COVENTRY SAFEGUARDING CHILDREN BOARD

Annual Report 2013/2014

Coventry Partnership

Working Together to Safeguard Children

www.coventrylscb.org.uk

Contents

Page

Section 1 – Structure of the 2013-2014 Annual Report 3
1.1 Foreword by Independent Chair 3
1.2 Executive summary – including the Ofsted review and the Daniel Pelka Serious Case Review 5
1.3 Children in Coventry 7

Section 2 - Governance and accountability arrangements 10
2.1 Role, function and structure of the LSCB 10
2.2 Relationship to key personnel and other strategic bodies 10
2.3 Board Structure 11
2.4 Membership and attendance of the LSCB 11
2.5 Managing Resources and capacity 13

Section 3 - Core LSCB Business 14
3.1 Board priorities and progress 14
3.2 Policy procedures and guidance 20
3.3 Training provision 21
3.4 Quality and effectiveness of local practice 24
3.5 Section 11 audit (including Schools Audit) 26
3.6 Partner agency contribution to safeguarding children 27

Section 4. Effective challenge in specific safeguarding circumstances 36
4.1 Multi-Agency Safeguarding Hub (MASH) 36
4.2 Private fostering 36
4.3 Looked after children 37
4.3 Permanence 38
4.5 Bullying 39
4.6 Management of allegations against people who work with children and young people 39
4.7 Missing children 42
4.8 MARAC 44
4.9 MAPPA 44
4.10 Hospital admissions 44
4.11 Police protection powers 45

Section 5 - Priorities going forward for 2014-15 46
Appendix One – Structure Chart 47

Section 1

Introduction to the 2013-14 ANNUAL REPORT

1.1 Forward from Amy Weir, Independent Chair

Purpose of this report

As the Independent Chair of the Local Safeguarding Children Board (LSCB), I am required to compile an annual report on the effectiveness of child safeguarding and the promotion of the welfare of children in Coventry.

Once published the annual report is submitted to Coventry City Council's Chief Executive, the Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. The national requirements of the report (Working Together 2013 - Department for Education) are that:

- The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the year 2013/14.
- The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective.

Introduction

This has been an exceptionally challenging and difficult year for everyone who works in services for children in Coventry. During the period of this report there were three highly significant events which had a major impact on the work of the LSCB; these events – the Peer Review, the publication of the Daniel Pelka Serious Case Review and the Ofsted inspection of children's safeguarding and review of the functions of the LSCB are described below.

Chair's commentary on the performance and effectiveness of local services

There is much to be positive about in relation to the LSCB's activities in 2013/14, as can be seen within the report. However, serious concerns about the effectiveness of the local safeguarding system emerged during the year culminating in an inadequate judgement from Ofsted in March 2014. As a result, Coventry is now on a Ministerial Improvement Notice and has an Improvement Board in place with an Improvement Plan for both children's services and the LSCB.

At the beginning of the year 2013, an independent Peer Review of children's services and safeguarding was completed. This identified significant gaps in the provision of early help for children and families in Coventry as well as the need to improve some specific elements of the safeguarding system. From the Peer Review, the LSCB was asked to bring all the partner agencies together to seek to identify the gaps and to ensure that partners improved the coordination and delivery of early help for children and families. As part of this process, the LSCB commissioned an independent review of the "child's journey" through services in Coventry. This identified again that services needed to work more closely together particularly at the earliest stage to prevent further problems.

The death of Daniel Pelka in March 2012 and the final trial of his mother and step-father in August 2013 have been very distressing for all those involved in children's services in Coventry. The Serious Case Review was published in September 2013 with significant national and local media interest. A further Deeper Analysis Report was required by the Children's Minister, Edward Timpson and this was published in December 2013.

Both of these documents identified several areas for improvement and they are on the Coventry LSCB website.

The LSCB has sought to ensure that all the recommendations from both the Peer Review and the Daniel Pelka Reviews have been implemented in a timely way. It has proved more difficult to demonstrate that there has been the required impact from the changes made and the action taken. This has been a challenge for the Board and its constituent partners. There was public acknowledgement of the need for significant changes to be made.

However, the pace of improvement has not been sufficient. This became clear from the findings of the Ofsted single inspection of children's services and the review of the LSCB in February 2014. Difficulties and failures were identified within the local safeguarding systems by Ofsted through its inspection. The LSCB and all the local agencies have publicly acknowledged the need for improvement and their determination to do all that is required to make a difference.

Whilst the overall Ofsted evaluation of the LSCB was inadequate, some positive practice was also identified by Ofsted which is also set out in this report.

Resourcing and capacity of the LSCB

The LSCB has struggled throughout the year to cope with the volume of work it has had to complete. Although several partner agencies contribute not only financially but in kind through giving staff time, the level of activity particularly in relation to the management of serious case reviews has placed considerable strain on the system. Ofsted raised this paucity of resources as a concern during the review of the LSCB. A review is being carried out by the LSCB partners to reconsider what the contributions of partners should be and how the LSCB can be better resourced.

Assurance statement

I am required as the LSCB Independent Chair to assess and evaluate the effectiveness of all the local safeguarding arrangements in Coventry. The LSCB is not directly responsible for providing safeguarding services but it is responsible for ensuring that its constituent partners work separately and together to keep children safe. Since there have been recent serious concerns raised by Ofsted about the effectiveness of these local services in Coventry, I have to qualify the assurance I can give.

It is clear that there are weaknesses and improvements required not only within local safeguarding arrangements but also in the LSCB's capacity to ensure and test whether services are effectively safeguarding children. The weaknesses and the causes of those weaknesses have been identified by Ofsted and accepted by the LSCB and its constituent partner agencies. As you will see in this report, the Board is generally well-attended and partners are clear in their commitment to change. There is no complacency about how much improvement is required and strong action is already underway to address the deficiencies.

The conclusion from the LSCB's away day in May 2014 was that the LSCB MUST find a way to demonstrate a decisive shift to a more integrated approach. The next few months will be crucial for the Board as partners work together to deliver the fundamental improvements needed, and it will continue to be vital for all partners to remain honest and transparent with Coventry residents, government and the media about the challenges that still need to be tackled.

Amy Weir MA MBA
Independent Chair
July 3 2014

1.2 Executive summary

Assessment of the performance and effectiveness of local services

There is much to be positive about in relation to the LSCB's activities in 2013/14 as seen within the body of this report. The Ofsted Review also identified several areas of positive practice and achievement across the year. Key developments included:

- Improvements to raise awareness amongst children, young people and professionals of the nature and extent of issues for missing children and those at risk of Child Sexual Exploitation.
- The LSCB has consulted with young people to inform the development of some individual projects, for example, involving young people in the development of a leaflet to raise awareness of child sexual exploitation and of children's experiences informing training, for example in relation to Female Genital Mutilation and Forced Marriage.
- The Board has developed and monitored a range of multi-agency procedures, including the threshold document and inter-agency safeguarding procedures. A set of supervision standards have been developed and are currently being rolled out within agencies across the partnership.
- A range of staff across the agencies attended and gave positive evaluations of the training and learning opportunities that were provided. A comprehensive multi-agency training programme has been delivered by the LSCB during the past twelve months. This has covered a broad range of safeguarding issues (see Training Provision, page 21.)
- This year 1,918 professionals have received multiagency training - over double the amount in the previous year of 984 professionals. This is linked to a high number of additional specialist courses and events being delivered to meet the needs of the workforce in Coventry.
- The LSCB conference on domestic violence and early help in line with the LSCB priorities was extremely well attended with over 100 practitioners and managers across Coventry attending. The feedback was positive about how the learning will be used with children and families. Learning from serious case reviews has also been widely disseminated to a range of 120 professionals through training workshops, with further sessions planned. In addition key messages and learning are being disseminated through leaflets and posters across the partnership.
- There has been more focus on safeguarding in schools during 2013/14. Learning from serious case reviews has been incorporated into the safeguarding training programme for schools. The Safeguarding of Children in Education Subgroup monitors education staff's attendance at LSCB training and briefing events and provides follow-up briefings for those not present. The LSCB has audited all schools to ensure compliance with the recommendation from a recent serious case review that schools ensure a robust system exists for the recording of injuries or concerns about a child, that staff are clear about the role of the designated teacher and that this role is used appropriately.
- The LSCB has been involved in some significant developments regarding the sharing of information throughout the past 12 months. It has improved aspects of information sharing between the police and schools, and a system of electronic sharing of all domestic violence notifications from the police to all schools is now established. This information includes specific guidance on what action schools should take to promote the welfare of children, and is leading to increased take up of the Common Assessment Framework by schools and some good outcomes for children.
- The LSCB has also been working in partnership with Warwickshire Safeguarding Children Board to engage faith groups and voluntary organisations across both areas to ensure that their staff have a full understanding of their safeguarding responsibilities and know what to do if they have concerns about risks to children.

Challenges facing the Board during 2013-14

However, serious concerns about the effectiveness of the local safeguarding system emerged during the year. These included the issues highlighted by

the Peer Review which took place in March 2013, the findings and recommendations arising from the Daniel Pelka review, published in September 2013, and the findings of the Ofsted single inspection of children's services and the review of the LSCB in February 2014.
The independent peer review of children's services and safeguarding identified significant gaps in the provision of early help for children and families in Coventry as well as the need to improve some specific elements of the safeguarding system. Arising from the peer review, the LSCB brought all partner agencies together to identify and close the gaps and to ensure that partners improved the coordination and delivery of early help for children and families. As part of this process, the LSCB commissioned an independent review of the "child's journey" through services in Coventry. This further identified the need for services to work more closely together particularly at the earliest stage to prevent additional problems.

Daniel Pelka

The death of Daniel Pelka in March 2012 and the subsequent criminal trial of his mother and step-father in August 2013 was very distressing for all those involved in children's services in Coventry. The Serious Case Review was published in September 2013 with significant national and local media interest. A further deeper analysis report was required by the Children's Minister, Edward Timpson which was published in December 2013. Both of these documents are on the Coventry LSCB website (see section on Serious Case Review for more detail).

The LSCB has sought to ensure that all the recommendations from both the peer review and the Daniel Pelka reviews have been implemented in a timely way. It has proved more difficult to demonstrate that there has been the required impact from the changes made and the action taken. This has been a challenge for the Board and its constituent partners. There has been public acknowledgement of the need for significant changes to be made.

The Ofsted review of the LSCB's effectiveness

However, the pace of improvement has not been sufficient. This became clear from the findings of the Ofsted single inspection of children's services and the review of the LSCB in February 2014. Ofsted identified difficulties and failures within the local safeguarding systems.
Ofsted found that *"the LSCB is not effective in ensuring that partners always work together effectively to ensure safeguarding arrangements safely reduce risk for all children identified as needing assessment, support and intervention. Insufficient progress has been made in some aspects of multi-agency working between the police, children's social care and health, particularly at an early stage, when children's needs are first identified."* Ofsted Report March 2014.

The main areas of concern raised by Ofsted were:

- Concerns with regards to the capacity of the service to manage the volume of work in children's social care have been known for some time and were highlighted in the Local Government Association (LGA) review of children's services in March 2013.
- Domestic abuse notifications were not all jointly screened between social care and the police at the time of the inspection to ensure that there was timely sharing of information to assess risk for children.
- The police do not routinely attend all child protection discussions or strategy meetings with social care managers. Police do not attend all initial child protection conferences nor do they always provide reports when these are required. These factors result in delays in information sharing and appropriate decision making to ensure children are safe.
- When children and families experience problems and need help, support is not always sufficiently targeted or co-ordinated. The early help and intervention strategy has recently been agreed but is not yet fully implemented. Not all partners are fully engaged in the early help offer, for example, health visitors undertake very few common assessments. Schools report that this results in many children entering education without their needs having been fully addressed and this affects their learning. The lack of a coordinated early help offer has a significant impact on services as problems escalate and this contributes to the increasing levels of referrals to children's social care.

- Not all children who go missing from home and education receive a return interview to ensure that they have the support they need to keep them safe.

- Linkages between the Health and Well Being Board, the Coventry Safeguarding Children Board and the Joint Commissioning Board are not yet well embedded although work is in progress to establish clear reporting and accountability.

Four areas for priority and immediate action and two areas for improvement were identified by Ofsted for the LSCB. These were discussed at the LSCB away-day in May 2014 and they are reflected in the LSCB priorities for 2014/15 which are set out at in this report. They have also informed the Improvement Plan.

Priority and immediate action

1. Ensure that partners, including children's social care, health and police, fulfil the responsibilities for their roles as set out in Working Together to Safeguard Children (Department for Education, 2013) to ensure that effective practices are in place to safeguard and promote the welfare of children in Coventry.

2. Ensure that there is a timely response from partners to actions identified in serious case reviews, and that this results in an improvement in outcomes for children.

3. Ensure that all partners are fully engaged in the delivery of the Prevention and Early Intervention Strategy, so that children and their families have timely access to early help support.

4. Ensure the practice and quality assurance sub-group utilise all information available, including audit findings and performance management information, to undertake a robust analysis of the effectiveness of services to help and protect children.

Areas for improvement

5. Ensure young people's views routinely inform service improvement

6. Promote awareness of private fostering to ensure that more privately fostered children and young people are identified and supported.

An Improvement Plan for the LSCB has been developed but falls outside the timeframe of this Annual Report. This will be monitored by the Department of Education to ensure the required progress is made to improve the effectiveness of local children's services and the functioning of the LSCB.

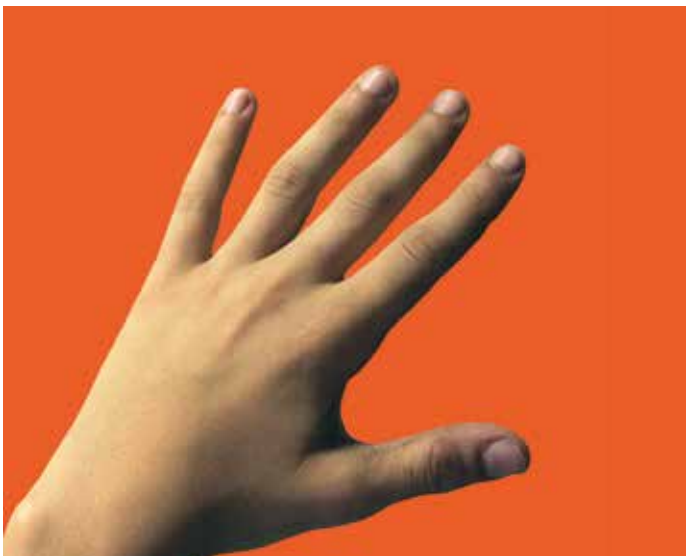
1.3 Children in Coventry

There are currently approximately 70,500 children and young people on Coventry aged 0-17 out of a total population of 316,900 (22%). This includes 13,900 children under three years old. (Source: mid 2011 Census based population estimates, Office for National Statistics). Recent years have seen a significant increase in the birth rate from approximately 4,000 per year in 2005 to approximately 6,000 a year in 2012 and 2013. We have also seen immigration into the city which is further increasing the population. Approximately 39% of children living in Coventry are from minority ethnic groups (as compared to 26% nationally). There are over 100 languages spoken in Coventry. The proportion of children and young people with English as an additional language is as follows (source: Jan 2013 School Census):

- in primary schools it is 28.7% (the national average is 18%)

- in secondary schools it is 25.1% (the national average is 14%)

- in special schools it is 19.2%



There remain high levels of deprivation across the city and significant differences across the city in health outcomes and life expectancy. Coventry has been designated a Marmot city and is actively striving to close these gaps. As a Marmot city, Coventry is one of seven councils in the country signed up to a national initiative aimed at tackling health inequalities. Coventry also has the highest rate of reported domestic violence in the West Midlands. These factors have contributed to an increasing level of activity in the social care system relating to safeguarding as shown in the table below:

	Total for 13/14	Total for 12/13	England average rates 12/13	West Mids average rates 13/14
Contacts – total number	22197	19466	Not published	Not collected
Referrals – rate per 10000	845.4	654.1	520.7	Not available
Strategy meetings – number of meetings held	2506	1392	Not published	Not collected
Section 47 enquiries – rate per 10000	260.3	127.5	111.5	Not collected
Children on Child protection plans – rate per 10000	108.1	72.9	37.9	44.7

The increase in activity has increased the numbers of open social care cases and this has presented challenges in terms of caseloads for social workers. Approximately half of the children on child protection plans as at the end of March 2014 were on a plan as a result of emotional abuse. This is a higher proportion than that nationally (34% in March 2013) and may relate to contextual factors around deprivation or to the high reported rate of domestic violence. The higher than national proportion of unborn children on a protection plan indicates proactive work to protect children as early as possible.

Abuse Category	Count	%	Coventry 2012/13	England 2012/13
Emotional Abuse	374	51.0%	48.7%	34.1%
Neglect	233	31.7%	33.1%	41.7%
Physical Abuse	70	9.5%	6.6%	9.9%
Sexual Abuse	57	7.8%	11.2%	4.7%

Age Group	Count	%	Coventry 2012/13	England 2012/13
Unborn	33	4.5%	4.0%	2.0%
Under 1	77	10.5%	9.2%	11.3%
1-4	216	29.4%	29.3%	30.3%
5-9	248	33.8%	28.7%	28.7%
10-15	136	18.5%	24.7%	25.2%
16-17	24	3.3%	3.9%	2.6%

Assessment protocol, frameworks and outcome

The increase in volume entering social care during the year has had a negative effect on the timeliness of assessments. Children's Social Care adopted a single assessment in July 2013 and this included a specific reference to multi-agency checks as part of the assessment form to embed this practice. Audits during the autumn of 2013 were collated into a report and from these audits 55% were rated green for the multi-agency assessment. Further improvement work is underway to improve the timeliness of assessments with an aim of delivering at least 90% on time.

Total Numbers of Looked After Children have increased during the year

As at the end of February our LAC rate per 10,000 children was 90.9. This compared to 87 as at the end of March 2013 and a national rate of 60 per 10000. It would be expected that our rates would be higher than national averages owing to the demographics of the city. Latest comparative data from our statistical neighbours will be available in the autumn of 2014.

264 children and young people entered care in the 11 months up to the end of February 2014. Of these children and young people, 83% of them entered care owing to abuse or neglect. This compares to 57% of entrants across England during the 2012-13 year. The high proportion in Coventry mirrors the high proportion of children and young people on child protection plans.

Section 2

Governance and Accountability Arrangements

2.1 Role, function and structure of the LSCB

Local Safeguarding Children Boards were established under the Children Act 2004 (section 13 and 14) requiring each local authority to set up a partnership board with the aim of having a partnership body in place to coordinate and help ensure the effectiveness of safeguarding children arrangements in the local area. It also specifies which key organisations and individuals must be represented on each board.

All LSCBs must be independent in order to provide effective scrutiny of local safeguarding arrangements. It should also have an independent chair that will support partnership working and hold agencies to account. The core functions of LSCBs as set out in Working Together 2013 (Home Office) are reflected in the core activity carried out by LSCB.

In establishing its priorities, the Board considered Serious Case Review findings, the effectiveness of local safeguarding arrangements, the revised Working Together 2013 guidance, the developing national agenda, recent audits carried out on safeguarding and child protection processes and recommendations made by the peer review which took place in March 2013.

The Board compiled a business plan for detailing the actions it will take primary responsibility for (progress can be found in section 3), with specific priorities for 2013-14 being:

1. Embed learning from recent serious cases
2. Challenge the effectiveness of early help
3. Work together to tackle child sexual exploitation
4. Improve multi-agency responses to domestic abuse
5. Challenge practitioners to listen to/see the needs of the child

2.2 Relationship to key personnel and other strategic bodies

These arrangements are being reviewed following the Ofsted inspection in February 2014. The arrangements for 2013/2014 were as follows:

Chief Executive Coventry City Council

In accordance with Working Together 2013, the LSCB Chair links with and meets regularly with the Chief Executive. There is at least monthly contact. There has been particularly intense involvement over the last few months related to the Daniel Pelka SCR including managing media and communications. The Chair's communication with Department for Education (DfE) has been shared with the Chief Executive and the Director Children's Services (DCS).

The Chair and Chief Executive have also met with the chief executives of the key local agencies for safeguarding – West Midlands Police, University Hospital Coventry and Warwickshire (UHCW), Coventry and Warwickshire Partnership Trust (CWPT), Coventry and Rugby Clinical Commissioning Group (CCG), NHS England to agree a joint strategy for handling the serious case review. Following this, it was agreed that this meeting would take place annually.

Executive Director (DCS)

The DCS is a member of the LSCB and regular contact take place between the DCS and LSCB Chair.

Lead (Cabinet) Member

The Lead Member is a participant observer of the LSCB. The shadow Cabinet Member for children is also a participant observer of the LSCB. Both regularly attend board meetings.

Leader of the Council

The Chair and the Leader of the Council meet regularly and communicate at least quarterly.

Scrutiny Board

There is regular, positive contact between the Scrutiny Board and the LSCB both formally and informally. The LSCB has reported into scrutiny at least quarterly over the last year.

The LSCB Annual Report is reported to the Scrutiny Board annually.

There have been three dedicated meetings to review and challenge progress on the Daniel Pelka SCR recommendations. An independent consultant was commissioned by the LSCB to meet with all partners and to deliver a regular report to Scrutiny on behalf of the LSCB partners. The last update will be produced by early July 2014.

Children's Joint Commissioning Group

The LSCB Chair is a member of this group to ensure that there is an awareness of service developments and that safeguarding is appropriately considered.

Health and Wellbeing Board

The Annual Report for the LSCB 2012/13 was presented to the HWB, the Annual Report will be considered each year. A number of senior representatives are members of both the LSCB and HWB and provide linkages between the two.

Next steps

A formal protocol outlining accountabilities and linkages has been requested by the Improvement Board, this will be completed by August 2014.

2.3 Structure chart – Appendix One

2.4 Membership and attendance of LSCB at March 2013

Number of meetings held within the year: 7

AGENCY	Attendance % for Board Member/ Deputy	Comments
MEMBERS		
Independent Chair, LSCB	100% 7/7	
Executive Director, People, Coventry City Council (previously Director of Children, Learning and Young People)	71% 5/7	
Deputy Director, Strategy & Communities, People, Coventry City Council	80% 4/ 5	Member since September 2013
Assistant Director, Children's Social Care, Targeted and Early Intervention, People, Coventry City Council	100%	7/7
Director, Education & Inclusion, Coventry City Council	100% 3/3	Member since January 2014
Chief Nursing Officer, Coventry & Rugby Clinical Commissioning Group, NHS	100% 7/7	
Executive Director of Nursing and Quality, Coventry & Warwickshire Partnership Trust, NHS: substitute attended the two other meetings.	71% 5/7	

Associate Director of Nursing (Women & Children's Safeguarding), University Hospitals Coventry & Warwickshire, NHS	100% 7/7	
Director of Nursing, NHS England	57% 4/7	
Chief Superintendent, West Midlands Police	71% 5/7	
Detective Chief Inspector, Child Abuse Investigation Unit, West Midlands Police	100% 7/7	
Head of Service, Staffordshire & West Midlands Probation Service	100% 7/7	
Service Manager, NSPCC	86% 6/7	
Partnerships Officer, West Midlands Fire Service	57% 4/7	
Head of Tenancy Support, Whitefriars Housing Group	71% 5/7	
Head of Service, CAFCASS	0% 0/1	Agreement with Chair to attend 1 meeting per year
Community Lay Member	71% 5/7	
PARTICIPANT OBSERVERS		
Cabinet Member, Children & Young People	100% 7/7	
Cabinet Member, Education	43% 3/7	Member did not attend due to serious illness and absence from work
Shadow Cabinet Member, Children & Young People	100% 4/4	Member since November 2013
OFFICERS/ ADVISORS TO THE BOARD		
Head of Safeguarding, Coventry City Council	71% 5/7	
Business Manager, LSCB	100% 7/7	
Designated Doctor, Coventry & Rugby CCG	86% 6/7	
Designated Nurse for Child Protection, & Rugby Clinical Commissioning Group, NHS	86% 6/7	
Legal Advisor, Children & Adults Manager, Coventry City Council	57% 4/7	

2.5 Managing resources and capacity: Budget and expenditure

Budget & Income	
Coventry City Council Contribution	141,198
Government Grant	20,266
Health	44,217
Police	14,677
Probation	3,000
Connexions	1,165
Police & Health additional contribution	20,200
Training Income (including £15,000 for CSE awareness raising with young people)	29,300
Total Budget	274,023
Expenditure	
Salaries	116,192
Staff Travel costs	2,187
Independent chair of LSCB	40,955
SCR Panel , Chair & Author costs	13,076
SCR DP Deep Dive	37,223
Independent chair of SCR Subgroup	3,620
LSCB Audits	14,573
CSE awareness raising	18,338
LSCB Summit consultant	3,250
Training consultants	15,095
Room Hire, Catering costs & Running costs	11,694
IT costs	1,200
Contribution to Child Death Overview Panel	24,800
LSCB Procedures & Website	4,095
Total Expenditure	306,298
Overspend	32,275
Additional contributions from LA and partners	32,275
End of year outturn	**0**

This significant overspend is attributable to the unforeseen and unplanned activity in relation to the Daniel Pelka and other serious case reviews. Additional essential activity was also required by the Independent Chair of the LSCB in relation to this and the Ofsted inspection. The overspend was dealt with by additional contribution from the local authority and other partners. The LSCB Business Unit consists of a Business Manager, Training Officer and Administration Officer. All of the above staff are funded through the LSCB partner contributions.

The Board had undertaken to review the costs of implementing the LSCB business plan for 2012-15. This review will specify required resources and contributions. Work on this commenced in January 2014, and current resources have been mapped. This work will continue.

It is already foreseen that the 2014/15 budget may overspend and that additional resources will need to be resourced from partner agencies not only to cover this but also to fund the additional support for the LSCB which has been agreed.

Section 3

Core LSCB Business

3.1 Board progress and priorities

The board compiled a business plan for detailing the actions it will take primary responsibility for, with specific priorities for 2013-14 being to:

1. Embed learning from recent serious cases
2. Challenge the effectiveness of early help
3. Work together to tackle child sexual exploitation
4. Improve multi-agency responses to domestic abuse
5. Challenge practitioners to listen to/see the needs of the child

There was also work undertaken in December 2013 to review the operation of the board, including LSCB membership in line with Working Together 2013, in order to review and refocus the attendance, ensuring those that required to attend were doing so and that the people at the right level of seniority were attending the board. A review of roles and relationships with existing and emerging partnerships has commenced in 2014 and is a feature in the improvement plan.

This section identifies progress against those priorities

Priority 1: Embed learning from recent serious cases

Success measures: Evidence provided by board partners to show progress has been made and lessons learned. More robust processes in place to safeguard children

Reported Progress relates to: Serious Case Reviews, Case Reviews and Child Death Overview Panel.

It is now 12 months since the latest version of Working Together was published by the DFE in April 2013. Whilst the essential criteria for undertaking serious case reviews has not essentially altered, Working Together now permits different ways of undertaking reviews. It also recognises that reviews should be proportionate and influenced by the scale of the case and scoping of the terms of reference. The SCR sub-committee has met on six occasions and continued to fulfil its purpose in managing the action plan's completed serious case reviews, recommending to the chair of the LSCB whether new reviews should be undertaken and the type and scale of those reviews.

As part of its remit the serious case review sub-committee has also considered six other potential serious case reviews – not all following the death of a child; some had been following complex police operations involving child sexual abuse. It is vital that the subcommittee reviews all the available information, before making a recommendation to the chair of the LSCB. We have learned through experience that it is always better to reserve judgement until the full facts are available when recommending a course of action as important as a serious case review. It is equally important that each case is judged on its own merits and not influenced by concerns about cost or resources.

During the year one serious case review was published while two were in progress from the previous year. A further SCR was commenced towards the latter part of the year. No case reviews were undertaken this year.

The SCR for Child W was published in December 2012, and used the SCIE Learning Together process as part of a DfE pilot. Actions have all been completed but evaluation of impact will continue and will form part of the multi-agency audit programme to assess whether the learning has been embedded. The evidence of action taken was reviewed by SCR subgroup and reported to the Board to provide additional scrutiny.

Daniel Pelka was murdered in March 2012 by his mother and stepfather, who were convicted in July 2013. In line with statutory guidance a serious case review (SCR) was commissioned to investigate and analyse the circumstances into Daniel's abuse and death. In addition, the Chair of the Board and Chair of the standing SCR sub-committee were also

independent of the Council and its partners. The Daniel Pelka SCR report was published on Tuesday 17th September 2013.

To ensure impartiality and objectivity the report author, Chair of the SCR Panel and educational advisor to the SCR were all fully independent of Coventry organisations.

The SCR report made recommendations to local partners, covering a number of key topics. They were:

1. Work to improve sharing of information on domestic violence and abuse incidents, including a review of the effectiveness of the Joint Screening Process, and how this can be measured and audited.
2. Efforts to implement an effective Early Help strategy across the city.
3. The effectiveness of the social care referral and assessment process, including consultation, strategy discussions and feedback to referrers.
4. Safeguarding issues in schools, including the recording of safeguarding concerns and the extent of child protection training and expertise across the workforce.
5. Wider multi agency training on child protection themes such as emotional abuse and neglect and the lessons arising from this review.
6. Specific health issues including health visiting provision.
7. The use of interpreters to capture more effectively the voice of the child.

The publication raised significant public and media interest, both nationally and locally. The Department for Education requested more detailed analysis by the board and a further panel of independent experts was engaged to undertake this work. They reported back their findings in December 2013.

The LSCB adopted a 35-point Priority Action Plan in January 2014 to measure the impact of the work undertaken by the board and its partners to effectively implement the original report recommendations and engaged a further independent analyst to report on overall progress. There remains some concern regarding the evidence to support effective implementation of the required action. Work continues for 2014-2015 to verify the impact on local practice and evaluate the improvements made.

Key progress can be summarised as follows:

- A more timely process of sharing domestic abuse incident information is now in place and the timescales for screening and sharing to key agencies have been significantly reduced. There are no backlogs of incidents.
- Interim screening processes to determine appropriate action are functioning and work continues to develop a Coventry Multi Agency Safeguarding Hub (MASH) for commencement in Autumn 2014.
- Scrutiny of the referral and assessment process has been revised using a range of updated audit processes to address concerns raised by the review.
- Safeguarding audit of schools completed and best practice guidance has been disseminated across Coventry. Training needs for education staff have been addressed.
- Messages from the review have been embedded in both single and multi-agency training processes for frontline workers.
- Assurances have been given by health partners on the work undertaken to increase health visiting provision in the city.
- Use of interpreters in safeguarding matters has been reviewed by key partners and an LSCB protocol has been developed and agreed.
- Provision of multi-agency training around emotional abuse and neglect. Following positive evaluations, which included good examples of where the learning has been used in practice, the training will continue to be provided.

Embed learning from recent serious case reviews

There has been a range of activity taking place to embed learning from Serious Case Review. This includes: producing an easy to read summary of the three most recent SCRs undertaken in Coventry

and identifying key themes which are common in all three reviews.

This has been disseminated in a number of ways including through training, by email as part of the LSCB newsletter and forming induction programmes for new staff. In addition posters have been designed and widely circulated which are displayed in partner agency offices throughout Coventry to serve as an aide memoire of key activity they must carry out in relation to safeguarding children. These messages are directly related to learning from SCRs. It has also been shared regionally with other LSCBs who wished to replicate the format.

As mentioned above seminars have been delivered across Coventry in early 2014 by the chair of the Serious Case Review Subgroup, these workshops focused on the three recent serious case reviews. All sessions were multiagency with exception of an additional session provided for education staff to have a more in-depth session on learning from reviews.

The sessions focused on common themes in respect of how agencies responded and worked together in these cases. Participants were provided with information and material to take back to their respective agencies with an expectation that this is cascaded to colleagues to provide on-going dissemination, agencies also agreed that this learning should form part of the induction for new staff.

Participants feedback was supportive of these sessions being an effective learning method; they also found the sessions to be informative and useful for putting learning into practice. Participants liked the opportunity to share with and learn from other agencies.

Further training is also planned to take place with social workers specifically to ensure lessons are being embedded into practice and to give practitioners an opportunity to reflect on their own practice and consider how this could be improved. A further two Serious Case Reviews are due to be published at the end of June 2014; progress on actions will be reported in the following year's annual report.

Child Death Overview Panel (CDOP)

The focus for 2013-2014 continued very much on the same theme as previous years by aiming to review cases in a timely manner, finalise outstanding areas of work, progress actions arising from reviews and continually reviewing and improving the process as a whole.

In 2013-2014 Coventry Child Death Overview Panel (CDOP) met six times (five full CDOPs and one Fast Track CDOP) and reviewed 28 deaths. Fewer deaths were reviewed this year compared to the previous year due to the number of deaths subject of a coronial investigation and Inquest before the review could take place.

During 2013-2014 the following work has been completed from the reviews conducted:

- Following a death from an undiagnosed congenital heart condition, enquiries were made to ascertain if surviving siblings had been investigated for this condition.
- In the case of a young baby who died at a hospital outside the area, the health visitor conducted a home visit, unaware that the baby had died. Notification protocols were ascertained with the hospital concerned and were found to be robust. Coventry Child Health Information Service was reminded of the urgency to share such information.
- In the case of a baby who died from a life limiting condition shortly after birth, the panel considered that mother should have been on a high risk care pathway due to her previous obstetric history as opposed to a low risk care pathway and this was conveyed to the hospital concerned.
- In the case of an infant that died of Sudden Infant Death Syndrome (SIDS) CDOP referred the death to the Serious Case Review Subgroup for consideration of a serious case review due to the risk factors identified.
- The Midwifery Service and Health Visiting Service have both agreed to implement the risk assessment model developed by Derbyshire NHS related to Sudden Infant Death Syndrome (SIDS).

- Following on from the work conducted in 2012-2013 to promote the 'Headsmart' project to raise GPs awareness of brain tumour symptoms in children, CDOP reviewed a further death where a child made a number of presentations to a GP prior to diagnosis. A further opportunity was taken to raise awareness of 'Headsmart'.
- Following the retirement of Dr Miriam Wood, GP, CDOP is seeking a GP representative to join the panel which greatly benefits from having general practice expertise.
- Following the ratification of the 'Involving Families' protocol, parents are being informed of the child death review process and given the opportunity to contribute information and/or ask any questions. This has been in effect since July 2013 and is proving to be a useful process to obtain the perspective of parents.

A separate annual report has been completed for the child death review process which outlines further detail on the activity of Coventry CDOP and outcomes. This can be viewed at www.coventrylscb.org.uk

Priority 2: Challenge the effectiveness of early help

Success measures: Monitoring through the LSCB performance framework, highlighting areas of concern and further challenge. Early help meets the needs of children and families and therefore prevents these children entering into the child protection process.

Reported progress relates to: Strategy development and the use of CAF.

The Promoting Children and Young People's Well-Being group was merged with the Commissioning Board's sub group on early intervention during the year and in January the first meeting of the new Prevention and Early Help Group took place.

Meetings in the early part of the year focused on the use of CAF. In the latter part of the year, the group has made significant input into the development of the Prevention and Early Help Strategy as well as working up a baseline of current activity and how we currently perform against relevant outcomes.

The development of the strategy has helped partners create a shared definition of early help. It has been agreed that more strategic oversight of the work is required and a small strategic group will be established during 2014-15 to provide this.

Health visitors, midwifery staff and childrens' centre staff are being co-located to provide a more co-ordinated approach to children aged 0-5 in two areas of the city, within the reach areas of Hillfields and Tile Hill Children's Centres.

During the year there has been an increase in the numbers of CAFs being held by schools. Work will continue during 2014-15 to engage health partners in the completion of CAFS with children and families in Coventry. Through the group other agencies have also been encouraged to access CAF training, such as the Citizens Advice Bureau.

The Children and Family First service and Children's Centres now provide a casework response through CAF level 2 and 3. To date this year, 1,542 CAFs have been completed with 1,183 of those being held by the local authority.

During 2014 partners will be working to increase the number of CAFs that have been closed with the action plans completed and a reduction in the percentage closed owing to parental refusal to engage with the process.

CAF training is delivered by colleagues from the CAF team within the Children and Families First Service. CAF awareness has been developed for those who are not directly involved but require some knowledge of the process. These sessions will be delivered from April 2014 onwards. Training for lead professionals has been developed for those who will need to complete CAF assessments and hold CAF episodes. This is run alongside eCAF training which is training for users of the computer based eCAF system. The total figure for those completing training for lead professionals was 555.

Number of staff trained to undertake CAF

	Total Trained in 2013-14
TOTAL	1393

Priority 3: Work together to tackle Child Sexual Exploitation (CSE)

Success measures: Professionals and young people are more aware of CSE, evidenced by an increase in reporting and recognition of cases of CSE, followed by a decrease where awareness raising reduces the risk.
Reported Progress relates to: preventing, identifying, protecting and supporting victims of CSE, bringing perpetrators to justice.

The Ofsted review commented that *'A variety of approaches have been used to raise awareness and minimise risk for young people at risk of sexual exploitation… While there is much evidence of positive feedback from these initiatives the impact has not been evaluated yet.'*

There has been a focus group in place for addressing CSE since February 2012. In December 2013 Board members agreed, due to the profile and serious harm caused to young people by this abuse, a subgroup should be formed which should also encompasses missing children as this is an area of additional concern and can be linked to CSE. With the restructuring of the multiagency overarching group for CSE the Multi-Agency Screening Panel also moved to a CSE and Missing Operation Group (CMOG) which is a multi-agency tasking group with the sole purpose of directing medium and long term actions to safeguard, disrupt and reduce opportunity for children to be harmed through sexual exploitation and missing episodes. This is in line with having an overarching strategic CSE and Missing Children Subgroup:

- The result of a scoping exercise to identify the number of CSE cases in Coventry were reported to the Board in July 2013. There was a good response from professionals in Coventry which enabled the group to have a deeper knowledge and understanding of the profile of CSE in the city to enable agencies to have a more effective response to victims and perpetrators.

- An inter-agency CSE procedure was finalised to assist professionals including a risk assessment tool.

- Training is in place and being delivered on the subject of CSE. Awareness training and training for professionals working directly with CSE victims is being delivered with Solihull LSCB.

- Awareness raising training with hoteliers has been undertaken linked to the "Say Something If You See Something" campaign. Currently the focus is on targeting establishments that are more at risk of being used for sexual exploitation.

- The LSCB successfully secured funding from Public Health, Respect Yourself and Community Safety Partnership to raise awareness of CSE to secondary school children across the city, in addition to our most vulnerable young people. This delivered a drama piece called 'Chelsea's Choice', in autumn 2013.

Thousands of young people including those in 26 of 27 secondary schools, all special schools, all colleges, young people in all care homes, all extended learning centres, young people in supported accommodation and young people accessing youth support services viewed the drama and discussed the messages and learning from this afterwards. Professionals including social workers and police officers also viewed the drama.

A feedback exercise was conducted with both young people and staff who watched the performance to ensure young people had understood the issues raised. Feedback included comments about how their use of social media and the internet could place them in a vulnerable position, how young people could take steps to protect themselves.

Since the Ofsted inspection there has been an evaluation of the awareness raising in schools to ascertain how effective the performance was and how schools are continuing to embed the messages and learning. Schools rated the work highly and gave examples of follow on work they are doing - this includes PSHE sessions on sexuality and e-safety, a tutor mentor programme covering sex and relationships. Schools identify the most vulnerable young people and are providing extra support such as the protective behaviour programme. Online safety work is being conducted in conjunction with police.

- It is acknowledged nationally that victims of CSE are more likely to engage positively with third sector professionals rather than those

from statutory agencies. CRASAC, Streetwise and COMPASS currently provide support to identified victims in Coventry. Streetwise received funding for this year from the local authority to allow one part-time worker to continue working on a one-two-one basis with high risk victims. Given the increase in awareness of CSE, the local authority will need to monitor service provision in the city to support vulnerable victims and the likely increase in victims being identified and coming forward.

- West Midlands Police has a dedicated CSE Team who support complex investigations and who also carry out awareness raising to front line staff. There has been an increase in offenders being brought to justice and developing a consistent response across the Force.
- A leaflet for parents and carers has been produced to help parents recognise and also know where they can go for support if they suspect their child is a victim of CSE. The leaflets are being sent out to schools to disseminate to parents.
- An audit was conducted into cases of CSE as part of regional activity; this identified a number of aspects where either further awareness raising of CSE is required or an improved multiagency response to CSE.

Priority 4: Improve multi-agency responses to domestic abuse

Success measures: An on-going review and strengthening of the process for screening notifications received and the follow on actions to safeguard children.

Effective action is taken in line with the severity of domestic violence (DVA), impact on the child and the cumulative number and frequency of incidents taking place.

Reported progress relates to: Work undertaken to effectively strengthen information sharing.

A significant amount of work has taken place in various forms to strengthen local responses to DVA. During 2013-14 the joint screening of domestic violence notifications was reviewed. It was recognised that to enable effective partnership working, ensuring all notifications were jointly screened and no backlog in cases requiring screening, the frequency of the multi-agency joint screening programme was increased. As of February 2014 all incidents have been jointly screened through the twice weekly multi-agency meetings.

In addition all partners involved in the process are receiving agendas prior to the meeting to ensure background checks on each case can take place before the meeting so that quality information and sound decision making can be made.

Through the increased commitment and frequency of meetings the process from incident to joint screening by a multiagency group of professionals has reduced from an average of 25.3 days in October 2013 to an average of 5 days in February 2014. In addition there has been a significant decrease in the number of days it takes for the information from joint screening to be passed to individual agencies, see below for data on this. This is an area of continual development.

In autumn 2013, a system was initiated to notify a school where a pupil's family had been subject to an incident notification to joint screening. This has proved successful in raising awareness within schools. Headteachers are now being sent summaries of notifications periodically so that they can track responses to individual cases. This notification system will be extended to Children's Centres in early 2014-15. As part of the joint screening process, domestic violence notifications are shared with GP practices. GPs practices are currently receiving this information between 0 and 6 days of the incident being jointly screened.

University Hospital Coventry and Warwickshire have carried out a number of audits to improve their response to DVA. This includes assessing the period of time for notifications to be received by hospital staff which has reduced from one month to currently an average of 10 days. Additionally regular audits are carried out in the Adult Emergency Department to ensure that DV screening questions are asked. Analysis demonstrates the referral rates to Children's Social Care have increased, when an adult presents, there are children in the household, and DVA is established. In addition more recently a sample of women on the postnatal wards were

asked if they had been questioned about domestic violence during their pregnancy. The outcome of this audit will inform safeguarding adult and children training.

Priority 5: Challenge practitioners to listen/see the needs of the child

Success measures:
Practitioners clearly evidence listening to/seeing the child's views and experience. Children are at the centre of decision making
Reported progress relates to: how young people's views being routinely sought to inform service improvement.
The LSCB will strive towards engaging on a regular basis with young people and a task and finish group focused on engaging young people is being set up. This will include asking young people how and in what format they would like to be engaged. In the past, the LSCB has tended to consult with children and young people on particular safeguarding/ child protection subject matters such as communication linked to CSE and raising awareness among young people. The Section 11 audit also focused on how partner agencies are engaging with young people.
The People Directorate participated in the Children's and Young People's survey 2013 which is one of the largest surveys in the UK of children and young people's education, aspiration and health and wellbeing. It informed the LSCB of how young people felt about their safety and also about the proportion that have experience harm or abuse. It gave commissioners, policy makers and teachers evidence from children's lives to shape services, and gave Coventry children (there were over 12,000 responses) a voice about their experiences and attitudes to life at school, home and in the community.
The survey was completed by all 27 secondary schools in Coventry including Pupil Referral Units, plus three private schools. It was adjusted for age, gender and ethnicity to reflect Coventry's population. Forty of the 57 primary schools in Coventry for Years 5 and 6 took part. Some of the findings were as follows:

- 97% of young people surveyed said they felt safe in their home
- 90% felt safe in the area where they live
- 91% felt safe at their school
- 95 % said their parents do not abuse them
- 86% said parents praised them
- The majority of young people feel safe and positive about the environment they live in

Targeted work to ascertain the views and wishes of LAC and their families has been undertaken. In relation to Education specifically, young people's views are collected prior to each Personal Education Plan meeting, and expressed in the plan. The views of parents, carers and social workers are expressed during PEP meetings, and inform the decision making process and writing of targets.

Close monitoring of attainment, together with the maintenance of detailed case notes and a range of interactions with schools provides LACES with a wide range of information about each young person's journey through the education system. This adds to the picture provided by past and current PEPs.

In one of their regular meetings with elected Members, members of the Voices of Care group raised the issue of bullying in their schools because they were in care. Some of them described their experiences. Elected Members took this very seriously and one of the group wrote to all members to highlight the issue and to ask those Members who were governors to review support for LAC in their schools.

3.2 Policy procedures and guidance

The LSCB uses a national company which assists in maintaining and updating procedures in line with latest legislation and guidance, ensuring these are up to date and accessible to practitioners. These are accessible through the LSCB website to all practitioners working with children and families. The Practice and Quality Assurance Subgroup oversee and ratifies these procedures. In the last 12 months the subgroup has worked on the following procedures:

- Thresholds and practice standards
- Working with interpreters produced as a result of the Serious Case Review into Daniel Pelka.

- Child Sexual Exploitation procedure and risk assessment
- Children missing from education
- Supervision standards – produced as a result of local and national serious case review learning and from local audits
- Children displaying sexually harmful behaviour

Any work being carried out to update or produce new procedures routinely involves practitioners to ensure that their views about what works best are captured.

All new or updated procedures and guidance are communicated to professionals through the LSCB newsletter and email communication through LSCB and Subgroup members.

3.3 Training Provision

The Ofsted Review in 2014 reported positively that a comprehensive multi-agency training programme has been delivered which covers a broad range of safeguarding issues. They reported that training programmes are routinely evaluated and updated; inspectors had seen evidence of impact of training on practice in respect of sessions on the findings of serious case reviews where practitioners had had their awareness raised about the use of interpreters to speak to children alone. Case files showed that interpreters had been used effectively. Ofsted also reported that there was evidence of consultation with young people to use their experiences to inform training. This is a key area of focus for next year's work plan to provide practitioners with skills that equip them to listen to the voice of children in line with LSCB overarching priorities. An on-going challenge remains for LSCB to continue to provide courses to meet the increasing needs of practitioners in Coventry.

The LSCB has a training strategy in place which outlines the level of training required and by whom. This is produced in partnership with agencies and accessible via the LSCB website. The LSCB also has a comprehensive multiagency training programme, which is reviewed in line with emerging national and local safeguarding issues. The content of training courses are also reviewed throughout the year (including the findings from local audits and case reviews) with changes made, or capacity added where necessary, to ensure they continue to equip practitioners with the skills to meet the changing and diverse needs of Coventry children. The programme is widely publicised within the children's workforce and is also available to access on the LSCB website. Due to the size of the city, and more importantly to ensure participants have an opportunity to learn and develop their skills in a multiagency environment, all training is delivered face to face.

All partner agencies are represented within the current membership as are other key agencies including the faith sector and links to voluntary organisations. This continues to ensure that the safeguarding training needs of all practitioners who work with children and young people and/or their parents and carers are represented. The Board is provided with regular reports identifying progress and highlighting any significant issues.

The multi-agency programme is regularly evaluated for quality and impact on management and front-line practitioners. A rolling programme of evaluating training is in place. Courses are selected each term and three monthly follow-ups are used to assess whether the training has had an impact on practice; six courses were selected to be evaluated throughout the year, these were based on LSCB priorities and SCR findings. The three month follow up evaluations evidenced that a high proportion of practitioners have used the learning in their practice and were able to give clear examples of how they had used this to improve practice with children and families. An example of this is a street warden who investigated an incident in a shop involving an older man and some teenagers. He made a referral to the police around concerns of CSE and stated that this course of action was a result of having undertaken the training.

Single agency training has been reviewed by the Training Strategy subgroup during the year this has included a review of four training course across four agencies and this continues to be an on-going priority. The subgroup has provided feedback and amendment for these courses. The subgroup is working towards unique training materials that can be shared across agencies to give an up to date national and local picture. This will shape the future training provisions and employ a range of delivery messages.

The Training Strategy Subgroup is responsible for ensuring that evidence is provided to LSCB that all partners are providing appropriate DVA training which is evaluated not just on numbers of staff completing single agency courses but also the quality and impact of the DVA training. This is an on-going focus of activity and is linked to learning from the SCR in relation to Daniel Pelka.

Additional training that has been delivered during the year in response to local need, emerging issues and learning from serious case reviews is as follows:

- Core Group Training has been provided to ensure that staff are equipped with the skills to contribute effectively to all aspects of multi-agency working. The aim was to ensure staff understood the importance of being a valuable member of the core group and consistently work in partnership with all agencies involved in the child's unique journey. Evaluations indicated that this sharing of knowledge and experiences from trainer to practitioner was invaluable.

- Working Together 2013 guidance updates regarding the changes in Government guidance 2010 to 2013 were successfully provided through a series of workshops where 157 practitioners and managers attended.

- Working Together Level 2 training has seen an increase in demand this year mainly from schools and in response two additional sessions were provided. The number of professionals who received this training was 144 – an increase from 92 the previous year. Following feedback from staff who attended this course, content will be reviewed to ensure it provides the appropriate focus of the ethos of Working Together. The review will also aim to ensure that staff understand the content and are clear about expectations and what they want to achieve from this course before they book.

- Objectives linked to Serious Case Reviews are not just part of a completed action plan but an on-going process to ensure that all training continues to provide national and local learning that allows practitioners to learn from each other and the impact that this has on children and families in Coventry. Review of training is not just at the time of impact but at recurring intervals so we can be reassured that training makes a difference to practice and has a positive impact on the quality of professional intervention with children in Coventry. The Emotional Abuse and Neglect Training, a recommendation from the Daniel Pelka SCR, evaluated very successfully and therefore has continued to be provided to practitioners in Coventry.

- A series of workshops have been provided to disseminate learning from the last three serious case reviews in Coventry, including Daniel Pelka. These sessions looked at common themes in respect of how agencies responded and worked together. Participants were provided with information to take back to their respective agencies to cascade to colleagues and to use to re-visit the themes on a regular basis.

Interagency Training Statistics from April 2013-March 2014

Category	Total Trained in 2013-14	% of total attendees to LSCB training
Health	589	31%
CAFCASS	2	<1%
Schools (incl. Private & Independent)	398	21%
Children's Social Care	115	6%
Other Local Authority Services	231	12%
Early Years & Childcare*	217	11%
Voluntary/Private& Independent Sector	164	9%
Staffordshire & West Midlands Probation	10	1%
West Midlands Police	30	2%
Faith Groups	7	<1%
All Other Agencies	155	8%
TOTAL	1918	

These figures are for multi-agency training, most of these organisations also provide single agency training and advise staff, depending on job role, on which training they should attend.

2013-14 Programme Year - numbers of professionals trained at each training level

LEVEL 1

	Total Trained in 2013-14
TOTAL	383

Level 1 is a basic safeguarding awareness course delivered 20 times this year. Many larger organisations including the Local Authority deliver their own in house course. This figure only reflects those that have attended this basic multiagency course, it does not reflect the number of individuals who have received this training across the Coventry workforce. It does not therefore reflect the full range and extent of safeguarding training which occurs in the city outside the training provided by the LSCB.

LEVEL 2 Working together to safeguard children training

	Total Trained in 2013-14
TOTAL	144

Level 2 is an interagency course for safeguarding leads in organisations, it details the multiagency processes that professionals will be involved. It is usually delivered 3 times each year but additional courses were delivered this year due to an increase in demand. Some agencies such as the Police also provided ther own additional Level 2 training so this chart is an under-reprensettaion of the totality of traininbg which occurs in the city.

LEVEL 3

	Total Trained in 2013-14
TOTAL	1393

Level 3 courses are specialist courses covering a wide range of issues linked to safeguarding children, this included training in response to Serious Case Review and any local or national emerging issues. Many of these are delivery a number of times throughout the year. The high number of staff receiving this training reflects the wide range and number of courses delivered.

Evaluating the impact of training on practice

This process began in March 2012 examining the impact of training from a range of courses. The interagency training officer carried out an analysis of feedback specifically linked to impact on practice. This was based on information provided by participants and line managers providing evidence of demonstrable changes in practice as a result of training.

During this reporting period, there was a focus on evaluating the Emotional Abuse and Neglect training. The courses which have been evaluated during this period include:

- Level 3 - Emotional Abuse and Neglect
- Level 3 - Child Sexual Exploitation Awareness
- Level 3 - Child Abuse Images and Grooming on the Internet
- Level 3 - Female Genital Mutilation Awareness

In 2012-13, 984 professionals attended inter-agency training; in 2013-14, 1918 professionals attended training courses. Some of the factors which contributed to the increase in figures this time around are:

- New training courses around core groups, disabled children and child sexual exploitation were delivered.
- Additional Level 2 training sessions were delivered to education staff.
- Workshops on the new Working Together guidance and briefings around the learning from recent SCRs were delivered.

3.4 Quality and Effectiveness of local practice

The Ofsted Review of the LSCB completed in February 2014 identified that the practice and quality assurance subgroup should utilise all information available, including audit findings and performance management information, to undertake a robust analysis of the effectiveness of services to help and protect children.

The Practice and Quality Assurance Subgroup started reviewing the performance framework in January 2014 and the need for this was further emphasised by the Ofsted review finding. The framework has been fully reviewed by the Practice and Quality Assurance Subgroup and is due to be ratified by the LSCB. The review has ensured the performance framework includes priority areas as highlighted by the Ofsted review and an independent audit of safeguarding and child protection services concluded in September 2013, Serious Case Review findings and audit findings.

The Practice and Quality Assurance Subgroup has recognised the need to have more robust monitoring of recommendations of audits to ensure the learning has shown an impact

The revised performance framework comprises of the following elements:

- The views of children, parents and carers and practitioners
- Section 11 audit/peer audits
- LSCB outcomes framework
- Multi-agency audits (themed and targeted through learning and findings from case reviews for example)
- Single agency data/performance and quality assurance activity
- Agency inspection reports and learning
- Learning from case reviews
- Learning from child death reviews

Independent audit and review of child protection, child in need and CAF cases.

The findings of this audit were reported to the LSCB in September 2013. This report highlighted the variable quality of practice in social care and the need for more rigorous supervision to identify lack of progress in cases. The rising number of referrals to social care was a key factor in this; the audit also highlighted the voice of the child needing to be more evident. The auditor identified that, although historically the arrangements for strategy meetings were strong, there were now concerns about the multi-agency nature of these. The timely distribution of conference minutes were of concern. In relation to cases held in CAF the auditor found that a proportion should be held by social care. As a response to the audit findings the local authority reviewed the cases held in CAF and stepped 50 cases up to social care as children in need.

In relation to the rising number of referrals the local authority has increased capacity in the referral and assessment service by one team manager and seven social workers. In April 2014 this is expected to increase to three team managers and 21 social workers. The LSCB are yet to see evidence of the improvement this has made. Member agencies are clear that all agencies need to commit to the early help agenda as this is crucial to reducing the number of cases coming into children's social care. There is a large volume of activity and focus on this going forward into 2014–15 which will be reported on in the next annual report.

Case file audit of child sexual exploitation cases

In August 2013, a multi-agency audit took place into cases of child sexual exploitation. The findings were reported to the practice and quality assurance subgroup, the CSE focus group and the LSCB. The audit identified a gap in health input when discussing cases at multi-agency operational meetings; that not all cases, particularly lower level cases, were receiving appropriate services at the earliest opportunity. It also found that police processes were not always consistent in dealing with perpetrators and they should triangulate information held by other agencies when conducting investigations.

As a result health engagement in the operational CSE and missing group was strengthened and now there is regular attendance and involvement with health services. Improvements have been made to information sharing. A multi-agency panel is in place and this has been strengthened with a triage process which has been put into place to enable all victims to receive support and intervention dependent on the level of risk identified.

The audit also found that a consistent response by police to investigate and disrupt perpetrators of CSE would assist in deterring and preventing further harm to victims. West Midlands Police has put in place a dedicated CSE unit who support local child abuse investigation units. In addition training and development has taken place within the police and this has included the range of police powers that can be used where children are at risk. A further follow up audit of CSE cases will be undertaken to ensure findings of this audit have been embedded in 2014–15 led by the operational CSE group.

Daniel Pelka Deeper Analysis

Following the Daniel Pelka Serious Case Review and subsequent deeper analysis, the practice and quality assurance subgroup have been tasked with monitoring and progressing a number of areas of weakness. This includes:

- the timely dissemination of domestic violence notifications
- improvements to the screening process
- having in place a multi-agency audit framework
- auditing the effectiveness of early help, and
- ensuring the timeliness and quality of assessment and the quality of strategy meetings being undertaken.

The Practice and Quality Assurance Subgroup started receiving this information towards the end of the reporting year for this annual report. At that stage clear progress had been made on the domestic violence screening process and notifications.
In addition, new guidance on strategy meetings has been produced and implemented. This has been introduced to ensure that such meetings are compliant with 'Working Together to Safeguard Children 2013', and to ensure timely distribution of

the meeting notes. As a consequence of this work, meeting minutes are now circulated to all attendees at the close of the meeting. This area of practice will be significantly improved with the proposed implementation of the Multi Agency Safeguarding Hub in September 2014.

3.4 Section 11 audit (Children Act 2004)

The board undertook to review agencies compliance with Section 11 'Children Act 2004 'promoting the safety and welfare of children' agencies which specifies how organisations should safeguard and promote the welfare of children. The LSCB periodically undertakes an audit with partner agencies to provide information on how they are discharging this duty. Each partner then evaluates their compliance with this duty.

Planning and preparation commenced on the latest Section 11 audit in March 2014. The learning from Serious Case Reviews, audits and from the recent Ofsted review of the LSCB influenced the questions being asked of agencies. The audit tool was finalised and circulated for completion by partners via a survey monkey format in March 2014 with a submission date in April. The findings from this audit will be reported in next year's annual report.

Schools audit (Section 175 and 157 Education Act 2002)

This audit was undertaken with all schools in the city and included special and independent schools along with colleges. The audit is based on the statutory requirement for schools to safeguard children in relation to section 175 and 157 of the Education Act 2002. The audit tool was devised in September 2013 and was designed to reflect the learning from the Daniel Pelka Serious Case Review; it also posed questions about other key aspects where schools have a role such as private fostering and bullying. Although the timescales to complete and return the audits was end of October, a full return was achieved in April 2014.

The process involved an independent expert analysing audits and reporting her findings. The audits were analysed to identify areas that require immediate or medium term follow up with each school receiving a letter to identify strengths and areas of improvement. In addition 10% of schools are due to be visited by LA senior staff for closer scrutiny of their safeguarding and child protection arrangements. The findings of the audit will be reported in the following year's annual report. The audit findings are also being reported to the Local Authority Scrutiny Board.

3.5 Member agency contribution to safeguarding children in Coventry

The following section details responses from key LSCB partners and their individual evaluation of their contribution to keeping Coventry children and young people safe during 2013-14.

Member agencies work together and have a collective understanding across agencies of the importance of keeping children safe. This is demonstrated by two summits in 2013, held by the LSCB, one with chief executives and one with senior officers and service managers. A public value proposition statement was agreed as follows:

LSCB promotes and has shared accountability for an effective city-wide safeguarding system to ensure that children and young people are safe and protected from harm. Working together for Coventry, we are committed to modelling a trusting culture of information sharing and focused action to significantly increase resilience and reduce risk for those who are, or may become vulnerable in our city, making best use of our resources.

In addition the board produced supervision standards for all agencies, to give clear guidance about the standard and elements of supervision required when working with vulnerable children. This was disseminated in December 2013; a multi-agency audit is planned through the Practice and Quality Assurance Subgroup in autumn 2014 to assess the quality of supervision received and how these standards have been imbedded.

Coventry City Council, Children's Social Care and Safeguarding

During the year Children's Social Care and Early Intervention services operated by the City Council have continued to deliver safeguarding services for children and young people. The audit undertaken by an independent auditor in the summer of 2013 highlighted some concerns about cases being held at the inappropriate level. This resulted in a review of all cases held by the Children and Families First

service. A number of these cases were stepped up to social care as a result of this work.

During the autumn, auditing continued and was introduced for Common Assessment Framework and Children and Families First cases as well as for social care. A summary report was created of these audits and further work in early 2014 is leading to a new audit process ready for the year 2014-2015.

The main challenge for the year has been around the volume of work, particularly following the publication of the Daniel Pelka serious case review in September 2013. This has, it is believed, contributed to a higher rate of referral to children's social care, higher caseloads and a very significant increase both in the number of children with a Child Protection Plan and to a lesser extent, an increase in the number of children in care. Staffing was increased in late autumn 2013 yet the workload has continued to rise and there remained challenges with high caseloads at the time of the Ofsted inspection in January 2014. As a result of this, three additional temporary teams have been established in the Referral and Assessment Service to support the workflow, ensuring that timely assessments are undertaken and enabling staff to reduce their caseloads. These are having an impact and caseloads are reducing.

Additional temporary staff have also been agreed for the Neighbourhood Teams. Work is in progress to ensure medium and long term sustainability with regards to workloads in Children's Services.

The Council has an active and effective Voices of Care Council who are heavily involved in shaping services. This group were complimented by Ofsted inspectors in their report. The group have been involved in commissioning activity, such as the supported accommodation tender and also in recruitment to key posts. Older members of the group are currently working with the Route 21 service to bring their own experiences to bear on improving that service for care leavers. They are also contributing to work on life story work (which was highlighted as an area for improvement by Ofsted).

The independent reviewing service continues to seek feedback from parents following conferences to highlight areas for improvement and Independent Reviewing Officers continue to engage with individual young people regarding their protection or care plans. We plan in the near future to also support young people in attendance at their Child Protection Conferences. The Council is also leading on work to develop the Multi-Agency Safeguarding Hub (MASH) to be launched in September 2014.

The focus for 2014-15 is the timely delivery progression of the action improvement plan.

UHCW NHS Trust

UHCW staff are committed to their contribution to safeguarding children in Coventry and Warwickshire. As with other agencies there is a heavy workload. In the last 12 months we have seen and treated over 30,000 children in the Children's emergency department of which over 96% were seen and treated within the 4 hour target.

The Maternity department is busy and is responsible for a considerable amount of safeguarding activity; there may be up to 200 cases on the maternity child protection database at any one time with more than 30 unborn children subject to a child protection plan. These cases are monitored by the safeguarding team. Midwives receive regular supervision in their management of this challenging group of clients.

Named Child Protection leads from UHCW attend the Coventry Safeguarding Children Board and a number of its subcommittees. In addition the Named Nurse has contributed to the development of the multi-agency safeguarding hub, (MASH) committing 5 days to the mapping exercise carried out in April. The Named Doctor has contributed to the organisation and delivery of the safeguarding board multiagency level 3 training focusing on recent serious case reviews including the case of Daniel Pelka. A level 3 training event held during the General Practitioners protected learning time in February attracted over 200 Professionals from health and other agencies. A further level 3 training session is planned for June.

Staff from UHCW have produced Individual Management Reviews and Individual Agency Reviews for Serious Case Reviews being undertaken in Coventry. The learning from these Serious Case Reviews is incorporated into level 2 training delivered twice monthly.

UHCW continues to audit its performance with

an annual "Laming audit" in addition to ad hoc audits as detailed below. The audit report for 2013 has been shared with the Quality and Practice subcommittee. Data collection for the 2014 audit is underway. This will incorporate a review on cases of failure to thrive to check if there is evidence that professionals consider abuse as a potential cause of growth failure.

The Trust has submitted its response to the section 11 audit. The RAG rating for all aspects apart from training was green. We rated ourselves amber for training, because our training figures were below the 90% compliance expected. UHCW has a training trajectory. To date we have increased our compliance with level 3 training to 79% and level 2 training to 81% (this equates to over 7000 staff members who have received training)

It is difficult to prove that this training has made a difference to any particular children, but it is generally accepted that increasing awareness of staff and sharing lessons from reviews is good practice and likely to improve the management of children at risk of harm.

Use of Interpreters

Interpreters are always used for families with language difficulties when children are admitted to hospital. In addition interpreters are booked for routine outpatient appointments. In the paediatric department alone we spent over £27,000 on interpreting services in the last financial years. In addition wherever possible we utilise the skills of multilingual medical and nursing staff. We have always used interpreting services and staff in this way.

The views and wishes of children and their families are regularly sought; for example the Trust has an impressions survey available to all service users. In addition, the Paediatric department uses a simple system of red, yellow and green smiley faces in all in and out patient areas to record the feedback of children and their carers using our facilities. The most recent results were collated in April 2014 and will be used to develop and change services provided.

UHCW has a children's forum at which young people who use the hospital services can express their views. This group meets fortnightly. They have reviewed a questionnaire used to collect patient views and adapted the wording for the paediatric population. The group is currently working on sketches and design for the new Children's Emergency Department waiting area. Findings from this show that the majority of children and young people are pleased with the service they receive from staff on individual children wards and at Accident and Emergency department.

Levels of need of every child admitted to UHCW are assessed at admission and recorded in an individual nursing care plan; there is a specific nursing care plan for use in cases of possible abuse.

Coventry and Warwickshire Partnership Trust

Safeguarding children, young people and their families is a key priority within Coventry and Warwickshire Partnership NHS Trust (CWPT).

The Trust expects all individuals who come into contact with us to experience a safe, sound and supportive service that is sensitive to their needs.

We are committed to preventing and identifying any abuse of children, young people and their families and we aim to improve the mental and physical wellbeing of all who use our services, with the additional aim of improving and enhancing the quality of life of anyone who has been recognised. Therefore CWPT has worked closely with Coventry Safeguarding Children's Board (LSCB) by being active members of the Board and its Sub committees, including our Named Nurse being the Chair of LSCB Training Sub Committee.

Coventry and Warwickshire Partnership Trust Achievements regarding Safeguarding Children:

Coventry and Warwickshire Partnership NHS Trust has completed its work plan for 2013 -2014 which included the following:

- Reviewed and further developed the Trust Child Protection Supervision for CWPT staff.
- Completed Safeguarding training for 2013 -2014 and developed safeguarding competence learning logs
- Completed its audit plan for 2013 -2014

- Review and further development of Safeguarding Training to include Domestic Abuse Stalking and Harassment (DASH) at level 2 training
- Achieved 84% of PREVENT Health WRAP training to Trust staff
- Developed a new Safeguarding Link Group for operational staff
- Complete the relevant local safeguarding boards Section 11 audits
- Production of 2013 Annual Safeguarding Newsletter
- Reviewed and amended the following of Trust safeguarding polices:
  - Safeguarding Children Policy
  - Sexual safety in Inpatient Settings,
  - Clinical Domestic Abuse Policy,
  - Child Protection Supervision Policy,
  - Missing Persons Policy.

What are the priorities going forward?

Coventry and Warwickshire Partnership NHS Trust outcomes for 2014-2015 are to maintain, review and further develop the safeguarding practices and activities within the Trust to ensure the safeguarding of children and their families remains 'everyone's business' and a key priority within the Trust and to complete the Trust 2014- 2015 work plan which includes work to;

- Review and update Safeguarding Polices.
- Produce 2014 Annual Report to Board.
- To comply with any recommendations and lessons learnt from Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) pertinent to the Trust.
- Complete the relevant local safeguarding boards Section 11 audits.
- Complete the Trust audit plan for 2014-2015.
- Complete safeguarding training programme for 2014 -2015.
- Produce Safeguarding Newsletter for 2014-2015.
- Review the work plan for 2014 -2015
- Respond to service users' views by developing a child and young person's audit pertaining to their experience of the safeguarding process.

West Midlands Police

During 2013/14 West Midlands Police have completed the following:

- Operational Sentinel, an overarching operation that focused on vulnerable people and ensuring they have a greater voice. This included a seasonal and thematic focus on both child abuse and domestic abuse.
- Training was delivered to all front line supervisors around safeguarding children and vulnerable adults using the 'Goose Theatre Company'.
- A range of Coventry officers from both the Local Policing Unit (LPU) and Public Protection Unit (PPU) attended 'Chelsea's Choice'. The Police Commander attended a number of these sessions (for professionals) and opened proceedings.
- Both LPU and PPU staff have received 'autism awareness' training. For PPU officers this was linked to awareness of the use of intermediaries to assist communication during interviews. This has been seen as good practice within the department.
- Briefings for uniformed officers who respond to emergency calls around the 'voice of the child' and general safeguarding of children has been delivered by the Child Abuse Detective Inspector. This included feeding back learning from local cases.
- Completed its audit for 2013/14.
- A 'voice of the child' campaign ran throughout the force area including Coventry in February 2014.
- DCI Public Protection chairs Coventry Strategic Multi Agency Safeguarding Hub (MASH) board.
- Detective Inspector PPU attends MASH operational group.

- DCI PPU chairs Child Sexual Exploitation (CSE) subgroup.
- DI PPU co-chairs a multi-agency 'Child Missing from Home and CSE' (CMOG) group. This group has been highlighted as best practice and is due to be replicated across the region.
- Schools have local neighbourhood team support throughout the city as well as two 'young person officers' within the co-located partnership team that work across the Ccity on overarching issues affecting children and young people.
- One full time police officer and one full time police community support officer run the 'Princes Trust' programme in partnership with Henley College. This sees 12 young people go through an intense 12 week course on an on-going basis throughout the year. The have been 3 courses in 2013/14.
- A police officer is located within the Youth Offending Team.
- Live time domestic abuse audits are conducted to ensure accurate recording and effective investigation at periods throughout the year. Two such audits were carried out in 2013/14.
- A multi-agency serial perpetrator case management forum is chaired by the police and seen as good practice in the region. This has led to the commission of a serial perpetrator mentoring programme which is currently being evaluated by Coventry University.
- West Midlands Police is a key partner within the Troubled Families programme in Coventry.
- Police in Coventry run a successful 'KICKZ' programme in partnership with Sky Blues in the Community. This includes female participants and although strongly linked to football, health, safety and life skills are also covered through the programme. It is based in priority locations throughout the city and has been recognised nationally and regionally as an excellent programme.

West Midlands Police Priorities for 2014/15

- The Local and Force-wide Police and Crime Plan refers explicitly to the 'protection of vulnerable people from harm'. This includes a priority around both 'protection' (including safeguarding) and 'prevention'. Locally Domestic Abuse and Child Safeguarding are priorities for 2014/15.
- Training PCs.
- Continuation of the 'voice of the child' campaign including road shows planned for September/ October for Coventry staff by the Commander and PPU Detective Chief Inspector.
- Greater investment of staff in all areas of public protection under the Service Transformation Programme. This includes child abuse investigation and domestic abuse.
- Full time (child protection) conference attenders in post across the force area including Coventry.
- All frontline officers within Coventry are receiving 'identification and brief advice (IBA) training around alcohol. This includes signposting and early intervention where alcohol is seen as a factor in police attendance at an incident.

West Midlands Fire Service

Our prevention services focus on public involvement and education, engaging with our partners, targeting schools, communities and vulnerable people with advice and guidance, and with particular reference to social inequalities.

This means that in Coventry, we work with professionals and partners to deliver hoax/arson, home fire and road safety education to children and young people within their educational settings their homes and West Midlands Fire Service premises:- We work with children and young people on a one to one basis with trained officers delivering fire safety tutoring to those who display fire setting behaviours. The objective is to change the behaviour of these young people by teaching them about the hazards and consequences of their actions in order to reduce the risk of fire related injuries and deaths.

A range of short and longer term interventions for disengaged young people aim to boost self-esteem. Through practical and classroom activities the young people learn about teamwork, develop communication skills and an understanding of consequences of actions and decisions they make.

We work with families within their own homes, delivering our Home Safety Service during which operational personnel give advice, guidance and support to reduce the risk of accidental fires, injuries and deaths.

Our protection service prioritises the risks to the business sector focusing on the provision of advice and importantly the enforcement of legislation. In Coventry our Fire Safety Inspectors monitor and enforce fire safety legislation in schools and preschool settings, Local Authority accommodation, hostels and hotels etc. to ensure that they are safe places for our children and young people to be.

Safeguarding achievements

All teams, managers, front line fire crews, fire safety inspecting officers and administrators have received level one training during the financial year 2013/14 that has been quality assured by the LSCB Training Sub group. 89% of our personnel attended. This training was interactive and role related. It included recognition of abuse and neglect, along with policy, process and procedure for raising safeguarding alerts.

West Midlands Fire Service has developed and implemented an effective supervision policy for our personnel who work with Fire Setters and those most at risk and vulnerable to accidental fires in the home.

Following completion of the Section 11 Audit which identified a need to develop a process by which to audit case files, the supervision policy and procedure has been further updated to include a random sampling of a case file during each supervision session.

WMFS has engaged in a Serious Case Review, authoring an Individual Management Review and providing a panel member. Work is already underway to implement organisational learning that being involved in this process has identified.

Whitefriars Housing (WM) Group

WM Housing Group is one of the largest and most successful housing groups in the Midlands, and exists to create places where people are proud to live and work. The group consists of several partner associations including Whitefriars Housing (Coventry). Together it owns and manages around 30,000 homes across the West Midlands in Coventry, Birmingham, Worcestershire and Herefordshire.

WM Housing Group recognises that all its staff, who are involved at the very heart of the community, have a vital role to play in safeguarding and promoting the welfare of children as part of their day-to-day work, recognising child welfare issues, sharing information, making referrals and subsequently managing or reducing risks of harm. This is a fundamental part of their housing management function. For instance front line housing practitioners through their day-to-day work come in:

- contact with families and tenants, and may become aware of needs or welfare issues that they can either tackle directly (for instance, by making repairs or adaptations to homes) or by assisting the family in accessing help through other organisations
- Contact with members of the public and with families, and may become aware of concerns about the welfare of particular children.

Auditing

WM Housing Group carries out an annual safeguarding audit in line with the Safeguarding Children and Adults at Risk Policy. The audit takes place between May/June. This year the Group will be using the Section 11 tool provided by the LSCB, previously it has used the Housing Quality Network Tool. This year's audit findings are due to go to Senior Management Team in September 2014 and each of the Boards thereafter.

Training

As a result of last year's audit, we have awarded Barnardos the safeguarding training contract with training due to commence in September 2014. We

also have in place online E-Learning Safeguarding training which is currently targeting all existing staff as well as new recruits. Specifically for Whitefriars (as part of the work through what was previously known as Promoting Children's Wellbeing Subgroup and now Prevention and Early Help Subgroup) Whitefriars ASB4 Team will be trained to use E-CAF.

Safer Recruitment

WM housing group is developing safer recruitment practices in line with legislative changes. This is currently being progressed through Birmingham Social Housing Partnership - Safeguarding Group working with Bournville Trust and Midland Heart.

Safeguarding Process Review

Currently a review of the safeguarding procedure is taking place. Last year's audit found that we needed to tighten the process, particularly for our teams/services whose role would be to identify and act on their concerns.

Performance Management/Case Management

The group is currently going through an internal programme (Journey 2 Excellence (j2e)) which includes amongst many things investing in the ICT infrastructure - new operating systems are due to come into effect 2015. Safeguarding is recognised as an integral part of this and will not only allow better performance management but allow mobile solutions for identifying/reporting and effective case management.

CAFCASS

Cafcass is the national agency responsible for court work in relation to children.

Internal audit of work to assess standard and quality of all work and safeguarding.

These are some elements of our work to promote effective safeguarding.

- Head of Service audits a specific number of cases each month, in accordance with the Cafcass Area Quality Review Framework.
- National Improvement Service undertake whole organisation audits twice a year to establish % of work good, met and not met.

The impact of this has been the increase from good work to 45% nationally in September 2013 audit. In accordance with improving work on a continual basis, another NIS audit is arranged for November 2014, where the target for good work is 60%.

The impact of the above, a robust QA framework, performance management and all learning and development activity led to improved Ofsted outcome:

Ofsted Inspection of CAFCASS:

The Ofsted inspection took place February/March 2014.

Private and public practice were both graded good. Local leadership was graded good. National leadership was graded outstanding.

A number of tools to establish evidence-based practice have been disseminated across all service areas in the organisation, use of tool to establish an evidence base mandatory in domestic violence cases, and mandatory where working with children. Cafcass has a service level agreement with The Big Word, an organisation that provides interpreting services, face to face, or via telephone. The SLA is reviewed quarterly, and an annual report is provided as to the main languages requested by Cafcass. In direct work with children, to ascertain their wishes

and feelings, it is now mandatory to use one of the tools identified in the suite of tools, when working with children. An interpreter can be booked to work with the child, with the Family Court Advisor, to complete these tools.

The impact of this was positive feedback from Ofsted in recent inspection (February/March 2014) as to the standard of integration of Equality and Diversity into casework across Cafcass.

Cafcass has a corporate learning and development strategy, supported by local staff development plans to improve practice across the organisation. All staff are provided with safeguarding training and Ofsted identified that this was positive.

Coventry and Rugby Clinical Commissioning Group (CCG) and NHS England

Coventry and Rugby CCG is responsible for commissioning a range of services from health providers including maternity services, acute hospital care, and some mental health and community paediatric services. This is predominantly achieved through contracts with the two large local providers; University Hospitals Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust. NHS England is responsible for commissioning primary care, health visiting, and specialist children's services. The CCG is committed to ensuring that there is a robust, coordinated safeguarding system in place which ensures children are safe, healthy and achieve their life chances. Coventry and Rugby CCG Chief Nursing Officer is the vice chair of Coventry LSCB demonstrating a clear intent to work closely with other agencies to safeguard children.

Specific activity to improve safeguarding in relation to the services commissioned and the wider health economy

- The Clinical Commissioning Group has taken action to ensure that learning from serious case reviews and "markers of good practice" for safeguarding children that were approved by the Safeguarding Board are delivered by the services that it commissions. Contracts have been amended for 2014/15 and the CCG monitors progress at monthly Clinical Quality Performance Meetings.
- The CCG has commissioned the health staffing into the Multi agency safeguarding hub (MASH) and are committed to ensuring the MASH is operational by autumn 2014. The CCG is represented both at the MASH Board and operational group and is actively involved in developing the quality performance framework.
- The CCG has delivered training to all GP practices in Coventry and support GP's to demonstrate that they and their staff are trained to the appropriate level. As a result, GP's report increased awareness and confidence in detection of abuse and escalation of concerns to designated professionals where appropriate. This can be evidenced through an increased number of relevant contacts with designated professionals and increased involvement in serious case review processes.
- Multi-agency training sessions, focusing on managing safeguarding risk in families with unborn babies have been led by the CCG designated nurse for safeguarding. This is in addition to supporting the LSCB multi agency training programme.
- The Clinical Commissioning Group is working with Bristol University and Coordinated Action Against Domestic Abuse (CAADA) as part of a research project to develop training and awareness sessions which aim to "bridge the knowledge and practice gap between domestic violence and child safeguarding. Five Coventry GP's practices have been identified to participate in the Researching Education to Strengthen Primary Care on Domestic Violence and Safeguarding (Responds) training and training is being delivered to them. This will be evaluated and will help to shape how primary care develops their skills, knowledge and experience in this key area.
- NHS England has revised the service specification for health visiting and the CCG safeguarding lead and public health leads have been core members of the health visiting implementation and strategy development groups. The impact of this is that local requirements specific to health visiting have

been incorporated into service contracts with specific improvement programmes required by providers. This includes a programme of work increasing the involvement as CAF lead from health visiting service where appropriate.

- The CCG is strengthening patient engagement with children through a number of initiatives, including working on specific projects with local colleges, recruiting young people to participate in specific service development workshops, working on media pilots using "augmented reality". This will ensure that the voice of the child is heard in the CCGs commissioning plans.

- Commissioning plans for the next five years have been agreed and include a programme of work for maternity, children and young people. Led by the Chief Nursing Officer, this programme considered local performance measures, NHS and Public Health quality indicators, and inspections such as the recent Ofsted report, outcomes from serious case reviews and professional and patient feedback.

- The CCG employs a number of staff to support safeguarding of children. The CCG's designated nurse and designated doctor for child protection are the LSCB's health advisors in relation to child protection and safeguarding and are actively engaged in all the LSCB sub groups. The impact of this is that there is expert input from safeguarding health professionals into all sub groups of the LSCB which is independent of providers, to challenge, identify good practice and support the development of quality assurance mechanisms such as audit and provide safeguarding leadership in relation to health practice. The CCG has this year invested in a training post for safeguarding and a lead GP for safeguarding children. Additionally NHS England is appointing a Named GP for safeguarding (adults and children).

- The CCG is a key player in the development of the city wide early help and Domestic violence strategy. This includes ensuring that engagement of providers in these areas is promoted and ensuring there are contractual elements to delivering improved outcomes for children.

- Following a joint service review with the Local Authority, the Clinical Commissioning Group has employed a designated nurse for looked after children with the specific focus of this of ensuring that the health needs of looked after children placed outside of the local area are met. Working alongside the designated doctor for looked after children the CCG has increased the number of children placed out of area receiving annual medicals by over 40%.

- A multi-agency task and finish group has been established to ensure that information sharing agreements and information governance arrangements are robust strengthening information sharing from health partners.

Coventry Probation

Coventry Probation has undergone a significant restructure as part of the Coalition's Transforming Rehabilitation agenda yet has continued to contribute to the child safeguarding agenda in Coventry through participation in Boards and sub-groups, inspections and audits. Coventry Probation undertook an internal child safeguarding audit in February 2014 which was supplemented by completion of the Safeguarding Board's section 11 audit in May 2014. In essence the learning from these audits is that there needs to be an ongoing focus on reflective practice supported by a robust role-specific training output.

We will also include learning from recent HMIP inspections around the country which have commented on the importance of appropriate management oversight of child safeguarding cases. The impact and outcome of this will be a staff body that is better equipped for the challenges at hand. A further audit has been carried out into the training needs of Coventry Probation's staff across the Community Rehabilitation Company and the National Probation Service and in house, role specific training will be commissioned accordingly. Coventry Probation has also engaged with Children and Families First through the Troubled Families agenda and has a CAF worker based at

its office for half a day a week. This is to enable practitioners to share information and to work together in the interests of children. As Probation is primarily an adult service, there is engagement with families, frequently in partnership with agencies also involved in safeguarding children and direct involvement with children is encouraged with officers being vigilant during office and home visits. This is an issue that will be an on-going focus of audit activity.

Coventry Probation commissioned Coventry University's Forensic Psychology team to deliver seminars to each team designed to raise confidence with working with domestic abuse perpetrators. It also commissioned an assessment of the domestic abuse workbook used by probation staff with a view to improving practice in this respect. The impact of the seminars was a self-reported increase in understanding and confidence in engaging with domestic abuse perpetrators. The outcomes will be an ongoing feature of this coming year's audit plan and the action plan arising from February's internal audit and the Section 11 audit. Coventry Probation has also contributed to improving the DVA process and is pro-actively involved in the screening processes; an officer will be seconded into the MASH and in the meantime Coventry Probation is actively involved in its development.

Section 4

Effective challenge in specific safeguarding circumstance

4.1 Multiagency Safeguarding Hub (MASH)

One area of particular importance is the work underway to establish a Multi-Agency Safeguarding Hub (MASH). The aim of the MASH is to co-locate professionals from a range of agencies in order to improve the effectiveness of the joint screening process. The agencies within the MASH are as follows:

- Public safety, children's social care and early intervention
- WM Police
- Probation
- University Hospital Coventry & Warwickshire
- Coventry & Warwickshire Partnership Trust
- Education

The Referral and Assessment Service will remain the first point of contact and where appropriate will pass referrals onto the MASH. The MASH will be able to quickly collate information from different agencies to build up a holistic picture of the circumstances of the case. As a result, decisions will be made quickly and support will be targeted on the most urgent cases. Better co-ordination between agencies will also lead to an improved service for children and their families, better risk management and mitigation.

In addition there has been closer working together between Children and Adult Services to ensure victims and their children are safe, whilst appropriate interventions are applied to the perpetrator. An example of this is the establishment of a multi-agency Serial DVA Perpetrators Case Management Forum and arrangements for joint working between Social Workers, Police and Community Safety Team Officers have been put in place.

A DVA task group set up under the LSCB brought together senior officers from a number of key statutory agencies. All agencies provided an outline of what their organisational response to DVA was in theory. This provided an overview of what each agency should be doing in practice but also gave an insight into where there were gaps in process and procedure or areas required for improvement both individually and collectively.

A key focus has been ensuring no disconnect between strategy and operational action. A DVA Operations Group was established in February which reports to the Police and Crime board but also has a clear link into the LSCB. This group will also work closely with the Quality and Assurance Sub-Groups in relation to responding to and improving performance using the DV monitoring tool that has been developed as part of the new performance monitoring framework.

A key role of the Operations Group will be to ensure appropriate information sharing and in doing so will seek to achieve a better connection between Community Safety & Safeguarding worlds and ensure professional practice is not delivered in silos. This work will also crucially inform and influence the development of the Multi-Agency Safeguarding Board (MASH) and the regional work in "Preventing Violence against Vulnerable People" (PVVP). Many Officers are already involved in these different strands of work and the enormity of the work involved in going forward has identified the need for some independent support for the DVA Operations Group.

4.2 Private Fostering

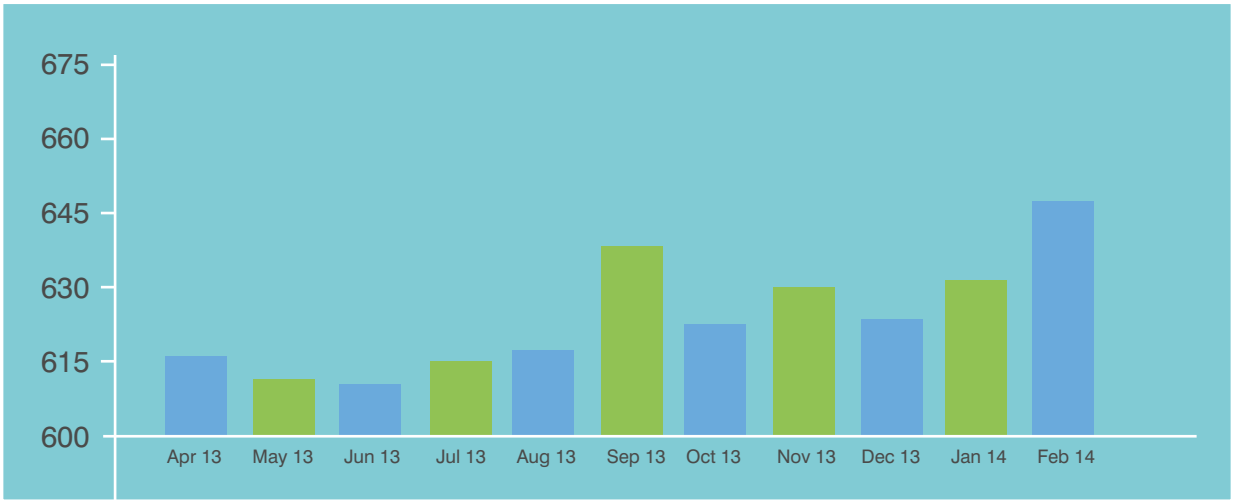
Private fostering is when a child under the age of 16 (or under 18 if the child is disabled) is cared for by someone who is not their parent or a close relative. This is a private arrangement made between a parent and a carer, for 28 days or more. Close

relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts (whether biological or by marriage). Nine children have been identified as currently being privately fostered in Coventry. In common with many other local authorities, this number appears low. Assessments of private fostering arrangements are undertaken by the Fostering Team. It has been identified that the processes for reviewing these children have not been swift enough. Work is now underway to improve this by the Local Authority.
The LSCB raises the issue of private fostering in a number of multi-agency training courses including the introduction to safeguarding, at events through the faith forum and training to BME communities.

Private fostering also features in single agency training for GPs and schools. In addition communication material including posters and leaflets outlining indicators of private fostering and who to contact have been produced and are being widely disseminated to local professionals.
Further work on awareness raising will take place during 2014-15 which it is hoped will result in a higher number of these children being identified and assessed, if indeed a higher number do appear to be placed in arrangements in Coventry. We will also be considering good practice that has taken place in other LSCB areas to increase the number identified.

4.3 Looked after children

Numbers of Looked After Children have increased during the year:



As at the end of February the LAC rate per 10000 children was 90.9. This compared to 87 as at the end of March 2013 and a national rate of 60 per 10000. It would be expected that our rates would be higher than national averages owing to the demographics of the city. Latest comparative data from our statistical neighbours will be available in the autumn of 2014.
264 children and young people entered care in the 11 months up to the end of February 2014. Of these children and young people, 83% of them entered care owing to abuse or neglect. This compares to 57% of entrants across England during the 2012-13 year. The high proportion in Coventry mirrors the high proportion of children and young people on child protection plans.

Work to support the local authority's duty to promote the education of children who are looked after is overseen by elected members and senior officers through Scrutiny Board 2, Corporate Parenting Board and the LAC Executive Board. The Looked After Children Education Service (LACES) works with colleagues in education, social care and other departments and agencies to support the local authority to fulfil its statutory duties in relation to the education of looked after children. All work is planned to raise the attainment of LAC, and is informed by national guidance, local circumstances and priorities and continuous measurement of impact.

Actions

Measures of impact for LACEs include:

- The attendance of LAC in Coventry schools is higher than or equal to that of their peers in Secondary and Primary mainstream schools and in Special schools. It is lower in Coventry PRUs, but this is largely due to the historical poor attendance of young people recently into care.
- For the past two years, we had no permanent exclusions of LAC. However, in the academic year 2013/14, there have been two permanent exclusions, in both cases involving LAC placed in out of city schools.
- History of strong relationships with secondary schools (100% satisfied or very satisfied: school satisfaction survey)
- Increased contact with primary schools from 2013.
- PEP completion at the end of the academic year 2012/13 was 89% - higher than it has been for many years.
- Consistently high level of satisfaction shown by delegates following training: average score of 1.4 (where 1 is excellent) from schools and 100% good or excellent from foster carers (see LACES impact folder)

- 84% of LAC supported by the LACES Learning Mentor showed improvements in their SDQ scores and this rose to 100% where the intervention continued over a sustained period.
- Percentage of LAC making 3 levels progress between Key Stages 3-4 was 43% higher in the group that received home tuition via LACES. (See LACES impact folder for details)
- NEET figures reduced in the group of LAC receiving additional support on WRL courses, over a 3 year period.
- The quality of academic targets in PEPs rose in four out of five years between 2006 to 2013, with the best results in 2013.
- 100% of young people said their involvement with a voluntary mentor helped with their education to some extent. 68% scored this at 5 or higher (on a scale of 1-10) in the areas of Schoolwork and Behaviour and these scores become higher the longer the young person has a mentor.

30 young people are included on the STEM Project. 14 mentors are already identified and trained, including 9 from Warwick University academic staff. There has been a uniformly high approval rating for all activities so far

4.3 Permanence

During 2013/14 52 children and young people (16% of all those who left care) were adopted. A further 27 children and young people (8%) achieved permanency through a Special Guardianship Order. Over recent years there has been an increase in adoption figures with 40 being adopted the previous year. The adoption inspection in August 2013 noted the improvement in achieving permanency, but there remains a challenge regarding the timeliness of adoption as Coventry children on average wait longer than children nationally for adoption.

There was a very significant increase in the numbers of children adopted in the year 1 April 2013 to 31 March 2014. 52 children were adopted, with a further 12 being adopted in the first two months of this financial year.

The projected number of adoptions in 2014/15 is likely to be 119. This will be dependent on

applications being lodged by prospective adopters after placements are made, and Court timescales.

4.4 Bullying

Coventry has an effective anti-bullying strategy and an anti-bullying steering group. This is a multi-agency group that meets twice a term with representatives from all partner organisations including the police, all schools and the youth service. This links into harassment and community safety policies and prevention and the work in schools. Many schools are now in the process of applying for the Coventry Young People's Anti-Bullying Charter Mark Award and a number have received it. Training in Kidscape Bullying Intervention Programme (BIT) endorsed by DfE is being delivered and rolled out to schools. Ofsted judge behaviour and safety to be "good" or "outstanding" in over 90% of Coventry schools.

4.5 Management of Allegations against People Who Work With Children and Young People

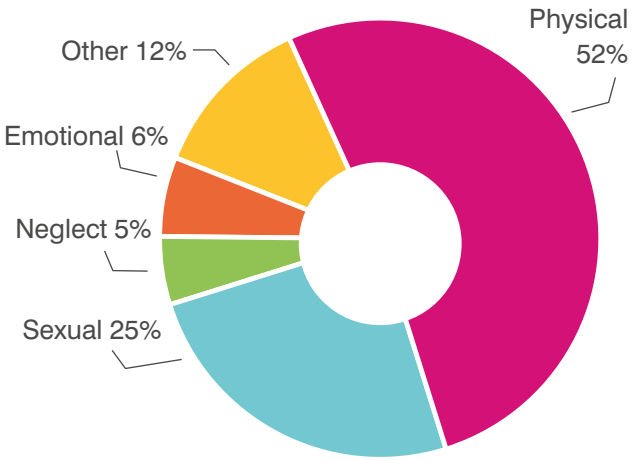
In Coventry there are currently three LADOs, who each operate the role alongside other responsibilities of the posts they hold within the Safeguarding/Education Service. The lead LADO is the Quality and Review Manager based within the Safeguarding Service.

Number of referrals to LADO between 01/04/2013 and 31/03/2014	107
Number of Initial Strategy Meetings held between 01/04/2013 and 31/03/2014	72
Percentage of referrals that progressed to Strategy Meetings	67%

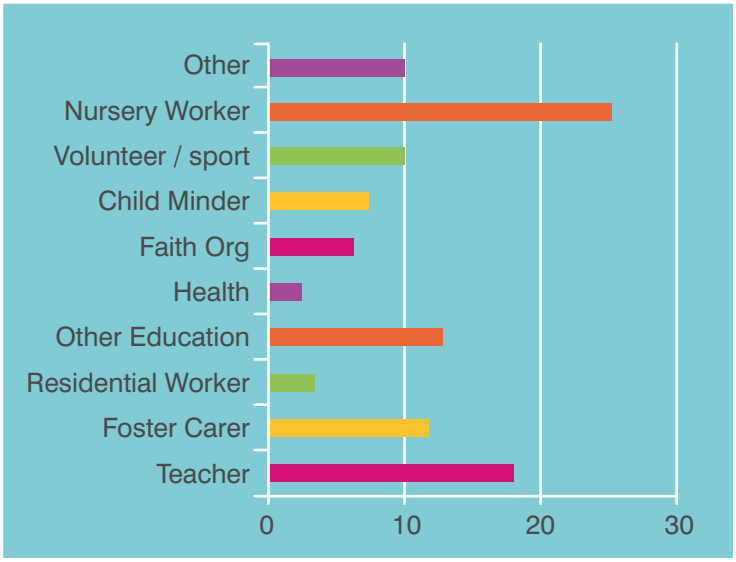
A) LADO REFERRAL DATA

By Category

Category	#	%
Physical	56	52
Sexual	27	25
Neglect	5	5
Emotional	6	6
Other	13	12
Total	107	100



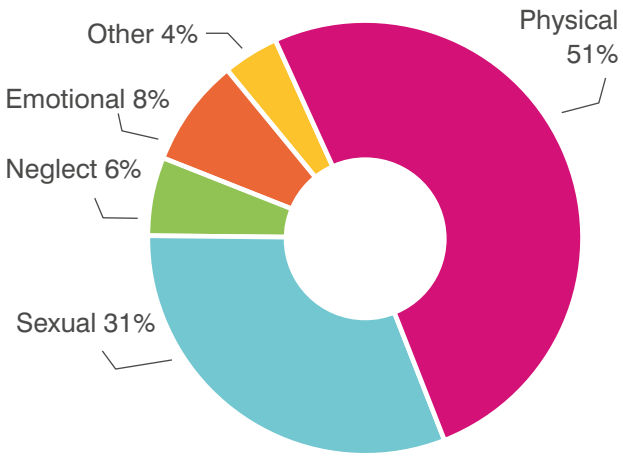
By Occupation



Referrals which do not meet the threshold for a Position of Trust Strategy Meeting are either subject to no further action or signposting on to other services/processes.

B) POSITION OF TRUST STRATEGY MEETING DATA

By Category



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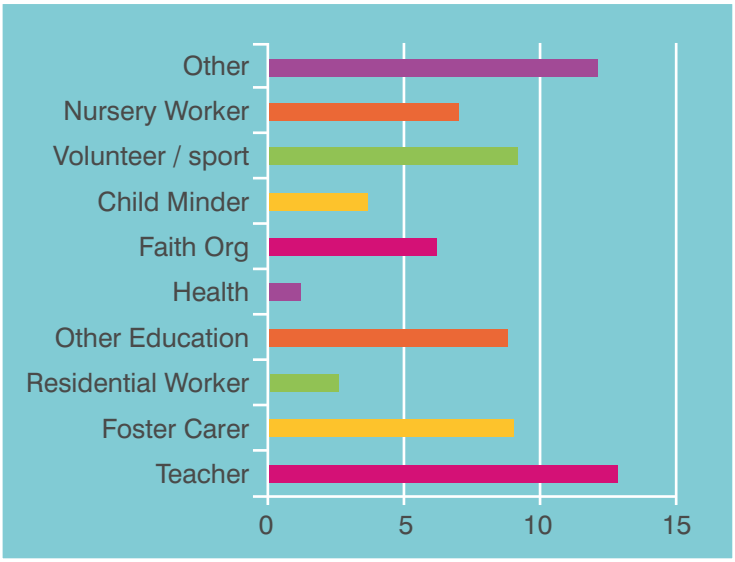


Police Investigation	19
Social Care Investigation	13
Internal Investigation/ management plan	22
Suspension	19
Refer to DBS/Ofsted	8
No further action	7

Some cases may appear in more than 1 category

Distribution of Action Plan/Outcome

Strategy Meeting Actions distributed in 48 hours	72 (100%)

Outcome of LADO Intervention at Closure

Criminal investigation/Prosecution	7
Performance management/training by the agency	19
Dismissal/Cessation of Use	14
Referral to DBS	6
Not concluded/on-going disciplinary process	11
Unsubstantiated following investigation	15

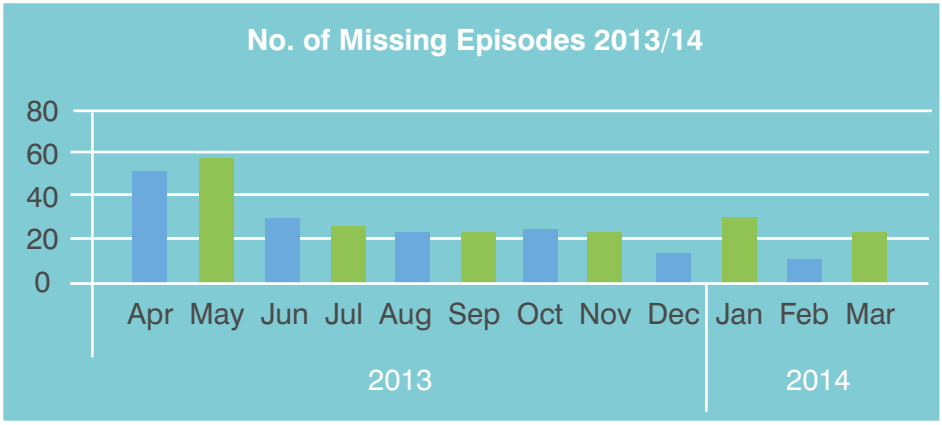
Local LADO Areas of Development to Improve Outcomes 2014/15

Improvement Required	Proposed Action
Referrals are not consistently spread across agencies/organisations. Some service areas rarely or never make referrals under these regulations.	• Development of publicity material and briefing sessions within the LSCB training programme. • Highlighting this area of work with partner agencies through LSCB • Targeting greater LADO awareness for agencies where referrals are lower than one would expect
A review of recording processes in July 2013 indicated a need to improve the robustness and consistency of referral/ follow up/ timescale data recording.	• Development of written referral information for staff/ potential referrers. • A resource has been identified to develop a specialist database to more effectively support LADO activity and reporting. • Improvements in storage/access restrictions in respect of confidential information relating to adults subject to allegations are in progress.
Monitoring and oversight of individual case management/consistency and effectiveness is not sufficiently robust.	• In recognition of the need to strengthen this area of work, agreement has been given to recruitment to a permanent substantive post holder taking on the LADO role. This is a development in line with other Safeguarding Services within the region. • A quality audit function in respect of LADO cases will be established. • A pro forma for LADO annual reporting will be developed.
There is recognition of the need to develop a strategy to deal with allegations in respect of specific faith based organisations.	• Multi-agency approach needs to be developed.

4.6 Missing children

The response to children missing from home and care in Coventry is delivered jointly by the Local Authority and West Midlands Police. Until recently, the operational mechanism for this was the Multi Agency Screening Panel (MASP), which provided a forum for analysis and recommendation making in regards of those deemed to be most as risk through frequent missing episodes. This included early preventative work for those children who are displaying early vulnerabilities and may have a first occurrence of missing.

In February 2014 MASP was replaced with the Child Sexual Exploitation and Missing Operational Group (CMOG), CMOG is directly accountable to the LSCB Child Sexual Exploitation and Missing Subgroup Group, chaired by DCI Dean Young.



Data Monitoring

Since June 2013, changes to the Police reporting and classification of missing or absent have had a significant impact on the numbers of children reported as missing. The previous MASP report to Safeguarding Board in May 2013, noted a total of children missing as 581. This year, April 2013 – March 2014 totals 323. As yet CMOG does not collect data on those reported as absent under the new Police guidance. The data clearly shows the implementation of the new Police guidance as the numbers of reported children missing per month drops significantly from June 2013 onwards.

Month	No. of Missing Episodes
Apr	47
May	59
Jun	27
Jul	25
Aug	22
Sep	22
Oct	24
Nov	22
Dec	14
Jan	29
Feb	11
Mar	21
Total	323

Of the 323 children reported missing, 208 were female and 115 were male, which in percentage figures is 64.4 % female and 35.6 % male. Compared to last year's figures there has been rise in the numbers of females reported as missing, with a percentage increase of approximately 13%. This could be related to the increased awareness and work in Coventry with regards to sexual exploitation and changes to the Police reporting criteria.

Compared with last year's figures there has been little change to the pattern of age of those reported as missing. The greater percentage most as risk of missing is still those aged 13 – 16 years. The figures show a marked increase at the age of 13 years, which is a change to the data recorded from last year. The increase in missing reports could be linked to the different reporting criteria to those children missing from Local Authority Residential Care Homes. The CSE Subgroup will need to consider the resources available to address those early signs of gong missing and absent at 11-12 years of age.

Of the 323 children reported missing 201 were missing from home, 113 were missing from LA Placements and 9 from other (Supported Accommodation). In percentage figures this is 62.2% missing from home, 35% missing from LA Placements and 2.8% missing from other. Those children missing from LA Care is higher in Coventry than the national average, which states 70 % missing from home and 30% missing from care.

Return home interview data (2013-2014)

The table below gives the number of young people who have gone missing and from the kind of accommodation they have gone missing from. The headlines from the data are that young women are more likely to go missing than young men. April, May, June and January have the highest number of missing episodes. In terms of ages range 15, 16 and 17 year olds are the highest episodes. In terms of return home interview the completion rate looks very low. However this does not take into account that when young people go missing repeatedly in a short period of time the return home interview often covers all the missing episodes.

Total	Male	Female	Return homes completed
324	116	208	112

Young people aged 11-18	Children under 11
290	34

LA Children's home	LA fostering	Supported accommodation	School	Home
71	43	6	3	201

Return home interviews timescales

The statutory guidance relating to conducting return home interviews within 72 hours remains an issue with only 36% of return home interviews being done within the 72 hours. There are a number of reasons for this; the main one is that young people often do not attend for their appointments with the youth worker.

Following the recent Ofsted visit, and the recommendation that 85% of return home interviews need to be completed within the 72 hours an internal review was undertaken. The recommendations of the internal review are being progressed.

Return home interview form

Intelligence gathered by a number of agencies has highlighted an increase in child sexual exploitation (CSE) activity within the city. This increase is one of the reasons we have altered the return home interview form to reflect this change and to gather intelligence. The CSCB has missing children and return home interviews as one of its performance measures and so will be closely monitoring this issue into 2014.

4.7 The Effectiveness of Multi-Agency Risk Assessment Conference (MARAC)

MARAC in Coventry has been operating since 2005. A MARAC is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to. The MARAC is attended by representatives from a range of agencies including police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, mental health and substance misuse and other specialists from the statutory and voluntary sectors.

Between April 2013 and March 2014 Coventry MARAC discussed 412 victims of which 210 were repeats. There was a review of Coventry MARAC by Coordinated Action Against Domestic Abuse (CAADA) in December 2013. Of the 13 cases observed by CAADA at MARAC 12 were considered appropriate.

There were 410 cases referred to MARAC in the data period CAADA reviewed which is 80% of the CAADA recommended volume of 510. 43% of these were repeat cases to MARAC. This is just above the expected range of 28-40% repeat cases for an effective MARAC. Cases that are referred to MARAC are often those that have experienced many incidents of domestic abuse so it is unsurprising that around 40% will experience a further incident following a MARAC. The repeat rate may be higher in Coventry because there is effective identification of a repeat incident. If the figure continues to increase then it may be necessary to review how the repeat definition is being interpreted to ensure that only those experiencing a repeat incident in line with the definition are referred again to MARAC.

In 2013 just 12% of cases came from partner agencies. For an effective and well embedded MARAC we would expect to see between 25-40% referrals from partner agencies with between 75-60% coming from police. Currently the LSCB is working with other partnerships to provide training on the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment tool to assist partners to understand how this should be completed and in what circumstances this should assist in increasing referrals from other agencies.

4.8 The Effectiveness of Multi-Agency Public Protection Arrangements

Number of cases where there is a risk to children

The total number of MAPPA level 2 and 3 cases during the year to 31 March 2014 where risk to children was identified as being medium, high or very high was six. This was made up of five sex offenders and one violent offender. The risk was identified as medium in one case, high in three cases and very high in two cases. There was also one case not known to Coventry Probation and therefore not assessed using OASys, the risk assessment tool used by the Probation service. There are currently no cases registered as Critical Public Protection Cases.

Comment on the quality of interagency work to manage risk

The quality of inter-agency work at panel is, as before, very good despite the pressures faced by all agencies, attendance at and participation in MAPPA is still being prioritised by partners. As MAPPA is a process that brings together partners in order to achieve outcomes that better protect the public, this is crucial to its impact in Coventry. Over the course of the year there has been a marked contribution by prisons, particularly in Level 3 cases, which assists greatly with sharing information across the custody and community thresholds.

Number of cases where there was reoffending

One MAPPA Level 2 case reoffended during the year. There was no risk to children from these offences. This case was recalled to custody for not complying with the terms of their release licence as a consequence of them re-offending.

4.9 Hospital admissions caused by injuries to children

The statistics for hospital admissions are now available to the LSCB and are shown by ward. This is the first year data at this level has been established and show some interesting variations which the LSCB and partners are considering. This will be subject to further analysis throughout the year.

For rates of self-harm per 10,000 for children 1-17, Longford (22.7) and Sherborne (21.84) wards have the highest rates with Wainbody having the lowest rate (5.55).

For attendances at Accident & Emergency which did not result in admission, there is also a wide variation across wards – with Longford (65.03) and Henley (62.39) being the highest rates per 1000 and Wainbody being the lowest (16.37).

4.10 Police Protection Powers

Between April 2013 and February 2014, 87 children came into care due to Police Protection Powers, compared with 14 in the previous year. This is a significant increase, illustrating the increase in protection work over the last 12 months.

The use of Police protection has increased and this was discussed during the Ofsted inspection. West Midlands Police regard this as an indicator that police duty inspectors are taking positive action to reduce significant harm to children.

The data identifies that in many cases these are new communities, where issues such as being left home alone or chastisement have been some of the main concerns. The safeguarding in education subgroup is tasked with exploring preventative work with parents regarding issues of managing children's challenging behaviour and consideration of how English law can best be conveyed.

Section 5

LSCB Priorities for 2014-15

5.1 2014-15 priorities

The priorities for 2014-15 for the LSCB have been agreed in response to the Ofsted judgement from the review of the Local Safeguarding Children Board. They have also taken account of the outcomes from the LSCB away-day which was held on May 12 2014.

An improvement plan has been devised and agreed by Board members which will be monitored by the Children's Services Improvement Board as part of the Improvement Notice issued by Department for Education on 30 June 2014.

The priorities for the LSCB are:

Priority One:

COMPLIANCE WITH WORKING TOGETHER 2013 - CHILD PROTECTION PRACTICE - Ensure that partners, including children's social care, health and police, fulfil the responsibilities for their roles as set out in Working Together to Safeguard Children (Department for Education, 2013) to deliver effective practice to safeguard and promote the welfare of children in Coventry. This will be achieved through LSCB challenge and evaluation of the impact of their activities.

Priority Two:

SERIOUS CASE REVIEWS - partners deliver improvements on time - Ensure that there is a timely response from partners to actions identified in serious case reviews, and that this results in evidence of improvement in outcomes for children.

Priority Three:

EARLY HELP Coordination & Evaluation - Ensure - through challenge and evaluation of impact - that all partners are fully engaged in the implementation and delivery of the Prevention and Early Intervention Strategy, so that children and their families have timely access to early help support.

Priority Four:

IMPROVE EFFECTIVENESS of LSCB CHALLENGE AND SCRUTINY - Ensure the practice and quality assurance sub-group utilises all information available, including audit findings and performance management information, to undertake a robust analysis of the effectiveness of services to help and protect children; demonstrable evidence of the impact of activity will be required from partners.

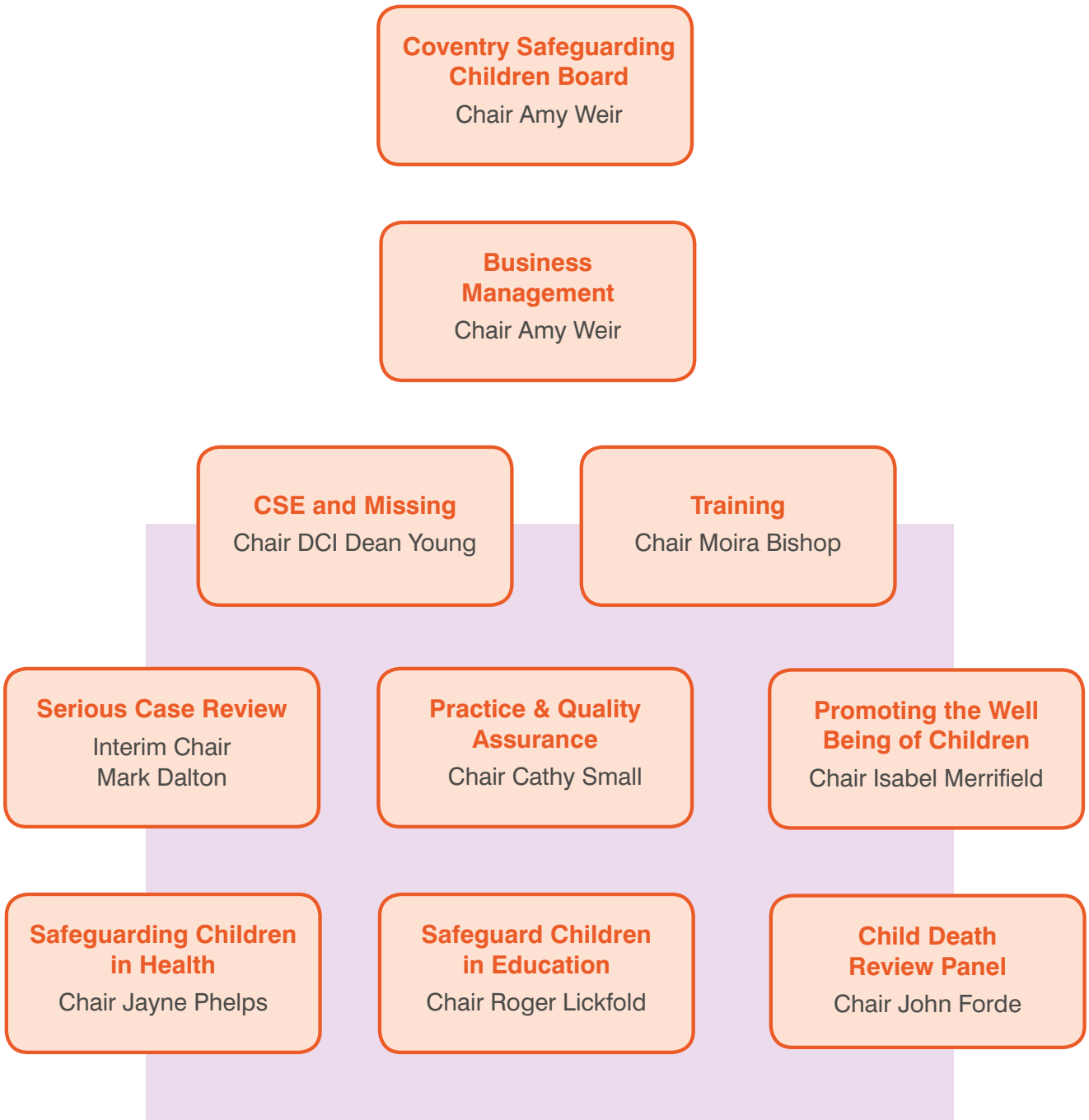
Priority Five:

Ensure young people's views routinely inform service improvement and training programmes.

Priority Six:

Promote awareness of private fostering to ensure that more privately fostered children and young people are identified and supported.

Appendix One – Structure Chart



This report is available online at:
www.coventrylscb.org.uk

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