions but pathways and processes varied between agencies.

Key themes:

- The importance of work being truly multi agency and the opportunity for practitioners to meet regularly, review the plan and the impact of the work.
- A common understanding among professionals of the interventions in place, their purpose and the desired outcomes.
- Importance of gathering information from family members and not the YP in isolation so as to gain a holistic understanding of the child’s world.
• Need to look at role of social media etc.

Recommendations include:

• Training on risk management and risky behaviours
• Clarity on use of Early Help Assessments in self harm cases.
• Guidance needed on engaging parents.
• Guidance for schools to be promoted.

These recommendations will be addressed in 2017-2018.

**Involvement in working with Gangs:**
The vulnerability of young people involved in gangs is managed effectively through the [Gangs Multi-agency Panel (GMAP)](#) arrangements and addresses these issues alongside the YOS and Children’s Services. In 2016-2017, an indication of gang activity and the correlation with safeguarding is the number and percentage of Children’s Services assessments that identify gang involvement or risk of gang involvement. Risk of gang involvement is highlighted as a concern in 28% (18/65) of referrals. Last year more information was provided in the referral forms regarding which gang they have links to but the proportion of referrals has remained consistent.

**No. of referrals to GMAP (on gangs matrix)**

<table>
<thead>
<tr>
<th>Qrt 1</th>
<th>Qrt 2</th>
<th>Qrt 3</th>
<th>Qrt 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>26</td>
<td>26</td>
<td>27</td>
</tr>
</tbody>
</table>

A number of bespoke projects have been designed to engage and motivate young people known to the Gangs team.
No. and % of assessments that identify gang involvement or risk of gang involvement

<table>
<thead>
<tr>
<th>Previous year’s outturn</th>
<th>Qrt 1 April-June 2016</th>
<th>Qrt 2 July-Sept 2016</th>
<th>Qrt 3 Oct-Dec 2016</th>
<th>Qrt 4 Jan-Mar 2017</th>
<th>Statistical neighbours</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statistical</td>
<td>26/914 2.8%</td>
<td>25/870 2.9%</td>
<td>29/812 3.6%</td>
<td>44/1221 3.0%</td>
<td>664/18913 3.5%</td>
<td>5200/448200 1.2%</td>
</tr>
<tr>
<td>46/1875 2.5%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Children with disabilities and special educational needs

The Children with Special Needs and Disability multi-agency safeguarding group is focusing on specific aspects of its work programme at each meeting. The group also needs to understand the outcome of the disability question which was included in the Section 11 audits for 2017 and any key actions particularly in relation to raising awareness that might arise as a result. It reports to the HWBB’s Child Health Overview and Clinical Reference Group (CHOCRG) has been re-established to progress the needs of this vulnerable group of children. The group has continued to review the Kingston SCR report and recommendations and met three times during 2016-2017.

The local offer

- The local authority has a comprehensive local offer, which is for all children and young adults aged 0-25 who have special education needs and disabilities.

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3 Westminster, Hammersmith, and Fulham, Islington, Kensington and Chelsea, Greenwich, Haringey/City of London, Manchester, Barnet, Camden
Children known to the 0-25 Disability Social Work Team

The number of the child protection within the 0-25 Disability Social Work Team in 2016-17 were 8 as of March 2017 but during 2016/17 were 10. The number of children looked after 0-25 Disability Social Work Team in 2016-17 were 9 as at end of March 2017 but 15 children during

Developing the 0-25 Disability Social Work Team

The 0-25 Disability Social Work Team has continued to come together through the year and there has been progress in the following areas

- Putting in place appropriate workforce development to enable social workers in the team to work with both children and young adults – key strands include Care Act, Mental Capacity Act and Safeguarding training so that managers can fulfil responsibilities in relation to both child protection and safeguarding vulnerable adults.
- Developing robust duty processes to manage both incoming referrals and also the range of reviews which need to be carried out for those children / young people who are accessing packages of support, but whose needs are largely stable.

There is further work to be done in relation to:

- Working with the Youth Support Service to finalise the pathway that would support young people with high levels of vulnerability but who do not have the levels of disability that would be expected to be supported by the 0-25 Disability Service, especially now in light of the End to End Review.
- Having a clear pathway for young people’s whose main area of need is mental health and where specialist expertise is required to ensure effective planning for the young person’s support / placement.
- Developing improved processes for tracking young people through the preparing for adulthood phase so that young people can achieve positive outcomes in relation to employment, independent living, maintaining good health and accessing appropriate social and leisure activities.
Female Genital Mutilation (FGM):
An audit of FGM was presented to the SCIL Sub-Committee Meeting on 15th April 2016. The implementation of the action plan was being monitored during 2016-17.

The local prevention strategy and guidelines and the FGM Mandatory Reporting & Safeguarding pathway are well used.

Katherine Low Settlement “KLS”, a multi-purpose local charity, have continued to support 21 FGM Champions. A small group of champions have worked to support professionals in health and education settings by raising awareness of FGM, the law and referral pathways to support. They have linked in particular with the Community Health Team and have delivered training sessions at Health Visitor Training in April 2016. The Champions have provided a support and signposting service to women from potentially-practicing communities and have provided one-to-one support as well as hosting coffee mornings, which have reached over 140 people. It is notable that the community champions have found the work challenging and it has been difficult to maintain a consistent number, however, the training has given a number of women with the confidence to enable them to find paid employment. Toward the end of 2016 it was becoming apparent that the work needed a new focus and the Chair of the SCIL Sub-Committee commissioned work on developing a WSCB Task & Finish Group to take the work forward and ensure that the champions concept.

A Survivors Support Network was set up for (mainly) Somali women, which out of FGM discussions restructured to become a Women’s Health Empowerment Group with a focus on keeping fit and public health areas.

The Home Office FGM ‘passports’ have been distributed (via the CCG) to all Wandsworth GP practices, these documents are invaluable for women and
girls who are travelling to FGM practicing countries. The passports were distributed to 700+ women at ESOL classes at South Thames College by June 2016.

The website www.wandsworth.gov.uk/vawg provides professionals with instant access to advice on how to deal with various forms of VAWG abuse. The abuse abroad booklet contains practical advice and information about FGM, forced marriage, modern slavery and human trafficking and travel to war zones which includes radicalisation. Leaflets have been updated to include up-to-date information in an easily accessible format and with a recognisable branding across all products.

**Bloodlines event 20 February 2017**

On 20 February 2017 the WSCB hosted a well-attended and evaluated conference in Roehampton run by the National FGM Centre and featuring a very powerful drama performance from Olive Branch Arts.

**Honour Based Violence/ Forced Marriage:**
These priorities are addressed through the WSCB Training programme and will be a key part of the Engagement Plan being developed in 2017.

Community Safety have led on the development of a leaflet with Karma Nirvana – www.karmanirvana.org.uk – a national charity supporting victims of honour-based abuse and forced marriage. This is available on the WSCB Resources webpage: http://www.wscb.org.uk/wscb/info/5/resources

It is now stated policy that all cases of forced marriage and honour based violence that come to the attention of services, including the police, should be referred to the MARAC.

**Involving young people:**
This is an area that has been identified as a priority for the WSCB in 2017-2018 as for capacity reasons the Board has not engaged with young people directly, though reports have been received on elements of participation by local authority services including the Report on Youth Council and CLICK in December 2016. A key priority for the next version of the Business Plan is an Engagement Plan which will address the need to hear the voice of the child much more clearly. Proposals to link this with the data and intelligence gathering of the Board will also look to monitor participation, including through audit, continuing the work that the Child Protection Conferences audit begun in December 2016. Agency reports for 2016-2017 and going forward specifically require key agencies to evidence how they are enabling participation and hearing the views of young people and families, ensuring that this are being used to direct service improvement.
Priority [3]. Neglect: Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work especially where there are concerns

The Board is very aware from its previous audit and case review work that the early identification of neglect when parenting deteriorates is a critical issue for safeguarding children. Children living with the ‘toxic trio’ of domestic violence, parental mental ill-health and substance misuse, often experience significant emotional and physical neglect. This in turn significantly impairs the child’s health and development, leads to poor progress at school and limited life chances.

We recognise there is more to do especially in providing Early Help to more children and parents to prevent the escalation of concerns. We have therefore agreed that this area will continue to remain a priority for the LSCB. We will be reviewing the strategy, incorporating the learning from our local partnership review that highlighted neglect as key issue within the reviews.

Domestic Abuse:
Public Health produces and coordinates its activities in support of the Wandsworth Violence Against Women & Girls (VAWG) Strategy & Action 2015-18. It enables and supports other departments, internal & external, in service delivery and provides some bespoke services in respect of VAWG. This contributes to a greater understanding of issues related to VAWG and ensures that high-risk victims of VAWG are identified and have responded by the appropriate use of an effective and robust multi-agency framework. During 2016 – 17 the Multi Agency Risk Assessment Conference (MARAC) met every four weeks on average and discussed 135 high-risk victims to minimise risk of harm through a multi-agency response.

No. and % of MARAC referrals where there are children in the family

<table>
<thead>
<tr>
<th>Previous year's outturn</th>
<th>Qrt 1 April-June</th>
<th>Qrt 2 July-Sept</th>
<th>Qrt 3 Oct-Dec</th>
<th>Qrt 4 Jan-Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>157</td>
<td>43 /53%</td>
<td>28 /36%</td>
<td>32 /50%</td>
<td>32 /56%</td>
<td>135</td>
</tr>
</tbody>
</table>
Project Tearose

The police, in conjunction with the local authority launched ‘Project Tearose’ during 2015-16, and this has continued very successfully in 2016-2017. If police respond to a domestic incident and there are children present then his or her head-teacher or school safeguarding lead will be told by 9am the next morning of what has happened. This is to make sure that a support network is put in place and the child’s teachers are aware. The school will work with the parents, Police and Children’s Social Care to help the child. The school is only told what they need to know. Information is shared confidentially through secure email, by trained police officers. Forty Wandsworth schools are currently part of the project and the plan is to expand it further to more schools. The feedback from schools have been extremely positive, as this has enabled them to better support the young person the following day, having a better understand of why he or she might be behaving in a more distracted or withdrawn manner. It has been a very successful initiative.

The project is in three phases – phase one began in January 2016:

Jan – July 2016

20 schools were in the project throughout and 20 further schools were included for phase 2. Tearose notifications were sent in respect of 144 children in 34 schools during this period. The highest number of notifications for a school was 11, three schools had eight, and five schools had seven. The remainder had five or less

Current academic year

By the 15th May 2017, notifications related to 947 pupils have been sent to schools since the start of the academic year on 5th September 2016.

Review and evaluation processes

A meeting was held with the pilot schools before the project was launched and a subsequent meeting was held to obtain feedback from schools.

The notifications have enabled us to identify any children where there are repeat notifications – schools have then flagged this up or made appropriate referrals for support. The highest number of notifications for one family during the September 16 – May 17 period is eight. Nine Families have had four or more notifications during the same period, 13 had three and 45 had two.

A survey in June 2016 found very positive responses to the project thus far and also asked for comments:
What difference did the referral make to the child? (What were you able to do for that child you would otherwise not be able to?)

“I was able to talk to child that morning and the child told me what happened at home and how she felt/ what she was worried about and she was less anxious.

“We were aware of incidents that occurred the night before, we are able to act that day and ensure the child is safe. If the child is not in school the next day we are able to inform the appropriate professionals and ensure a welfare check is requested.”

“Able to look out for change in behaviour or attitude”

“Better understanding of child’s behaviour. Referral to learning mentor for therapeutic intervention”

“Because the child did not disclose anything, we would not have otherwise known about the incident and would not have been able to provide the support and understanding for a difficult period of time for that child. We were able to make adjustments and allowances that were subtle but which supported the child in a period of difficulty for them. We have also been able to reach out to parents and to enable a conversation which might otherwise not have taken place, which has also had a positive impact on the child.”

“Prepare for any upset that child may have. Keep a closer watch on both siblings.”

“They were supported appropriately”

A follow up evaluation in May 2017 was equally positive.

Future possibilities include a roll out of the approach across London, and an extension of the methodology to other areas, e.g. incidents of reported bullying in the community which may impact on pupils in school, missing children notifications, pupils who have been arrested.

• Parental mental health
• Substance misuse
Priority [4]. Children living away from their parents: Ensure children not living at home are safe, receive high quality support to achieve better outcomes

Children Looked After:
The WSCB recognises that placing children in care out of borough can be challenging in terms of safeguarding and promoting their welfare. There are arrangements in place for responding to children who go missing from care. There is more work needed to scrutinise actions taken to find missing children, undertake return home interviews consistently and learn from what they say and what is known about the ‘push and pull’ factors that lead them to go missing and to prevent this happening again. There is a continuing focus to increase the number and proportion of children in Wandsworth fostering placements, so that CLA are placed closer to their schools, family, friends and communities.

For more detail please see Section 8. Statutory Reporting, Children Looked After

Privately fostered children:
Raising awareness of Private Fostering has proved challenging in 2016-17, not least because of changes in management in Children’s Services and declining national activity, numbers are always considered to be under represented. Numbers identified remain static and very likely under reported.


Young people in custody:
The work is continuing on concerns about the number of young people under 18 kept in police cells overnight under the age of 18, which are seen as too high. However, at any one time there can be five young people in cells around London. The MPS have demonstrated a clear commitment to keeping the numbers down and ensuring that there is good communication with other support teams, notably Emergency Duty Teams to provide alternative Local Authority accommodation. A concordat on the issues remains unsigned in London between police and children’s services, but is expected to operational in 2018.
<table>
<thead>
<tr>
<th>WSCB's key priority areas for 2017-18:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Early help</strong></td>
</tr>
<tr>
<td><strong>2. Vulnerable Children and Young People</strong></td>
</tr>
<tr>
<td><strong>3. Neglect</strong></td>
</tr>
<tr>
<td><strong>4. Children living away from their parents</strong></td>
</tr>
</tbody>
</table>

### Early Help
Ensure services provide appropriate early help and intervention, consistent application of thresholds between preventative, targeted and specialist services and monitor the effectiveness of the Multi-agency Safeguarding Hub (MASH).

### Vulnerable Children and Young People
Address the challenges and risks faced by vulnerable children and young people, in particular:
- Going missing from care, education and home
- Child Sexual Exploitation
- Radicalisation
- Self-harming behaviour
- Involvement in gangs
- Children with disabilities and special educational needs
- FGM
- Honour Based Violence
- Forced Marriage

### Neglect
Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work especially where there are concerns of:
- Domestic abuse,
- Parental mental health
- Substance misuse

### Children living away from their parents
Ensure children not living at home are safe, receive high quality support to achieve better outcomes, which includes:
- Children Looked After
- Privately fostered children,
- 'Sofa surfing/Bus hopping"
- Modern Slavery/Trafficking/
  Unaccompanied minors
- Young people in custody

### 4. WSCB priorities for 2017-2018
The WSCB Priorities have been streamlined and refined for 2017-18 arising from a Development Day in May 2017.
5. Governance & Accountability

Safeguarding is everyone’s business. For services to be effective, each professional and organisation should play their full part. The service user should be central to service delivery. For services to be effective they should be based on the needs and views of children and young people, their families and vulnerable adults. As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people of Wandsworth are safe and their well-being is protected. The WSCB has the responsibility to scrutinise and challenge these arrangements across the partnerships within Wandsworth. These partnerships include the Health and Wellbeing Board (HWBB), Safeguarding Adults Board (SAB) and Community Safety Partnership (CSP), as well as the newly formed Corporate Parenting Panel (CPP). The current joint governance protocol will be updated to include the link with the CPP.

Since the Ofsted inspection, published in February 2016, the Improvement Board also has a role in ensuring safeguarding performance for a local authority in special measures – see Improvement Board – progress below.

The WSCB has a Three-tier structure: An Executive Board, a Network Board and four Sub-Committees. The Executive is the strategic and decision making body made up of the all director level or equivalent representation the statutory partners and some key other partner agencies, which meet at least six times a year. We also have a lay member who sits on the Executive. The Executive annually reviews the safeguarding priority areas, taking into consideration any key safeguarding issues brought to its attention by frontline workers; the outcome of the monitoring, analysis and recommendations undertaken by the WSCB Sub-Committees; key issues identified through audit and review processes; the analysis of local data provided to the WSCB through its dataset; and reflecting on regional and national issues.
The Network Board is a broader board, which includes a wide representation from all statutory agencies and other agencies in the borough such as all the school sectors – primary, secondary, special and independent schools, as well as the voluntary sector. It is a more operational board and will consider implementation of the strategic drive set by the Executive. It meets three times a year.

All the Sub-Committees (SCs) report to the Executive. Each Sub-Committee has a clear mandate as set out in its Terms of Reference. These were fully revised in March 2017.

The WSCB will:

- Take responsibility for monitoring action to improve safeguarding including action plans arising from Serious Case Reviews.
- Hold the other boards to account on matters of safeguarding in all its activities, providing appropriate challenge on performance and results of performance indicators.
- Undertake audits and feedback results to the other boards, advising on ways to improve and highlight areas of underperformance.
- Feedback learning from Serious Case Reviews and ensure that the lessons are learnt.
- Highlight gaps in service for the other boards to consider as part of its commissioning process.
During 2016-17 the WSCB had four functioning Sub-Committees, as well as key standing groups (PIXI Panel, S11 Audit Review Group, etc.).

5.1 Monitoring Sub-Committee:
The **Monitoring sub-committee** undertakes the quality assurance and scrutiny role on behalf of the WSCB. It meets six times a year. During the last year it called in over 30 reports for scrutiny and to seek assurance that service delivery is contributing to better outcomes for children and young people in Wandsworth. Reports are sent on to the Executive Board where appropriate. The areas reviewed by the Monitoring SC include:

- Anti-bullying Strategy
- Online Safety
5.2 The Serious Cases Improvement and Learning Sub-Committee:
The Serious Cases Improvement and Learning sub-committee (SCIL) leads on multi-agency audits, reviewing learning from single agency safeguarding audits, considers whether a case meets threshold for undertaking a serious case review (SCR) or Local Partnership reviews. It will coordinate any SCRs as required. It also reviews learning from other SCRs. It will convene extraordinary meetings to consider specific cases for review or area of concern; there were two of these in 2016-17 – one to discuss learning from FGM and MASH audits (April 2016) and one to consider a case for a Serious Case Review (July 2016) see Section 9. Case Reviews below. It also reviews learning from SCRs published by other authorities across London and nationally.

Audits Reviewed included: FGM, MASH, St George’s NHS Trust Audit, Step up Step Down processes

For more information on WSCB auditing see Section 9. Multi Agency Audits below.
Reports on SCR learning included reviews from:

- Kingston – including actions for Wandsworth
- City & Hackney
- Greenwich
- Richmond
- Croydon
- Somerset

5.3 Child Death Overview Panel:
The Child Death Overview Panel (CDOP) function is to review all Child deaths who are Wandsworth residents. As per the Working Together To Safeguard Children 2015, Chapter 5 - These arrangements are to include:

- An overview of all child deaths (under 18 years, excluding those babies who are stillborn) in the LSCB area undertaken by a panel (para 5.8 – 5.10); and
- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (para 5.12 – 5.28).

The overall principles are that in all cases enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household, the needs of all family members, to monitor the support services offered to families and, also to consider any lessons to be learnt about how best to safeguard and promote the children’s welfare in the future. All families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

Full details of activity are in the CDOP annual report, see Appendix 16.

Number of Deaths in the CDOP Area

There were a total of 55 deaths reported to the Wandsworth Single Point of Contact from 1 April 2016 to 31 March 2017. 15 (27%) of these deaths are Wandsworth resident children and will be reviewed by the Wandsworth CDOP Panel. The remaining 40 (73%) were children resident in other areas and these were passed onto the relevant local authority SPOC.

There are a high number of child deaths from surrounding boroughs due to St George’s Hospital role as a large tertiary referral hospital attracting complex paediatric cases, including trauma for across the South East of England.

The Merton and Sutton CDOP has now split so the boroughs are now independent from each other. Hounslow has now left the tri-borough CDOP of Richmond, Hounslow and Kingston.

**Number of Meetings Held and Reviews Conducted**

The Wandsworth Child Death Overview Panel aim to meet quarterly to review deaths. The panel has met three times during the data year. A total of 19 cases were reviewed.

**CDOP Meetings**

Attendance at panel meetings continues to be consistently high with most members attending all meetings.

There are nine cases awaiting review up to 31\textsuperscript{st} March 2017. The panel will aim to complete these reviews in the upcoming CDOP year.

**Multi-Agency Response Meetings**

A response meeting is required for unexpected deaths with a view to ensuring any investigation and support is appropriate from the beginning. All agencies and professionals who have been involved with the child’s family are expected to attend. The multi-agency response process is now working well. The meetings are generally held within one week of the death being notified and attendance is always very good. These meetings continue to be a very valuable way of sharing information, identifying any additional investigative actions and arranging support for the family.
There have been five Wandsworth cases deemed as an unexpected death during the data collection period 01/04/2016 to 31/03/2017. Response meetings were held for three of these deaths, the other two were extremely premature infant deaths and a virtual meeting was held where the case was discussed with the lead clinician involved.

**CDOP Leadership Meetings**

The CDOP Manager/ SPOC and Designated Paediatrician meet when necessary to discuss cases being prepared for review and any other CDOP issues that arise.

**CDOP Bereavement Counselling Service**

The Wandsworth CDOP dedicated Bereavement Counsellor/ Co-ordinator left the panel in October 2016. The recruitment process to replace the counsellor was timely and the new counsellor started in June 2017. The Bereavement Counsellor/ Co-ordinator will continue to make contact with families following the death of a child to offer counselling as well as guidance on bereavement matters.

This service is now embedded into the CDOP process although due to the service being without a counsellor for 9 months there is now a slight backlog which will be dealt with by the new counsellor. All bereaved families have been or will be written to by the CDOP Bereavement Counsellor and offered bereavement support and advice. The Bereavement service is also offered via the Neonatal Unit, GP, Health Visitor, Paediatric Psychology Service or support was sought by the parent.

The future of the Wandsworth CDOP remains under review following the Alan Wood Review⁵, commissioned by the Government. It is expected that changes to be made will follow after the new safeguarding partnerships expected to be replacing LSCBs in 2019.

**5.4 Training and Workforce Sub-Committee:**

This was set up in November 2015. The Executive agreed to a group with a wider remit to include and scrutinise areas of safeguarding in relation to the workforce. Terms of Reference were reviewed in January 2017. The first meeting was on 11 May 2016, and meetings are now scheduled quarterly. The Sub-Committee is chaired by the Designated Nurse for Safeguarding Children, employed by the CCG. There is considerable development needed of the role and purpose of the group in 2017-2018. This will include an increased emphasis on evaluation of learning outcomes for training.

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Reports are received on progress of the WSCB Multi Agency training programme, including online/e-learning and the groups work plan to monitor and develop both multi agency and single agency training in Wandsworth. The training offer and take up is now much larger than previously – see Section 8. Statutory reporting, Multi Agency Training delivery below,

6. Responsibility of the WSCB in relation to other strategic groups/Boards:
The WSCB is not a delivery or commissioning body, it has a scrutiny and challenge role – this is explicit in Working Together to Safeguard Children, 2015. However it would expect to initiate activities which investigate and improve practice in safeguarding. It has the authority to call any agency represented on the HWBB, SAB or CSP to account for its safeguarding activity. The work of the WSCB contributes to the wider goals of improving the well-being of all children. Within the wider governance arrangements its role is to ensure the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard and promote the welfare of children. The WSCB continues to work with partnerships to ensure procedures and processes are in place to minimise risk and maximise the safety of children and young people in Wandsworth. In 2016-2017 the key connection was with the Improvement Board for Wandsworth’s Children’s Services – see below.

6.1 Wandsworth Improvement Board – progress:
Following the Ofsted Inspection published in February 2016 the immediate focus of Wandsworth’s Children’s Services department was on improving social work practice and strengthening management oversight to reduce risk and ensure children were safe. The actions to achieve this were set out in a 12 month improvement plan which was agreed by Executive in April 2017 and was approved by the Department for Education on its first submission.

The Improvement Plan has been monitored on a regular basis by Children’s Services Senior Management, the Member-led Children’s Social Care Group and the externally chaired Improvement Board- the Independent chair of the WSCB being a member of this. After 12 months, 63 actions had been completed and were rated green, 44 were rated amber and 13 were rated red. A number of significant actions have been implemented which has resulted in three positive Ofsted monitoring visits in 2016-2017 which have all found evidence of improvements in practice and management oversight across the services inspected.

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6 LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding. WT15, Chapter 3, 3
The Department for Education also conducted a separate check on progress in December 2016 which also found evidence of improvements, stating “The Council and its partners have responded positively to the inspection result, and performance data and intelligence reflect a clear improvement since the inspection by Ofsted.” This visit highlighted the importance of partnership working particularly in relation to early help.

The “Front Door” was reviewed as a priority action. This resulted in an additional third Assessment Team being established and the MASH arrangements being changed. The impact of this was noted by Ofsted in their first monitoring visit “Additional resources and the remodel of the MASH have brought clarity to referral pathways. Staff report that communication with senior managers has improved: their views are considered and action is taken to address concerns. Consequently, they have more capacity to respond to the volume of work, with most contacts and referrals seen receiving a prompt response”.

Early and comprehensive actions were taken to ensure consistent standards of social work practice. Practice Standards and a set of ‘non-negotiable’ were rolled out across the Department, supported by mandatory training and practice development sessions. Ofsted have seen the impact of this in work with children and young people noting “social work practice is becoming stronger, leading to better outcomes for most children. Social workers spoken to by inspectors know children well. They see them regularly and carry out imaginative child-centred direct work that is informing decisions and plans.”

Throughout the year there has been a focus on improving management oversight of performance. New weekly performance reports have been developed for team managers. A weekly performance day has also been put in place by the Assistant Director for Children and Families alongside a monthly in-depth review of performance by the Senior Management Team. This has resulted in improved management oversight of performance with Ofsted noting “Comprehensive performance reports support effective monthly and weekly scrutiny, ensuring that managers at all levels in the organisation have sufficient oversight of frontline practice. Effective targeted action is taken to address poor performance. Frontline managers have additional tools to monitor team performance, ensuring that children are seen routinely, timely assessments are completed and supervision is taking place.

In February 2017, Children’s Services agreed a new vision which puts the child/ young person and their family/ carers at the heart of everything it does, with an un-relented focus on empowering the children and their families/ carers to make the changes necessary to improve their lives (Paper No. 17-48). The vision set out a stronger focus on early intervention, and on improving aspirations for children and young people in terms of their attainment, well-being and safety. It seeks to move the Department from a focus on compliance to a focus on delivering improved outcomes.
7. Communication and Publicity:

7.1 Newsletters and review of leaflets:
The WSCB aims to produce two newsletters during the year containing key messages from learning from reviews, introducing new members of the WSCB to the partnership, upcoming events, etc. Only one newsletter was produced this year because of capacity issues with the WSCCB Business Management team.

The WSCB has created a range of leaflets to raise awareness with members of the public and those working in Wandsworth. All the leaflets were updated during 2015-16 and are published on the website and can be downloaded via www.wscb.org.uk/resources. Free copies are provided to agencies when requested.

7.2 WSCB Website:
The WSCB website, www.wscb.org.uk, remains the key repository for information and communication of the Board’s messages. All WSCB policies and strategies are now available to download there and kept current. The site attempts to be as accessible as possible as it is also a vital gateway to services for the community as well as partner agencies. A number of the key referral forms are also available through the site, including Early Help Assessments and Children’s Services, plus referrals for CSE and the LADO etc.

7.3 Safeguarding Week between 13-17th June 2016:
Safeguarding Week is celebrated every year in conjunction with the Safeguarding Adults Board (SAB). Safeguarding stalls are held at key locations in the borough during the week where representative from partner agencies hand out information about safeguarding children and adults to members of the public. During the safeguarding week over 750 leaflets and safeguarding bags, which displays the number of Children’s Services on it, with the message ‘If you are worried about a child or young person, call 020 8871 6622’ were given out. Very positive feedback was received on each of the day from members of public about the awareness-raising events.

| Safeguarding Adults/ Children's Week 13 - 17 June 2016 Schedule: |
|------------------------|------------------|------------------|------------------|------------------|
| **Date**               | **Monday 13th June** | **Tuesday 14th June** | **Wednesday 15th June** | **Thursday 16th June** | **Friday 17th June** |
| **Venue**              | Sainsbury’s 77 Tooting High Street, SW17 | Putney Exchange Shopping Centre, SW15 | Sainsbury’s, Garratt Lane Wandsworth | Southside Shopping Centre | Sainsbury’s Balham |
| **Time**               | 9.30 - 11.00 am  | 11.00 am - 1.00 pm | 2.00 - 4.00 pm | 10:30 am - 1.00 pm | 11.00 am - 1.30 pm |
8. Statutory Reporting:

8.1 Multi-Agency Safeguarding Training delivery:

The WSCB is committed to providing high quality learning opportunities for the children and young people’s workforce in Wandsworth to ensure it is capable and confident to safeguard children and young people. Training is driven by an understanding of the skills, knowledge and abilities that the workforce requires to achieve good outcomes for children and their families. The multi-agency safeguarding training programme is delivered in line with the key safeguarding priority areas identified and agreed by the WSCB. There is an expectation that the workforce will access the multi-agency training in addition to single agency training provision, as it promotes improved inter-agency working on all aspects of safeguarding children. The programme is regularly reviewed to ensure it takes account of local and national changes.

The OFSTED report, published on 16th February 2016, stated that multi-agency safeguarding ‘training is provided in relation to the key priorities of the Board, using learning from case audits and internal management reviews’. The report further stated ‘an extensive and appropriate range of multi-agency training has been developed and delivered on behalf of the LSCB’.

The WSCB has seen improved performance of the training programme in 2016-2017. Highlights include:

- A broad and varied multi-agency safeguarding training programme was offered to the children’s workforce – 317 training events were delivered with 6,574 attendances; an increase of 22% increase in courses offered with 39% increase in attendances
- Increase in offers and attendance to the voluntary and community sector from 6% to 7.1% progressing towards to the target of 10%
- Training attendee on the day and impact evaluations were positive overall - 98% of attendees in the sample either ‘strongly agreed’ or ‘agreed’ that the training event will help them do their job better
- 47 training events specifically for school staff (whole workforce and Designated Safeguarding Leads) which includes key safeguarding subject areas such as safer recruitment at basic and advanced level
- Delivery of a modular blended learning training programme for Designated Safeguarding Leads in Early Years settings, equipping DSL’s to embed safeguarding practices within schools. Please see Appendix 3 for a summary of schools training delivery
- Development of Wandsworth Workforce bespoke e-learning in Signs of Safety and wellbeing (SoSWB) module
- Promoted learning across the multi-agency workforce from Serious Case Reviews: 2 Learning From Experience (LFE) Events, 98 attendees
- Extension of the online learning safeguarding programme (see Appendix 5 for a breakdown of attendance by course) - 3,064 course completions during the year extended and improved on knowledge and skills
- Advanced Signs of Safety and Wellbeing to grow 38 Practice Leads to continue to support building practice depth and expertise in SoSWB as the common practice framework across the Children’s workforce - including provision of on-going development and learning sessions for the Practice Lead role
- Annual Safeguarding Conference
- Annual SoSWB practice celebration – showcasing practice across children’s social care and multi-agency partners

<table>
<thead>
<tr>
<th><strong>Number of events offered, delivered and cancelled</strong></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>change</th>
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</thead>
<tbody>
<tr>
<td>Total no. of events offered</td>
<td>235</td>
<td>276</td>
<td>338</td>
<td>+22%</td>
</tr>
<tr>
<td>Total no. of events delivered</td>
<td>191</td>
<td>245</td>
<td>317</td>
<td>+29%</td>
</tr>
<tr>
<td>Total no. of events cancelled due to low numbers</td>
<td>32</td>
<td>14</td>
<td>5</td>
<td>-65%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Bookings and attendance</strong></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>No. of requests to attend multi-agency safeguarding training received</td>
<td>5,144</td>
<td>6,461</td>
<td>338</td>
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<td>No. of requests to attend multi-agency safeguarding training confirmed</td>
<td>4,339</td>
<td>5,288</td>
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<tr>
<td>No. of multi-agency safeguarding training attendances</td>
<td>4,047</td>
<td>4,724</td>
<td>5</td>
<td>+39%</td>
</tr>
</tbody>
</table>

Practitioners or volunteers who applied for courses may not be confirmed on a course either because the training is not appropriate for them or if their application is not approved by their manager.

The largest sector that accesses the safeguarding training is schools.

**Training attendee evaluation and impact:**
Monitoring and evaluating the impact of training is regarded as central to ensuring that the multi-agency safeguarding training offer is good quality. The ‘Code of Practice’ on Wandsworth TPD Online also states that the TDS uses ‘effective monitoring and evaluation systems, including seeking out and acting on user feedback to inform the quality of provision’. This is achieved by the use of pre, post and 3 months post evaluations. When an individual books a place on a training event, the ‘Terms and Conditions’ they agree to specify that ‘Each attendee will be expected to give an evaluation of the event. Depending on the activity this may be in the form of a feedback sheet at the end of the event but could also include an online evaluation of the impact that the activity has had on practice from 3 months after the event’. 
**Training event participants evaluation**
Participants of multi-agency safeguarding training events are asked to complete two short ‘on the day’ questionnaires. At the beginning of each event they are asked to complete a pre-event evaluation and at the end of the training they also complete a post-evaluation questionnaire. All participants are also invited to complete an impact questionnaire (at least three months after the event delivery date).

**How the data is used**
The TDS pays close attention to all training attendee feedback and uses it to inform the development and improvement of future training events. The TDS encourages staff and managers to regularly discuss learning from training during supervision and impact on practice. The impact evaluation from managers tells us that 98.8% of staff who have attended training courses have been helped by the learning acquired from attendance on the course with 67.6% of managers embedding discussion about learning from training in supervision.

The data in the table below from the WSCB S11 audit table below (collected over 3 years) indicates that whilst single agencies access e-learning training offers, they predominantly still access more classroom based learning. In particular attendance in specialist subject areas such as CSE, FGM and Prevent (WRAP) are high. Despite a high number of cases across the continuum featuring parental mental ill health, domestic violence and substance misuse as risk factors there appears to be fewer practitioners accessing these courses. WSCB need to encourage partner agencies to access more multi-agency based offers.

**Learning from Experience - Learning from two local Serious Case Reviews**
As part of the key role of the WSCB to promote learning across the multi-agency workforce ‘Learning from Experience’ (LfE) events are held to share learning from serious case reviews and audits. During 2016-2017 the Board organised and delivered:

- **Neglect event, 20 April 2016**

This multi-agency learning from experience event focused on two case reviews one of which involved Kingston, Merton and Wandsworth agencies. The other case involved a family whose children experienced severe neglect and gave the participants the opportunity to discuss how practitioners can learn from the findings, change practice, and processes to prevent the same things happening again in the future.
• Audits, Good Practice, and Learning from Inspections, 12 October 2016

This covered:

• Learning from the Step up/ Step down Audit
• Wandsworth Multi-Agency Safeguarding Hub (MASH) Audit – Changes made
• City of London & Hackney – learning from a high profile Serious Case Review
• Change for Children’s Social Work Services: Non-Negotiable 10 and Practice Standards

**Family A 2015 - key learning objectives**

This review found that professionals across the multi-agency group did not fully comply with or understand:

• Thresholds for intervention - missed opportunities to escalate concerns
• Information sharing Challenging professionals/ decisions
• Working with middle class, resistant families
• Large and complex relationships
• Roles and responsibilities of the Team Around the Child and large networks
• The complexities of disability, and neglect
• Professionals not recognising or challenging disguised compliance
• Fathers or significant males missing from the assessments
• The voice of the child/ journey not being centre of assessments

Subsequently these key learning objectives were integrated into the multi-agency training offer.

**Child E (not yet published) key learning objectives** (to be incorporated into the multi-agency training offer)

• Professional curiosity, ‘respectful uncertainty’
• Information sharing between professionals
• Recognition of the impact of CSE, mental ill-health, substance misuse and domestic abuse on parenting capacity
• Professional sympathy for a vulnerable parent, overshadowing risks to vulnerable child
• Care leavers as parents
• Importance of chronologies
• Gendered abuse of girls and women
• Ensuring understanding of commonality of terms (core group v team around the child)
• Persistence in encouraging full involvement of professionals e.g. GPs
• Professionals not recognising or challenging perceived errors, judgements from other professionals

8.2 LADO (Local Authority Designated Officer) – allegations against staff:
Working Together to Safeguard Children 2015 places a duty on Local Authority’s to “put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process”. (Chapter 2, Section 6). This function is carried out by the Local Authority Designated Officer (LADO).

Working Together 2015 further states that the framework for managing such cases should be used where it is alleged that a person who works with children has:

• Behaved in a way that has harmed a child, or may have harmed a child.
• Possibly committed a criminal offence against or related to a child.
• Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Where the above criteria are met, the LADO is responsible for chaired strategy meeting to consider whether there should be:

• A police investigation of a possible criminal offence.
• Enquiries and assessment by children’s social care about whether a child is in need of protection or in need of services.
• Consideration by an employer of disciplinary action in respect of the individual.

The LADO’s key role is to provide advice and guidance to employers and voluntary organisations, and to:

- Liaise with the Police and other agencies, including Ofsted and professionals bodies, such as the General Medical Council.
- Monitor the progress of referrals to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.
- To provide oversight of the investigative process through to its conclusion.
- Chair LADO Strategy Meetings and establish an agreed outcome of the LADO investigation.
- Facilitate resolution to any inter-agency issues.
- Liaison with other Local Authority LADO’s where there are cross boundary issues.
- Collect strategic data and maintain a confidential database in relation to allegations.
- Disseminate learning from LADO enquiries through the children’s workforce.

At the time of the last Annual LADO report the operational aspect of the LADO role was shared by all of the Child Protection Co-ordinators and Independent Reviewing Officers in the Safeguarding Standards Service on a rostered basis. However after a Service Review in June 2016, which reviewed data outcomes and stakeholder views, it was agreed to pilot the operational aspect of the LADO role to be shared by two Child Protection Co-ordinators who also continued to chair Child Protection Conference. Subsequently a further Service Review led to one full time delegated LADO being allocated in March 2017. The effectiveness of this will be reviewed again in September 2017. Having a full time delegated LADO provides consistency of threshold and the opportunity to develop good working relationships with partner agencies.

Cover arrangements remain in place to enable Child Protection Conference Co-ordinators and Independent Reviewing Officers to undertake the LADO role on a rostered basis when required, such as annual leave. The full time delegated LADO will offer support and mentoring to colleagues undertaking the LADO role in her absence.

The delegated LADO also works closely with the Safeguarding in Education Advisor to cover issues involving schools.

Referrals to the LADO Service

There were 261 referrals to the LADO Service between 1st April 2016 and 31st March 2017. This shows a continued trend in a rise of referrals or contacts with the LADO from the previous recording year where there were 220 referrals. Of the 261 referrals received 84 did not meet the threshold for LADO intervention. In those cases written guidance and advice was given to the employer to keep for their records.

The referral resources for allegations where the LADO threshold was not met, was not recorded. However for those where the threshold was met the data analysis indicate that fewer referrals have been received from parents, children, early year settings, health services and children services. LADO Annual Report 2016-2017 Page 14
The police have made more referrals to the LADO Service and referrals from education settings remained the same. There has been a significant increase in referrals from other sources, such as the Church safeguarding advisor. For the second year running, no referrals were received from Ofsted that met the LADO threshold.

**Nature of Allegation**
The nature of the allegations where the LADO threshold was not met, was not recorded. It is however interesting that there has been a significant drop in allegations of physical abuse, emotional abuse and of allegations recorded as other, which relates to concerns about professional conduct and failure to follow protocol. This is believed in most cases to be linked to allegations received from schools and early year settings stemming from interactions by staff or volunteers where children have been shouted at, restrained or physically directed to carry out instructions. If there is no evidence of significant harm and the allegation does not require Police or Children’s Social Care involvement, organisations have been supported to undertake their own internal management investigation and follow their own internal procedures. The delegated LADO then provides advice regarding disciplinary matters, training and changes needed in relation to policies and procedures. There has been an increase in online abuse of children, which is in most cases reported to the LADO by the Police. There has also been an increase LADO in referrals where children have been neglected by staff or volunteers who work with them.

Feedback from agencies on the development of the LADO function is very positive. For the full Annual report on LADO please click on this Link: [Wandsworth LADO Report 2016-17](#).

**8.3 Private Fostering:**
The number of children known to be living in private fostering arrangements in Wandsworth at the end of March 20167 was five. Between 1st April 2016 and 31st March 2017 there were three new notifications received (compared to none in 2015/2016). Statutory visits were within timescales for all cases. One young person moved out of the area to live with mother in a different borough.

Out of the six private fostering arrangements at 31 March 2017:

- 1 child was between 0 - 4yrs
- 3 children were aged between 5- 10
- 2 children were aged between 11 – 15yrs.
In previous years there had been a dedicated post for privately fostered children that fulfilled the statutory responsibility of being the allocated social worker for this cohort of children, as well as moving forward the awareness campaign within the borough. Between 1st April 2016 – 31st March 2017 the service experienced a number of difficulties which detracted from pursuing a full awareness raising campaign. These difficulties included a number of changes of social workers and manager in the Intensive Intervention team led to gaps in the strategic arrangements for awareness raising and in the application of a programme of publicity and awareness campaigning. This is also in the national context of the closure of the British Association for Adoption & Fostering in 2015 – now replaced by Coram BAAF Adoption and Fostering Academy - which did a good deal of UK wide campaigning. The fostering recruitment officer will help the service develop a strategy and publicity campaign as part of the work with fostering. The apparent continuing challenges of not having a dedicated post and low awareness of private fostering is an area of concern for the WSCB and has been raised by the Independent Chair to Children’s Services previously, and will be revisited during 2017-2018. Responsibility for private fostering has moved within Children’s Services back to the Families and Communities Service which is developed a Private Fostering Board to specifically address the issues

8.4 Children Missing from Home, Care and Education:

Children who go missing from home, care and those missing from education continue to be a key priority area for the WSCB. We also recognise the increased vulnerability that children face when they go missing to issues such as child sexual exploitation, involvement in gangs, possible risk to radicalisation. As this is recognised across the board, mapping takes place at meetings such as SEMAP and GMAP and consideration also is given to whether the young person has been reported missing in the past, whether they are known to go missing frequently, etc.

Missing Episodes

1,057 missing episodes were recorded on Fwi, the IT system, in 2016/17, which is a decrease from 1,290 episodes in 2015/16. There was a 55% increase in missing episodes between 2014/15 and 2015/16 which was largely attributable to improved data recording and this now appears to have stabilised.
The trend in missing episodes over the last year is an increasing one. This is partially due to seasonality; the summer holidays led to a marked reduction in the number of reports of missing young people in 2014/15, 2015/16 and 2016/17. One prolific missing young person generated high levels of missing episodes in Q4 2016/17.

Gender

The gender split is fairly even with 52% being female, last year, males accounted for a slightly higher proportion of missing young people.

<table>
<thead>
<tr>
<th>Gender</th>
<th>No of Young People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>163</td>
<td>52%</td>
</tr>
<tr>
<td>Male</td>
<td>149</td>
<td>48%</td>
</tr>
<tr>
<td>Total</td>
<td>312</td>
<td>100%</td>
</tr>
</tbody>
</table>
Ethnicity

Black or Black British young people appear to be over represented in the cohort of young people who are reported missing. The 2011 Census for Wandsworth states that 21% of 10-19 year olds in Wandsworth are Black or Black British, and in January 2016 23% of Wandsworth resident pupils attending Wandsworth state-funded schools were Black or Black British. These figures suggest that one could expect around 22% of missing young people to be Black or Black British compared to the actual figure of 40%. Young Black Males are more overrepresented than females with 43% of males being Black or Black British, compared to 37% of females.

When only those young people whose ethnicity is known are considered, the proportion of Black or Black British young people increases to 44%. 48% of the male missing person whose ethnicity is known, are Black or Black British.

<table>
<thead>
<tr>
<th>Known Ethnicity</th>
<th>Female</th>
<th>%</th>
<th>Male</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or Black British</td>
<td>60</td>
<td>41%</td>
<td>64</td>
<td>48%</td>
<td>124</td>
<td>40%</td>
</tr>
<tr>
<td>White</td>
<td>45</td>
<td>31%</td>
<td>37</td>
<td>28%</td>
<td>82</td>
<td>26%</td>
</tr>
<tr>
<td>Mixed</td>
<td>23</td>
<td>16%</td>
<td>20</td>
<td>15%</td>
<td>43</td>
<td>14%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>18</td>
<td>11%</td>
<td>15</td>
<td>10%</td>
<td>33</td>
<td>11%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>14</td>
<td>9%</td>
<td>8</td>
<td>6%</td>
<td>22</td>
<td>7%</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>3</td>
<td>2%</td>
<td>5</td>
<td>4%</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>145</td>
<td>100%</td>
<td>134</td>
<td>100%</td>
<td><strong>312</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

Age

The age of missing young people is increasing; the average age of the 312 individuals is 15.1 years old (up from 14.3 last year). The most common age range is 16 to 19, compared to last year when the most common age category was 11 to 15 years with 52% of missing young people falling into that age band.

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Data provided by S Momber 21/03/17
17 year old girls are the most likely to be missing. There were four missing children who were age five or under and they all related to domestic incidents/disputes between parents.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 and Under</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>3</td>
<td>7</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>11 to 15</td>
<td>67</td>
<td>74</td>
<td>141</td>
<td>45%</td>
</tr>
<tr>
<td>16 to 19</td>
<td>90</td>
<td>66</td>
<td>156</td>
<td>50%</td>
</tr>
<tr>
<td>Not Known</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>163</td>
<td>149</td>
<td>312</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Missing Children Looked After**

The proportion of the cohort of missing young people that are CLA is increasing and they are generating a larger proportion of the missing incidents. 91 of the 312 (29%) missing young people were CLA when they went missing, but they generated 654 missing episodes which is 62% of the total. Last year 24% of missing young people were CLA and they generated 58% of the total and in 2014/15 25% of the young people were CLA and they generated 50% of the episodes.

CLA children are over represented in the missing figures; 62% of all the missing incidents pertain to young people who are CLA, yet in Wandsworth 0.48% of young people are CLA. The latest figures for England state that 0.6% of the total child population is in care.

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9 Wandsworth has 288 CLA (rate of 48 per 10,000 using 0-17 population of 59,703) which is 0.48% in care of total child population
10 In England (March 2016) - 70,440 CLA (rate of 60 per 10,000 which means population used is 11,740,000) which is 0.6% in care of total child population
11 Information provided by S. Momber 12/05/17
It is important to try and understand the relationship between being in care and being reported missing. Does being CLA make a young person more likely to go missing or does going missing make a young person more likely to become Looked After?

**Repeat Missing Young People**

In 2016/17 312 young people generated 1,057 missing episodes. 193 of those young people were only missing once, so the impact of repeat missing young people on the total figure cannot be underestimated. The remaining 119 young people generated 864 missing episodes; 38% of the young people generated 82% of the episodes. This is consistent with last year when 39% of the young people generated 84% of the episodes.

The Top 10 young people were responsible for 29% of all missing episodes (304 incidents). The Top 20 Missing Young people generated 454 missing episodes. That is to say that the Top 6% of the Missing Young people generated 43% of all the missing episodes. All of the Top 10 are CLA. Eight of the Top 10 are known to SEMAP – six were referred to SEMAP during 2016/17 and two were referred prior to 2016/17. All five of the girls in the Top 10 are known to SEMAP.

**Overlap with SEMAP – Child Sexual Exploitation**

11% (33 of 312) of missing young people are also SEMAP referrals, and they generated 338 missing episodes which is 32% of the total. Last year 15% of missing young people were also SEMAP referrals, generating 34% of missing episodes. 16 of these SEMAP Missing persons are also CLA.

All five females in the Top 10 missing young people (by number of missing incidents) are female and they are all current or previous SEMAP referrals. This clearly highlights the overlap between CSE and missing.

**Children Missing Education**

The Education Welfare Service monitors and takes appropriate action to support all pupils who are at risk of missing education and out of school, as well as those leaving and starting at non-standard transition points.

Children are usually deemed to be missing education, and therefore not at that point on the roll of a school, due to being newly arrived in the borough and, in the majority of cases, parents will be somewhere in the process of making applications for schools. In a very small number of cases, children missing education (CME) checks are made to establish each child's whereabouts.
Snapshots of the numbers of children missing education and out of school are taken at various points in the year. Taking a like-for-like comparison of the figures at both March 2016 and March 2017 snapshots during this reporting period, the numbers of children missing education and out of school remain low, with the majority of children out of school for shorter periods. However, children can be out of school for longer periods where more complex issues, such as those related to housing, can delay the start date for a child’s school placement. This number varies over time.

Combined figures show 90% of children were missing education for between six and 16 weeks, with just 10% between 17 weeks and 32 weeks. No children were missing education longer than 33 weeks.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>March 2016</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 weeks – 16 weeks</td>
<td>53</td>
<td>50</td>
</tr>
<tr>
<td>17 weeks – 32 weeks</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>33 weeks – 48 weeks</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Chart: Combined data snapshot figures for March 2016 – March 2017
8.5 Child Sexual Exploitation (CSE)

The 2016 Ofsted Inspection reported\(^\text{12}\) that, ‘Partnership arrangements to protect children at risk of child sexual exploitation are well established strategically and operationally via the sexually exploited multi-agency panel (SEMAP). When concerns are identified accurately, social workers use a risk-based assessment tool to determine the level of risk and refer to the sexual exploitation multi-agency panel (SEMAP). The panel ensures that appropriate action is being taken to safeguard and promote the safety of the child referred. In a small number of cases, inspectors saw effective mapping exercises being completed by managers and social workers to identify risk, consider known hotspots in the area, make links to other children at risk and put strategies in place to protect children’.

However, ‘Inspectors identified inconsistencies in the identification of and response to children at risk of child sexual exploitation, with some children experiencing inaccurate assessments of risk and insufficient protection. These are not consistently underpinned by robust practice. More work is required to ensure that all sexually exploited children are effectively protected’.

In response to this challenge, a number of actions have continued

- Ensuring that all Social Care staff complete CSE online training module.
- Ensuring that Social Care staff have a clear procedural understanding and compliance at all levels (e.g. Use of s47s, risk assessments, strategy meetings, 2014 CME regulations, compliance with ‘Working Together’ 2015).
- Increasing the use of CSE risk assessment tool across all teams. All notifications to SEMAP are required to use the CSE Risk Assessment Tool.
- Reviewing the number of strategy meetings and S47 investigations being undertaken for Children Missing and at risk of CSE.

In March 2017, the Executive Board received a final draft version of a revised CSE Strategy and action plan – the latter will be developed through 2017 and reported in the 2017-2018 annual report. Priorities have also been updated to reflect the new DfE guidance which was released in February 2017\(^\text{13}\) and learning from the Joint Target Area Inspection (JTAls) which focused on CSE.

\(^{12}\) [http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/wandsworth/053_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf](http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/wandsworth/053_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf)

\(^{13}\) [Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation, DfE, February 2017](http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/wandsworth/053_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf)
8.5.1 Prevalence of Child Sexual Exploitation:

1. Data on the prevalence of child sexual exploitation is not comprehensive, as it is restricted to those cases which are reported, meaning the numbers available are likely to only be the tip of the iceberg’. Trends in the data may reflect increased public awareness and changes in policy rather than an increase in incidence. Police recorded child sexual offences against under 18s up 76% in the UK, with 38,575 recorded offences. 652 were ‘sexual grooming’ offences and 347 were ‘abuse of children through sexual exploitation (includes under 18s)’14.

2. However research has provided some contextual figures, for example the below statistics, which were pulled together in a 2015 DfE commissioned review15:
   - 2038 victims of CSE (localised grooming, rather than online grooming, trafficking, or peer-on-peer abuse) were reported to CEOP in 2011 - where there was relevant information 311 were in care (15%), 842 were known to have been reported missing at least once (41%), 61% were white, and most came into contact with agencies at the ages of 14 or 15 (CEOP, 2011).
   - 1145 reports of online CSE were received by CEOP in 2012. 80% of victims were female. 13-14 year olds were the largest victim group at 35% (CEOP, 2013).
   - There were 1400 cases of CSE in Rotherham between 1997-2013 (Jay, 2014). The CLG inquiry indicated that Rotherham was not an outlier and CSE in the UK is large scale, nationwide and increasing (CLG Committee, 2014).
   - 2409 children were known to be victims of CSE by gangs August 2010-October 2011. 16,500 from across England were identified as being at high risk of CSE (April 2010 - March 2011) (Berelowitz et al, 2013).

3. Within London, analysis conducted by the Metropolitan Police Service (MPS) highlighted that over 50% of CSE cases involved peer-on-peer exploitation, that two thirds of CSE victims had been reported missing at some point in the preceding 12 months to the police report and a large number were CLA.

4. One of the main challenges in understanding the prevalence of child sexual exploitation is that practitioners or young people themselves do not often recognise when abuse is taking place. As such, it is accepted that there are likely to be many more incidences of child

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14 How safe are our children? NSPCC, 2016
15 Child Sexual Exploitation: A study of international comparisons. Desk Review for the Department for Education
sexual exploitation than identified by research. In Wandsworth, a screening tool is available to help workers identify children and young people at risk and the Strategic Sexual Exploitation Multi-Agency Panel (SEMAP) has oversight of the local landscape.

5. There were 68 SEMAP referrals in 2015-16, requiring multi-agency information-sharing and discussion of risk, an increase on the 53 SEMAP referrals in 2014-15. Data for 2016-2017 is summarised below:

CSE data 2016-17

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency of reporting</th>
<th>Previous year’s outturn</th>
<th>Qrt 1 April-June</th>
<th>Qrt 2 July-Sept</th>
<th>Qrt 3 Oct-Dec</th>
<th>Qrt 4 Jan-Mar</th>
<th>Narrative/Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of referrals to SEMAP</td>
<td>Quarterly</td>
<td>68</td>
<td>16</td>
<td>18</td>
<td>18</td>
<td>13</td>
<td>There were 65 referrals for 2016/17 compared to 68 in 2015/16 and 53 in 2014/15. The trend in SEMAP referral levels is a rising one with the average number of referrals increasing from 4 per month to 6 per month between April 2014 and March 2017. The 65 referrals related to 63 young people as two people were referred twice during 2016/17.</td>
</tr>
<tr>
<td>% of SEMAP referrals that identify gang involvement /risk of gang involvement</td>
<td>Quarterly</td>
<td>29%</td>
<td>13%</td>
<td>33%</td>
<td>28%</td>
<td>38%</td>
<td>Risk of gang involvement is highlighted as a concern in 28% (18/65) of referrals. This identifies links between the young person being referred and gangs, but doesn’t necessarily mean that gang members are sexually exploiting the young person. Last year more information was provided in the referral forms regarding which gang they have links to but the proportion of referrals has remained consistent.</td>
</tr>
<tr>
<td>Measure</td>
<td>Frequency of reporting</td>
<td>Previous year's outturn</td>
<td>Qrt 1 April-June</td>
<td>Qrt 2 July-Sept</td>
<td>Qrt 3 Oct-Dec</td>
<td>Qrt 4 Jan-Mar</td>
<td>Narrative/Commentary</td>
</tr>
<tr>
<td>---------</td>
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<td>----------------</td>
<td>---------------</td>
<td>---------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>% of SEMAP referrals that identify young person as regularly going missing</td>
<td>Quarterly</td>
<td>50%</td>
<td>25%</td>
<td>67%</td>
<td>72%</td>
<td>46%</td>
<td>52% (33/63) of the SEMAP Young people were reported missing on Fwi\textsuperscript{16} and generated 338 missing episodes. When the young people who are known to go missing, but have not been recorded on Fwi are included 63% (40/63) of the SEMAP young people are demonstrating missing behaviour.</td>
</tr>
</tbody>
</table>

6. This increased referral activity represents successful awareness-raising work and improved understanding of the issue amongst practitioners. It is expected this trend will continue, although as stated above the number of cases referred to SEMAP is likely to represent only a proportion of total cases.

7. In 2015-16, 100 of the 2109 assessments with factor information (5%) had CSE as one of the recorded factors and 40 had ‘going/being missing’ (2%). This is an increase on 2014-15, where CSE was recorded for 67 of 2041 (3%) and ‘going/being missing’ for 30 (1%).\textsuperscript{17} This is in line with England and London figures, both 4% for CSE and 3% for ‘going/being missing’.

8. A continuing challenge in relation to child sexual exploitation is successfully identifying cases so that interventions can be delivered. This includes understanding that sexual exploitation does not generally occur in isolation and can be linked to a variety of other factors, for example gang association, or young people who frequently go missing from home or education. All practitioners in Wandsworth are supported to recognise the risk factors associated with sexual exploitation, in order to be able to identify cases and intervene early.

9. The five priorities reflected below are the drivers behind work to tackle sexual exploitation in Wandsworth. Each agency in Wandsworth is committed to delivering on these priorities at both a strategic and operational level. Following a review in 2017, they remain the key priorities for the partnership across Wandsworth.

\textsuperscript{16} Framework – Children’s Services IT system
\textsuperscript{17} Children in Need SFR, DfE, 2014-15 and 2015-16
10. Under each of these five pillars there is a range of work underway as well as identified areas for further development. The CSE action plan sets out the identified actions for improvement in relation to each of these priorities year on year.

**Prevent**

- Prevent the occurrence of child sexual exploitation by raising awareness and undertaking work with children and young people to address risk

**Identify**

- Effectively identify young people at risk of exploitation through coordinated partnership working. Put in place robust plans to address the

**Engage**

- Provide services that young people and their families are able to engage with in order to address the risk of sexual exploitation and wider factors.

**Impact**

- Ensure that services deliver interventions that have an impact on the young person’s life and effectively reduce the risk of sexual exploitation.

**Disrupt**

- Disrupt the activity of perpetrators, using arrests and seeking prosecutions wherever possible, to reduce the occurrence of child sexual exploitation.

8.6 Child Protection information:

These investigations relate to Section 47 of the [Children Act 1989](http://www.legislation.gov.uk/ukpga/1989/41/contents) which places a duty on a local authority to investigate and make inquiries into the circumstances of children considered to be at risk of ‘significant harm’ and, where these inquiries indicate the need, to decide what action, if any, it may need to take to safeguard and promote the child’s welfare.

S47 investigations increased following the OFSTED inspection where significant concerns were raised about the application of thresholds. Following a thorough review of MASH during and post the OFSTED inspection, a new system was put in place, which has
contributed to a more consistent and balanced process of decision-making and the application of threshold to referrals that are being received through the front door (MASH) than during the periods prior to the OFSTED.

There has been a considerable rise in numbers since the Ofsted inspection, and measures have been put in place by Children’s Services.

As previously the majority of children are subject to CP plans under the category of emotional abuse. Most children in this cohort have been exposed to and harmed by domestic abuse. Neglect follows a similar pattern. Children subject to plans for physical abuse rose and peaked in August 2016, but since have then reduced slightly. Throughout 2016/17 additional practice improvement work has focussed upon ensuring that the threshold for statutory intervention was being understood and consistently applied. Audit has indicated that progress is being made in this area.

Plans made in relation to sexual abuse have continued to rise and have reached highest level for the year. This also exceeds previous years. This should be seen within the context of overall increased numbers of children on CPP. In June 2016 there were 8 CPP for sexual abuse 2.41%, in December 2016 18 CPP or 4.95%, by March 17 this was 6.43% or 26 children. The national average for sexual abuse is 4%.

There has been significant work to reduce children put on Child Protection Plans.
## Child protection plans in wider context

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts received</td>
<td>2170</td>
<td>2243</td>
<td>2197</td>
<td>2370</td>
<td>2449</td>
</tr>
<tr>
<td>Referrals</td>
<td>482</td>
<td>676</td>
<td>818</td>
<td>929</td>
<td>934</td>
</tr>
<tr>
<td>conversion rate</td>
<td>22.1%</td>
<td>27.5%</td>
<td>37.2%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>S47 completed</td>
<td>263</td>
<td>158</td>
<td>321</td>
<td>298</td>
<td>502</td>
</tr>
<tr>
<td>Of those leading to ICPC</td>
<td>65</td>
<td>81</td>
<td>102</td>
<td>64</td>
<td>141</td>
</tr>
<tr>
<td>conversion rate</td>
<td>24.71%</td>
<td>51.3%</td>
<td>31.78%</td>
<td>21.5%</td>
<td>28%</td>
</tr>
<tr>
<td>CP plan made at ICPC</td>
<td>36</td>
<td>77</td>
<td>73</td>
<td>50</td>
<td>131</td>
</tr>
<tr>
<td>conversion rate</td>
<td>55.38%</td>
<td>95.1%</td>
<td>71.57%</td>
<td>78.1%</td>
<td>92.9%</td>
</tr>
</tbody>
</table>

### Number of children subject of a CPP by duration

- 3 months or less
- Over 1 year less than 2 years
- Over 2 years
- Over 3 months up to 6 months
- Over 6 months up to 1 year
Work is underway in 2017-2018 to address the rise in the number of children on CP Plans for three months or less, very evident in the data for the last quarter of 2016-2017. This includes practice improvement sessions within team meetings and clear management guidance. Plans should not end at three months unless children become looked after otherwise change may not be well established and sustainable.

The number of children on plans longer than two years is low and has been reducing, and cases at 15 and 24 are subject to robust scrutiny at the Child Protection Quality Assurance Panel. This also now reviews cases of children under five on plan for more than nine months.
Demographics – Ethnicity, Age and Gender

The majority of children currently subject to CPP are white. However Black or Black/British children are over represented. In Wandsworth the 2011 Census found that 44% of the 0-19 population was BME. The January 2016 Schools Census showed that 57% of Wandsworth pupils who were resident in the borough were BME. 22% were Black/Black British. This is the most up to date data available.

Similarly BME children are disproportionately over represented within the children looked after population.
The majority of children subject to CPP are of school age. This reflects the extent of schools ability to identify and refer vulnerable children at risk of harm as a universal service with a high level of daily contact. In total there are 225 (61.8%) school age children on CPP in December 2016 and by March 17 this had risen to 252 (62.3%).

The number of children aged 16 or more has risen consistently since January 2016 (2.33%). A greater emphasis has been placed upon their protection and the use of child protection procedures has been reinforced. Young people 16+ made up 6.04% at Q3. At end of Q4 there were 30 children on CPP aged over 16 years (7.42 %) this is the highest level across the year. In light of the increase audit will focus on the application threshold to check that is consistent and correct. Work will be done to review the impact and effectiveness of CPP for those young people. Exploratory work is also in progress to look at other models of managing adolescent risk.

Across the year the numbers of children aged less than 12 months increased however the percentage in December within the context of overall increase in CPP numbers is down to 8.24% compared with 11.4% in June 16 and 8.9% in January 16. At the end of Q4 the number of children aged less than 12 months was 35 (8.6%).
8.7 Children Looked After:

Numbers of Children Looked After

At 31st March 2017 289 children were looked after (CLA) by the local authority. The number of CLA children continued to increase along with the number of children subject to a Child Protection Plan (see Section 8.). March figures have now exceeded the target for 2016/17 and have increased by 23% in the past 12 months. This is also a reflection on the increased contacts, referrals and assessments which have been carried out over the year.

<table>
<thead>
<tr>
<th>No. of Children Looked After</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outturn</td>
<td>235</td>
<td>248</td>
<td>241</td>
<td>252</td>
<td>252</td>
<td>262</td>
<td>260</td>
<td>266</td>
<td>269</td>
<td>275</td>
<td>275</td>
<td>278</td>
<td>289</td>
<td>240-280</td>
</tr>
</tbody>
</table>

Children with multiple placements

The percentage of children with three or more placements has showed a reduction during 2016-2017, despite the increase in CLA numbers. The increased levels of performance management of placement through placement planning meetings, permanency planning and use of placement support services is helping to limit placement moves to a more reasonable level. It is a challenging target to maintain because of many unpredictable factors in placements especially amongst the older age group, but heightened awareness by staff and increased rigour of the regularity of visiting contribute to better placement management.

More foster homes are being recruited to keep children in care closer to Wandsworth and local services. Fewer children experience 3+ placement moves and the turbulence of change. The number of children ‘staying put’ is increasing so giving them stability for longer. The recruitment of mentors, skills workers and independent visitors has increased so providing more children and young people with a source of support and stability.
<table>
<thead>
<tr>
<th>No. of CLA</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of CLA with 3+ Placements</td>
<td>29</td>
<td>36</td>
<td>36</td>
<td>32</td>
<td>31</td>
<td>31</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>35</td>
<td>30</td>
<td>36</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>No. of CLA</td>
<td>235</td>
<td>248</td>
<td>241</td>
<td>252</td>
<td>252</td>
<td>262</td>
<td>260</td>
<td>266</td>
<td>269</td>
<td>275</td>
<td>275</td>
<td>278</td>
<td>289</td>
<td></td>
</tr>
<tr>
<td>%age of CLA with 3+ Placements</td>
<td>12.3%</td>
<td>14.5%</td>
<td>14.9%</td>
<td>12.7%</td>
<td>12.3%</td>
<td>11.8%</td>
<td>10.8%</td>
<td>10.9%</td>
<td>11.2%</td>
<td>12.7%</td>
<td>10.9%</td>
<td>12.9%</td>
<td>8.0%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

**Looked After Children Visit Timeliness**

Visit performance has fluctuated in 2016-2017 and declined, as the number of required visits has increased at a faster rate than the number of visits undertaken. Managers have addressed this by tightening up the performance management of the regularity of visiting and placed a higher premium on writing up visits and direct contact with children in care placements.

All out of borough placements are visited with the same frequency and CLICK, the Children in Care Council, has introduced a pen pal service for those further away and uses social media to contact more distant placements.

<table>
<thead>
<tr>
<th>No. of CLA</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of CLA whose latest visit was undertaken on time</td>
<td>217</td>
<td>235</td>
<td>233</td>
<td>233</td>
<td>246</td>
<td>254</td>
<td>252</td>
<td>248</td>
<td>249</td>
<td>260</td>
<td>263</td>
<td>261</td>
<td>263</td>
<td></td>
</tr>
<tr>
<td>No. of CLA due for a visit (Snapshot) where latest visit was held during the year (YTD)</td>
<td>227</td>
<td>244</td>
<td>250</td>
<td>254</td>
<td>263</td>
<td>266</td>
<td>271</td>
<td>274</td>
<td>283</td>
<td>272</td>
<td>279</td>
<td>280</td>
<td>291</td>
<td></td>
</tr>
<tr>
<td>%age of CLA whose latest visit was undertaken on time</td>
<td>95.6%</td>
<td>96.3%</td>
<td>93.2%</td>
<td>91.7%</td>
<td>93.5%</td>
<td>95.5%</td>
<td>93.0%</td>
<td>90.5%</td>
<td>88.0%</td>
<td>95.6%</td>
<td>94.3%</td>
<td>93.2%</td>
<td>90.4%</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

Missing children and those at risk of CSE are reviewed regularly and strategy meetings held on the third episode. Return home interviews are offered to all after each episode.
The ‘Voice of the Child’

Children’s views are reported in CLA visits and reported by CLA SWs in their reviews. CLICK has trained young people to chair their reviews, encouraged participation and attended some reviews as a supporter. Surveys conducted by CLICK on Reviews, contact, semi independence units have impacted on the way services are delivered.

9. Learning and improvement

9.1 Audits & Reviews

Multi Agency Audits

Mash Audit
The Serious Case and Learning Implementation (SCIL) Sub-Committee commissioned an independent audit of the effectiveness of the Multi Agency Safeguarding Hub (MASH) in 2015. A report to the Board in May 2016 detailed nine recommendations and the SCIL Sub-Committee noted in April 2016 that progress has been made on a number to date. This is running alongside actions during the year to address issues found by Ofsted. Re-audit is proposed by Spring of 2018.

The conclusion of the audit was delayed by the OFSTED inspection between 23rd November and 18th December 2015. Following the submission of the initial draft report in January 2016, it was agreed with the WSCB SCIL chair to delay submission to the WSCB and that an additional plenary would be completed with key multi-agency stakeholders. This would ensure that key managers within the MASH were involved and that changes put in place during and subsequent to the inspection could be reflected with the addendum. The authors were asked to write-up the plenary and developments that have taken place in MASH since the completion of the audit, to be added as an addendum. Any additional information gathered from these meetings and added companying data from the audited cases to be added as appendix to the final draft of the report.

This is significant and in reading the audit findings it is important to recognise the period of audit and when the cases were drawn from (April 2015 to October 2015), i.e. before the Ofsted inspection of November/ December 2015.

This multi-agency audit was carried out by two independent consultants. The following activities were carried out to meet the objectives of the audit:
20 cases were selected for audit by Wandsworth. Ten of these had gone through MASH prior to decision-making of whether to progress to assessment or not; and 10 cases had gone straight from referral to Social Care for assessment. The identification of the cases considered the following characteristics:

- Age, ethnicity, gender of the child
- Date of referral to Children’s Social Care
- Rating of risk
- The key focus of this audit was to compare processes and outcomes in terms of notifications which went through MASH against those which went straight from notification to social care assessment. Matching the findings of the Ofsted inspection, cases audited evidenced a lack of consistency in process and practice across the board. Although no child was found to be at risk of immediate harm, the auditors found two cases which they judged to require escalation for action to be taken in order to promote positive outcomes for the children involved. In one of these cases a Section 47 investigation was initiated.

Recommendations

In summary these involved:

1. Review of the MASH model overall.
2. Improvements to the Early Help Assessment process, including for IT systems.
3. Consideration should be given to carrying out an audit focusing on the interface between Children’s and Adult services where cases sit between the two. Whilst it is recognized that the current audit was small scale, there was some case evidence and anecdotal feedback of difficulties in complex cases in terms of delineation of roles and services, ultimately leading to a lack of support to children and families.
4. Better Information sharing within Children’s services.
5. Addressing over assessment of cases as neglect.
6. Clearer understanding of purpose and underlying protocols for meetings with partner agencies.
7. Rectifying wide scale lack of awareness of any policies and procedures, including the use of Wandsworth’s existing levels of need and escalation policies.
8. Addressing the likely impact of significant changes in personnel, including its effect on tracking of cases over time.
9. Significant team building activity to ensure that all members are clear about the purpose of the MASH and their role in the team.
‘Step Up – Step Down’ Audit:
The purpose of this audit was to examine practice around ‘Step up/ Step down’ processes among the multi-agency network in Wandsworth (LBW). The report summarises and provides an overview of a number of audits carried out by agencies across the WSCB partnership - an Independent Social Work Consultant produced this summary report.

The audit aimed to identify:

- The effectiveness of the ‘Step up/ Step down’ processes including use of Early Help Assessments (EHA) and Team around the Child (TAC) meetings to address concerns arising before reaching the threshold for specialist statutory services;
- Multi agency awareness and application of thresholds;
- Timeliness of referrals to targeted and specialist services;
- The quality and timeliness of information sharing; and
- Whether it improved outcomes for children, young people and their families.

This audit further intended to inquire whether all multi agency partners are using the ‘Step up/ Step down’ process effectively to deliver intervention in a timely manner with positive outcomes for children.

There was a clear focus on impact and outcomes within the audit in line with Ofsted’s current inspection framework which should also assist with preparations for forthcoming inspections. The report will form part of the overall quality assurance summary for WSCB and fits into the overall findings from the other QA activity over the year. The overview report will be available to members of SCIL who will be responsible for developing and implementing a multi-agency action plan.

Agencies who submitted audits were as follows:

- Community Health (health visiting and school nursing)
- St Georges Midwifery
- GPs
- Children’s Social Care
- Schools (including the PRU)
- Education Welfare Service (EWS)
A few themes emerged which were across the partnership. These included:

- The importance of supervision in terms of measuring progress on the impact of the work undertaken (use of Signs of Safety tool)
- Audits have afforded the opportunity to discuss, reflect and challenge which is positive
- The relevance of including historical information when assessing families
- The importance of chronologies and case summaries when assessing risk over time
- Assessments should be more analytical and less descriptive
- There needs to be more emphasis on the child and hearing the child’s voice
- It is important to be clear about who the Lead Professional is
- The quality of TAC meeting minutes needs to be improved.

The majority of the audits concluded that the cases that had been ‘Stepped up’ were successful and led to better processes in place for the child. The reason for this is likely to be because there is a more formal structure around CIN and CP cases.

The process for ‘Step downs’ was however less clear and auditors were generally uncertain about what had happened to the child after the step down had occurred so were not confident that the process had been effective. The reason most cited for this for that was due to the lack of TAC meetings at the point of step down and therefore the lack of clarity about what the plan was. In one case the auditor considered that the step down had happened too quickly resulting in the family being referred back to statutory services.

Recommendations were:

- The WSCB to build into their training portfolio (or review if it exists) courses that build practitioners knowledge of Step up/Step down processes
- In line with the above there needs to be some clarity for practitioners about the purpose of TAC meetings, when to hold one, what the agenda should look like and who should be invited.
• WSCB to review agencies currently sitting within the MASH to incorporate a greater multi agency presence to assist in progressing referrals that do not meet the threshold for intervention from CSC.
• Agencies to consider how practice is improved to ensure that the child’s voice and issues arising from diversity and identity are captured in all assessments and plans
• The WSCB (via the Section 11 process) should require all agencies to report on the frequency and effectiveness of their supervision and management processes in ensuring that the work of front-line professionals is scrutinised and challenged
• WSCB to ensure that professionals have an understanding of consent e.g. when it is required from parents and carers before undertaking a piece of work with them.
• WSCB to review how children’s plans are currently written to ensure that they keep the child at the centre and are outcome focused

**Self Harm Audit**

Work for this was carried out during 2016-2017 and has been reported in full in April 2017. Actions will be taken forward in 2017-2018. The audit aimed to identify:

• The effectiveness of the help offered to children and their families where self harm has been identified, including use of Early Help Assessments (EHA) and Team around the Child (TAC) meetings to address concerns arising before reaching the threshold for specialist statutory services;
• The prevalence of self-harming behaviour in Wandsworth’s local community and schools?
• How agencies are responding? (*multi agency awareness and application of thresholds*)
• What services are available? (*timeliness of referrals to universal, targeted and specialist services*)
• How effective are they? (*the quality and timeliness of information sharing; and*)
• Are agencies working together?
• What are the outcomes for young people as a result of above? (*Whether interventions improves the outcomes of children, young people and their families*).
**Child Protection - Initial Conferences Audit:**

A multi-agency audit of initial child protection conferences and the quality of multi-agency engagement and reporting quality was begun in December 2016. The intention is to track the eight cases, which were selected to be as representative of the demographic profile of Wandsworth as possible, examined through their journey in the system to map out the quality of multi agency working longitudinally. This work will continue in 2017-2018

Agencies taking part included:

- St George’s Acute Trust
- Met Police Wandsworth CCG
- Secondary School
- LBW, Safeguarding Standards
- Primary School
- WSCB

Preliminary findings were:

**Attendance**

The results indicated that while meetings were all quorate, full representation by agencies is not often achieved, and key agencies may be missing – the group did recognise the challenge of responding to meetings called at short notice. Other teams, e.g. Housing, Drugs & Alcohol Service, where appropriate, should be identified and invited better enable an understanding of the care needed.

**Quality of reports**

The quality of reports was highly variable, partly perhaps as a reflection of the short timeframe for initial conferences.

**Signs of Safety**
The consistency evident from the audit’s analysis of Signs of Safety – virtually all were assessed as good - would indicate that the approach is now well embedded and working well. Not all parents exercised their right to participate.

The importance of recognising diversity particularly with families where there are children with a disability or special needs, and the cultural implications for parents was stressed by the auditors.

**Child’s voice**

Engagement of children in the conferences was generally of a good quality. In some case the age of the child, e.g. babies, makes it difficult to hear their voice directly, but here are methods of observation which can be used.

**Quality of the plan**

Quality of plans was variable, and the audit assessment was downgraded from Good to Requires Improvement in two cases where good quality plans had to be marked down because of the lack of a backup plan.

**Section 11**

Section 11 (4) of the Children Act 2004\(^\text{19}\) requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children. Working Together to Safeguard Children 2015\(^\text{20}\) states that one of the key functions of a Local Safeguarding Children Board is “monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve”. The WSCB discharges this function is by carrying out a Section 11 assessment on an annual basis.


Practitioners’ Survey

A new online process was piloted this year in response to requests from partners to ease the burden of managing high number of paper forms. 4,811 responses were received for the survey sent out in January 2017. This is a little below the 5,100 achieved in 2016. The analysis and feedback process continues into 2016-2017, and a full report will be available in September 2017. The online system using specialist survey software provided challenging to match to the aims of Section 11, which is to both quality assure and support development work with individual members of staff. Changes to the process will be made to the 2018 review, to ensure that individual services, e.g. school nurseries, get more ongoing information on response levels which proved difficult to provide with this year’s survey. Full reports have been sent out to all key agencies enabling them to feedback the findings to services or individual practitioners as appropriate. A sample of organisations were invited to meetings to discuss the findings and give feedback on the process in June 2017. A number of those welcomed the new online system, particularly as it reduced workload, but also noted that the centralised IT system made it more challenging to monitor take-up while the survey was being undertaken. This is an important aspect of process learning for 2018. They also reported that the size of the survey – 40 questions in total, while quick to complete for individuals – around 10 to 15 minutes on average – produces a very large amount of data, which can make analysis time consuming. Reducing the number of questions to pick up the key issues, e.g. ‘Do practitioners know what to do when there are concerns about the safety of a child?’ will be a priority for 2018.

Section 11: Breakdown of responses by organisation/sector

<table>
<thead>
<tr>
<th>What type of organisation do you work for?</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 School - Primary/Nursery</td>
<td>29.7%</td>
<td>1431</td>
</tr>
<tr>
<td>2 School – Secondary</td>
<td>5.0%</td>
<td>242</td>
</tr>
<tr>
<td>3 School – Special</td>
<td>3.0%</td>
<td>142</td>
</tr>
<tr>
<td>4 School – Independent</td>
<td>13.7%</td>
<td>661</td>
</tr>
<tr>
<td>5 Education – College/FE</td>
<td>0.6%</td>
<td>29</td>
</tr>
<tr>
<td>6 Education – other</td>
<td>2.0%</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Service Details</td>
<td>Percentage</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>7</td>
<td>Police – Wandsworth Borough</td>
<td>3.1%</td>
</tr>
<tr>
<td>8</td>
<td>Police – CAIT etc.</td>
<td>0.0%</td>
</tr>
<tr>
<td>9</td>
<td>Police – other</td>
<td>0.2%</td>
</tr>
<tr>
<td>10</td>
<td>Probation – National Probation Service</td>
<td>0.2%</td>
</tr>
<tr>
<td>11</td>
<td>Probation – Community Rehabilitation Company</td>
<td>0.0%</td>
</tr>
<tr>
<td>12</td>
<td>Faith group</td>
<td>0.2%</td>
</tr>
<tr>
<td>13</td>
<td>Voluntary/Community Sector Organisation</td>
<td>0.7%</td>
</tr>
<tr>
<td>14</td>
<td>Sports Club</td>
<td>0.1%</td>
</tr>
<tr>
<td>15</td>
<td>Culture – arts/theatre/music etc.</td>
<td>0.1%</td>
</tr>
<tr>
<td>16</td>
<td>Health – Acute Trust</td>
<td>0.8%</td>
</tr>
<tr>
<td>17</td>
<td>Health – Adult Mental Health services</td>
<td>0.1%</td>
</tr>
<tr>
<td>18</td>
<td>Health – CAMHS</td>
<td>0.2%</td>
</tr>
<tr>
<td>19</td>
<td>Health - GP</td>
<td>5.6%</td>
</tr>
<tr>
<td>20</td>
<td>Health – Community Services</td>
<td>0.8%</td>
</tr>
<tr>
<td>21</td>
<td>Children’s Services - Early Years Intervention and Support Service</td>
<td>1.0%</td>
</tr>
<tr>
<td>22</td>
<td>Early Years Sector - Full Daycare Settings</td>
<td>10.9%</td>
</tr>
<tr>
<td>23</td>
<td>Children’s Services – MASH</td>
<td>0.1%</td>
</tr>
<tr>
<td>24</td>
<td>Children’s Services – Children in Need</td>
<td>0.1%</td>
</tr>
<tr>
<td>25</td>
<td>Children’s Services – Children Looked After</td>
<td>0.2%</td>
</tr>
<tr>
<td>26</td>
<td>Children’s Services – Family Recovery Project/Troubled Families</td>
<td>0.2%</td>
</tr>
<tr>
<td>27</td>
<td>Children’s Services – Education Inclusion Service</td>
<td>0.6%</td>
</tr>
<tr>
<td>28</td>
<td>Children’s Services - Family Information Service</td>
<td>0.0%</td>
</tr>
<tr>
<td>29</td>
<td>Children’s Services - Special Needs/Disabled Children</td>
<td>0.4%</td>
</tr>
<tr>
<td>30</td>
<td>Children’s Centre</td>
<td>1.0%</td>
</tr>
<tr>
<td></td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Cafcass</td>
<td>0.0%</td>
</tr>
<tr>
<td>32</td>
<td>Local Authority - Housing</td>
<td>1.1%</td>
</tr>
<tr>
<td>33</td>
<td>Local Authority - Leisure/Culture</td>
<td>0.2%</td>
</tr>
<tr>
<td>34</td>
<td>Local Authority - other</td>
<td>0.2%</td>
</tr>
<tr>
<td>35</td>
<td>Libraries</td>
<td>1.8%</td>
</tr>
<tr>
<td>36</td>
<td>Adult Services – Social Care</td>
<td>0.1%</td>
</tr>
<tr>
<td>37</td>
<td>Leisure provider</td>
<td>0.5%</td>
</tr>
<tr>
<td>38</td>
<td>Early Years Sector - Sessional Nurseries</td>
<td>3.6%</td>
</tr>
<tr>
<td>39</td>
<td>Health - private provider</td>
<td>0.1%</td>
</tr>
<tr>
<td>40</td>
<td>Health - other</td>
<td>0.3%</td>
</tr>
<tr>
<td>41</td>
<td>Schools - Pupil Referral Unit</td>
<td>1.5%</td>
</tr>
<tr>
<td>42</td>
<td>Health - Clinical Commissioning Group</td>
<td>0.8%</td>
</tr>
<tr>
<td>43</td>
<td>Early Years Sector - Childminders</td>
<td>1.2%</td>
</tr>
<tr>
<td>44</td>
<td>Early Years Sector - Play Groups</td>
<td>0.2%</td>
</tr>
<tr>
<td>45</td>
<td>Early Years Sector - Independent School Nurseries</td>
<td>3.7%</td>
</tr>
<tr>
<td>46</td>
<td>Early Years Sector - Afterschool/Holiday Clubs</td>
<td>0.6%</td>
</tr>
<tr>
<td>47</td>
<td>Children’s Services - Safeguarding/Quality Assurance</td>
<td>0.4%</td>
</tr>
<tr>
<td>48</td>
<td>Other (please specify):</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

The table above demonstrates that response levels were excellent in education and the early years sectors, but less so for others, for example, the Voluntary and Community Sector, this will be an important aspect of the Engagement Plan the Board is looking to develop in 2017-2018, as the line of communication with these groups need improvement. The survey is more aimed at practitioners outside Children’s Services, where safeguarding is an integral part of professionals” roles, and feedback indicates that they struggle to find the relevance of some of the questions in Section 11.
Key questions

- **Have you read and understood your organisation’s local safeguarding policies and procedures?** 95% answered ‘In the previous year’
- **Do you know who the designated/named safeguarding children lead in your organisation is?** 97% answered: ‘yes.’
- **If you have safeguarding concerns about a child or young person, when would you report it to the safeguarding person for your school/organisation/setting?** 98% said: ‘As soon as practically possible, that day’
- **When should a referral be made to MASH?**
  - When a professional/colleague has harmed a child or put a child at risk: 69.0%
  - When a parent/family member has harmed a child or put a child at risk: 90.4%
  - When a student/volunteer has harmed a child or put a child at risk: 66.8%
  - When a neighbour has harmed a child or put a child at risk: 78.7%
  - When an owner/senior manager/director/governor has put a child at risk: 65.2%

- **What types of concerns does the LADO team investigate?** 92% said: ‘When a professional/colleague has harmed a child or put a child at risk’.

- **When sharing information about a child safeguarding concern which one of the following statements describes what you should do?**
  93% said: ‘If I am concerned about a child and have decided to share information, the information I share must be accurate, relevant, proportionate and shared with the correct agency via an appropriate secure method of sharing information’.

- **Would you feel confident to use a ‘whistleblowing’ process in your organisation if you felt it was necessary?** 91.6% said yes.

- **Which is the most important question to ask adult clients with regard to child safeguarding?**
  - Are you working?: 1.1%
  - Do you have any caring responsibilities for any child?: 83.6%
  - Have you suffered Domestic Abuse?: 7.5%
  - Are you alcohol dependent?: 7.9%

- **When was the last time you attended child safeguarding training?**
  - Within the last year: 79.2%
  - Within the last 3 years: 13.4%
More than 3 years ago
Never/don’t know/can’t remember

2.4%  5.0%

The responses indicate an overall very encouraging level of awareness of safeguarding across the range of services to children and families in Wandsworth, particularly the vital question of their knowledge of what to do when there is concern about a child.

**Strategic Survey**
In May 2017, a ‘Strategic Questionnaire was sent to all agencies asking for a self-assessment of safeguarding practice under each of the eight standards of Section 11 and to provide executive level signoff of that statement. This runs concurrently and complements the practitioners’ survey and is therefore reported here. So far 76 agencies, including schools, police, health, children’s services, leisure providers, have made a return and more will be encouraged to complete. All agencies were asked if practice either Met, Partially Met or Not Met each standard, and to assure the WSCB that where actions were required to meet the standards they place to make improvements. Equally all agencies were required to assure that, if requested, evidence is available to support the self-assessment.

Responses so far indicate a high level of reported compliance with Section 11 standards:

- 86.5% - Met
- 13.0% - Partially Met
- 0.0% - Not Met

<table>
<thead>
<tr>
<th>Standard 1: Senior management commitment to the importance of safeguarding and promoting children’s welfare</th>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>94.7%</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Not Met</td>
<td>0.0%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Partially Met</td>
<td>5.3%</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Standard 2: A clear statement of the agency’s responsibility towards children is available**
<table>
<thead>
<tr>
<th></th>
<th>Met</th>
<th>Partially Met</th>
<th>Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>93.4%</td>
<td>6.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Partially met</td>
<td>89.5%</td>
<td>10.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not Met</td>
<td>75.0%</td>
<td>22.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Met</td>
<td>86.8%</td>
<td>13.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Partially met</td>
<td>89.3%</td>
<td>10.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not Met</td>
<td>75.0%</td>
<td>22.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Met</td>
<td>86.8%</td>
<td>13.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Partially met</td>
<td>89.3%</td>
<td>10.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not Met</td>
<td>75.0%</td>
<td>22.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Met</td>
<td>86.8%</td>
<td>13.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Partially met</td>
<td>89.3%</td>
<td>10.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not Met</td>
<td>75.0%</td>
<td>22.4%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Standard 3: A clear line of accountability within the organisation for work on safeguarding and promoting the safeguarding of children**

- Met: 93.4%
- Partially met: 6.6%
- Not met: 0.0%

**Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children & families**

- Met: 89.5%
- Partially Met: 10.5%
- Not Met: 0.0%

**Standard 5: There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency’s primary functions, in contact with children and families**

- Met: 86.8%
- Partially Met: 13.2%
- Not Met: 0.0%

**Standard 6: Safer recruitment procedures including vetting procedures and those for managing allegations are in place**
Detailed table for Standard 7:

<table>
<thead>
<tr>
<th>Category</th>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88.2%</td>
<td>10.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Met</td>
<td>67</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Partially Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detailed table for Standard 8:

<table>
<thead>
<tr>
<th>Category</th>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>85.5%</td>
<td>14.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Met</td>
<td>65</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Partially Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case Reviews

Serious Case Reviews

In 2016-2017 the WSCB continue to finish off the improvement work arising for the Kingston Action Plan, for example, see Children with disabilities and special educational needs above.

In July 2016 the WSCB SCIL committee met and recommended to the Independent Chair of the WSCB that a Serious Case Review should be initiated into the case of a young child seriously harmed. This review concluded in May 2017, although the report could not be published for

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legal reasons. The focus of the SCR was always on identifying learning and this has already been applied to aspects of the Board’s work and multi agency practice, subject to the restrictions identified above. It is expected that the Board will be able to fully report on the SCR during 2017-2018.

In September 2016 the SCIL Sub-Committee was notified of an independent learning review to be commissioned into serious concerns about the care of children from a Wandsworth family. This review did not commence until May 2017 following issues with contracting an appropriate independent reviewer. This will report in the Autumn of 2017 and learning picked up by the relevant agencies. While this review does not meet the criteria in Working Together 21-5 for an SCR, it is still receiving a full and robust independent review on behalf of the WSCB
10. WSCB dataset and performance management

Dataset Revision 2016-17
The WSCB dataset has undergone significant review in 2016-17, overseen by the WSCB PIXI Panel. The full dataset at Appendix 16 has been streamlined from 152 Performance Indicators to 120, removing those PIs which were not realistically possible to collect effectively while making sure that all areas of the Board’s monitoring duties are represented.

Specific data is also reported to the Monitoring Subcommittee regularly on a cycle of annual or more frequently reporting, e.g. Child Protection data – see 8 above - is reported quarterly – this data also goes to the Executive Board.

Revised Dataset for 2017-2018:
A new dataset for 2017-2018 has also been under construction and will be reported in future WSCB annual reports. This will involve a number of important principles:

- Good demographic data, including from the Health & Wellbeing Board Joint Strategic Needs Assessment (JSNA)
- More narrative/commentary
- Outcomes data – measuring impact of services by surveying methodologies
- Working with neighbouring boroughs to coordinate data collection, particularly as many partner agencies are combining or plan to combine during 2017-2018, e.g. health agencies, police.
- Simplifying data collection for partner agencies by use and combination of existing agencies datasets:
- Improvement Board dataset. The WSCB or it successor will be expected to pick up this dataset, which has been revised for 2017-2018, at the stage when the Improvement Board hand over full responsibility for safeguarding. It presents a smaller and more focused set of indicators for Wandsworth Children’s Services.
- Housing data – this has been revised.
- Health indicators – These are likely to undergo thorough review with the changes happening in the Clinical Commissioning Group
- Police and community safety data – Most data is collected centrally by the Metropolitan Police Service, and there have been problems since 2015 with provision of data to LSCBs. A new MOPAC Police & Crime Plan dashboard is being constructed which will include
- A range of indicators covering areas which the Board is required to mentor statutorily, including:
Private fostering – numbers are low, so this is an indicator that requires more challenge, and is not in the Improvement Board dataset.

- Young people Not in Education, Employment or Training (NEET).
- Child Sexual Exploitation data
- Female Genital Mutilation
- Young Carers data – number engaging with commissioned services?
- Children Missing from Education
- Youth Offending data
- Early Help – particularly the number of children ‘stepped down’ to Team Around the Child services which has proved hard to retrieve previously. A new IT system in Children’s Services may provide more detailed data.
- Team Around the Child - The WSCB will be looking to find a way to assess some information by proxy, e.g. how many children on GP lists are regarded as safeguarding risks or vulnerable families.

The WSCB needs to get beyond data and audit to performance assessment and scrutiny, which requires an holistic approach viewing and quality assuring outcomes for: the experience of the child, the experience of families and the experience/ effectiveness of multi-agency practice. The aim will be to draw upon the learning and encourage/ broker practice development.

With the support of the Board chair, a complete rethink of the data needs of the Board has begun. This has meant looking at the current data set as well as the set currently provided to the Improvement Board. A view has also been taken of what the Board should be provided with to demonstrate, (with regard to all children in the borough), that it is monitoring:

1. The child safeguarding, (as well as the child protection) needs of the Borough
2. The interventions that are in place to improve wellbeing and protection
3. That the right outcomes are being achieved for all

Derived from these questions there are a number of secondary inquiries that fill out the context of each main question. Behind this process is the expectation that the work of the Board will be to challenge and influence partners to build and maintain positive relationships with their charges. And where it is apparent that such relationships are not being developed, challenge will follow based on the premise that no safeguarding work is effective without the development and maintenance of durable positive relationships.
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Partner Agencies Reports

As part of the process to produce the WSCB’s annual report, each statutory partner agency was asked to complete a report, using a template provided by the WSCB. The report therefore includes not only the work of the safeguarding board itself, but a summary of the work undertaken by all partners to promote safeguarding children during the past year. Each agency was asked to provide a rigorous and transparent assessment of the performance and effectiveness of their service; and to identify areas of weakness, the causes of the weakness and actions being taken to address them as well as proposals for action.

All key statutory partner agencies reports are included in this report and are within the appendices (published separately).