Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Children's Services Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **10 February 2015**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Val Morris-Cook (Chair), James Halden (Vice-Chair, in the Chair), Charles Curtis, Martin Kerin, Tunde Ojetola and Graham Snell

Patricia Wilson, Roman Catholic Church Representative
Reverend Darren Barlow, Church of England Representative
Parent Governor Representative – vacancy
Parent Governor Representative – vacancy

Substitutes:

Councillors Jan Baker, Terry Brookes, Mark Coxshall, Sue Gray, Yash Gupta (MBE) and Sue MacPherson

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 14**

To approve as a correct record the minutes of Children's Services Overview and Scrutiny Committee meeting held on 6 January 2015.

3 Items of Urgent Business

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

Queries regarding this Agenda or notification of apologies:

Please contact Stephanie Cox, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **2 February 2015**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Children's Services Overview and Scrutiny Committee held on 6 January 2015 at 7.00 pm

Present:	Councillors Val Morris-Cook (Chair), James Halden (Vice-Chair) and Tunde Ojetola Reverend Darren Barlow, Church of England Representative
Apologies:	Councillor Martin Kerin Patricia Wilson, Roman Catholic Church Representative
In attendance:	Carmel Littleton, Director of Children's Services Janet Clark, Strategic Lead Operational, Resources and Libraries Unit Sue Green, Strategic Leader Early Years, Families & Communities Mark Livermore, Children's Commissioning Officer James Henderson, Youth Cabinet Representative Stephanie Cox, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

Reverend Barlow paid tribute to local resident Bradley Arthur in light of recent sad events and led those present in prayer and a minute's silence was observed.

17. Minutes

The Minutes of Children's Services Overview and Scrutiny Committee, held on 11 November 2014, were approved as a correct record.

18. Items of Urgent Business

There were no urgent items of business.

19. Declaration of Interests

Reverend Barlow declared a non-pecuniary interest in the general business of the meeting as he had children attending St Thomas Primary School, Grays Convent and Palmer's College. He was also a trustee and corporation member at Palmer's College.

20. 2014-15 Savings - Libraries

The Director of Children's Services briefly introduced the report, and in doing so explained the library service had been relatively stable since the last restructure which had taken place in 2011/12, however the budget now needed to be reduced and the community consulted on possible options.

The Strategic Lead for the Operational, Resources and Libraries Unit further highlighted the following key points:

- Between £569,000 of savings needed to be achieved from the library service and the proposed options would be consulted on with the local community following this meeting.
- The Library had been through a restructure in 2011/12 and staffing was currently at a minimum owing to previous government budget cuts.
- A significant proportion of the library budget was spent on staffing; therefore any option would have a considerable impact on the service.

The Committee were informed of the three proposed options and advised that a consultation document had been prepared in order to gain the views of stakeholders.

Councillor Halden commented that he had given the proposals considerable thought and recognised that officers had made a good case as to why the savings needed to be made. He made the following further key points:

- That Options 2 and 3 were clever and had merit, but felt that Option 1 was not an option.
- That the mobile library was a needed flexible resource.
- He was concerned that the proposed library restructure would decrease opening hours and therefore capacity, and that this in turn would make the service less viable in future as footfall would fall as a result.
- He did not feel that the any of the options proposed presented a comprehensive offer and that enough detail had not been provided to demonstrate how the options would work in reality, for example if the opening hours reduced what would become of the buildings in the days that it was closed.
- That the proposals would have an impact on Community Hubs and if a hub was established in Stanford what this would mean for neighbours such as Corringham.

Members were concerned that a vague consultation document could drive down response rates and therefore the validity of the overall consultation.

Councillor Ojetola supported a wider review of the library service rather than a piecemeal restructure and felt that proposals needed to be both realistic and pragmatic in order to achieve the savings. He further added:

- That the timing was not perfect and felt that wide scale changes would be difficult to implement.
- He recognised that a consultation needed to begin as soon as possible but was concerned that due to the timings of meetings and the forthcoming election it was unlikely that the Children's Services Overview and Scrutiny Committee would be able to fully consider the outcomes of the consultation in detail and recommend alternatives due to time constraints.
- He felt that it was important the consultation results be referred back to the Children's Services Overview and Scrutiny Committee even if it required an extraordinary meeting to be scheduled.
- He questioned what would be the alternative uses for the library buildings if option 2 was agreed and how in reality these could be re-let to achieve the required savings.
- That option 1 – the closure of libraries – was not an option.
- That increasingly residents relied on the libraries to access IT services in order to conduct business, especially as the public sector was encouraging the use of online services.
- He recognised that this was a politically sensitive issue by all and recounted what had happened when the Chafford Hundred library was closed.

Reverend Barlow felt that the report was well written and highlighted the following key points:

- That it was important the public and library users had the opportunity to express their views.
- He echoed that that if the library opened less it would be used less and therefore could be viewed as a service not required in future budget savings.
- He felt that it was important a central library was retained in Thurrock and that any change to Grays Library at Thameside was not a good option.
- He raised concern that this work would be politicised especially in the time before the next election.
- That in the examination of options 2 'Community Hubs' and 3 'Community Partnered Libraries' it was important to consider disadvantaged communities and the fact that some library users were reliant on the service to obtain access to computers or have a social place they can meet to combat loneliness.

Councillor Morris-Cook made the following key points during the course of the discussion:

- That the service should begin with a 'blank sheet of paper' in order to fully examine what Thurrock wanted from a library service rather than making piecemeal cuts which would dilute the resource.

- That she would like to see a 21st Century library service which was fit for purpose.
- She felt that community hubs were beneficial to the community and the proposals could affect the viability of hub development.
- She recognised that the mobile library had been off the road for a long time and questioned whether savings could be made in this area.
- She felt that Thurrock should offer library users an 'Amazon' style service so that books could be requested and delivered to their homes.
- Whether the service could be delivered differently and other options considered, for example by sharing a mobile library service with another authority in order to retain this benefit for residents.
- That if libraries needed to be closed it was preferable to close a library that was nearby to another, as Blackshots Library was close to Grays.
- She was concerned about closing libraries in communities such as East Tilbury, as the residents would need to travel further for this service and could become isolated.
- She questioned whether areas of excellence could be created in different locations with specialist libraries in different subjects.
- She felt that it was important the main Grays Library should be open 7 days a week and questioned whether the library could be moved into another council building to improve efficiency.
- Whether the use of kindles could be supported to reduce pressures.

The Director of Children's Services welcomed the comments made by Members and advised that the library service did loan kindles and were expanding the way residents could use the library service. She acknowledged that this was a particularly emotive issue and that library provision in Thurrock was valued.

The Committee were advised that Thurrock already operated an 'Amazon' style service through the Homelink programme.

Revered Barlow recognised that there was a danger that the most unhelpful outcome would be to only open a library for a few hours each week.

Members questioned what would be an acceptable response rate to the consultation as there needed to be a decent measurement to evaluate the options against.

Members were concerned that with gradual cuts to the libraries year on year there was potential for Thurrock to be left with an unviable service.

All Members were in agreement that a consultation needed to take place but that it needed to be a wide ranging consultation in order to for the public to explain how the service added value to their lives.

The Director of Children's Services outlined some of the questions that had been included in the draft consultation document, and following the Committee's request, confirmed that additional questions would be added to the consultation document to seek the public's views on the three proposed options and an open ended question to allow for other ideas to be put forward.

The Committee were in agreement that each option should be fully detailed within the consultation document and that a further 'Mobile Library' option should be included within options 2 and 3 so that residents could note their preference. All members felt that this additional option of a mobile library as part of the service proposed in options 2 and 3 should be included.

Councillor Halden was concerned that the consultation was going out to reduce the library service but the savings figure had no approval.

The Director of Children's Services informed the Committee that the higher savings figure of £569,000 had already been approved in principle by Cabinet and advised that the outcomes of the consultation would be reported to both Council in February and Cabinet in March 2015.

Members had a discussion on the savings figure, during which it was emphasised that the level of savings was not a question for the Committee as it was beyond their remit (as the Committee had no decision making authority), rather it was the role of the Committee to add value to how the savings could be realised.

Following the debate Democratic Services reworded recommendation 1.2 in the printed agenda until it was agreed by the Committee.

Members were in agreement that the outcomes of the consultation should be reported back to the Committee in the form of a briefing note as soon as possible for comments which could then be incorporated in any future report to Council and or Cabinet, to which officers agreed.

Councillor Morris-Cook added that the consultation should be widely accessible and available in schools, sheltered accommodation and libraries.

The Director of Children's Services acknowledged that this would be the case and that the consultation was expected to close on 19 February 2015.

RESOLVED:

1. **That the concerns and comments of the Children's Services Overview and Scrutiny Committee on the options put forward be referred to Cabinet.**

2. **That it be recommended a broad public consultation takes place, to include full details on the options as outlined within the report including mobile library provision, and that the outcomes be**

reported back to the Committee in the form of a briefing note before being referred to the appropriate decision making body.

21. Early Offer of Help Commissioned Services

The Strategic Lead for Service Transformation and Children's Commissioning introduced the report which was a good news story, and reported on the quarterly outputs and Key Performance Indicators (KPI's) of Commissioned Services and their impact.

Councillor Ojetola left the meeting at 8.19pm and rejoined the meeting at 8.20pm.

Councillor Morris-Cook requested that, in future, the numbers of total respondent s be included within the report in addition to percentages, as it was difficult to evaluate the performance of the service without this figure.

This was echoed by Reverend Barlow who acknowledged that percentages can be skewed without the figure of the total number of respondents.

The Children's Commissioning Officer agreed and assured Members that in future this detail would be included.

Councillor Ojetola commended the good work of the service but questioned why it had taken so long for the report to be referred to the Children's Overview and Scrutiny Committee as the results had been available in February 2014. In response officers explained that this was a new area of work that had not been scheduled on the work programme.

Members requested that officers provide a regular update to the Committee so that impact of the Early Offer of Help Commissioned Services could be monitored.

Democratic Services questioned whether the regular update should be provided in the form of an informal briefing note with one formal report being referred to the Committee for review annually, to which Members indicated that an update should be provided but that officers should determine the appropriate format and that a financial impact analysis be included as part of the future reporting process.

RESOLVED:

1. **That the outcomes being achieved through the current commissioned services be noted.**

2. **That officers be requested to provide a regular update to the Children's Services Overview and Scrutiny Committee in order to monitor the impact of the Early Offer of Help Commissioned Services.**

22. Emotional Well Being and Mental Health Services – Project Update

The Strategic Lead for Service Transformation and Children's Commissioning briefly introduced the report which outlined that the service had worked hard to provide greater value for money whilst also ensuring one holistic pathway that aimed to deliver more services in schools and the community in order to improve accessibility.

Members agreed that it was a positive report although it was questioned whether data and intelligence was being shared in a positive and swift way where there were many Clinical Commissioning Groups (CCG's) and Public Health working across Essex.

It was clarified that the Clinical Commissioning Group came together to Commission the service and that officers worked hard to ensure that the contract worked for Thurrock.

Members recognised that the age of 14 was a crucial time for Mental Health in Young People and questioned what was being done to identify the triggers to ensure intervention and support was available.

Officers explained that Emotional First Aid training had been provided for all schools and that specialist services would also be delivered within schools to offer support for young people. It was further reported that the Social Care team delivered a number of programmes to complement this work, which included a support for young people affected by Cyber Bullying.

The Committee were in agreement that the importance of reducing the stigma of Mental Health was crucial in approving accessibility, and questioned what was being done to help more difficult to reach individuals. Officers explained that providers were expected to think about access and engagement as it was crucial to the Commissioning process, and that a key part of the model was to move away from a clinic based approach and offer more help within schools.

The Youth Cabinet Representative felt that more training should be offered within schools so that peers could help spot the signs of Mental Health needs and that young people could offer support to one another, particularly as teachers may not have the time or dedicated role to offer individual support.

Reverend Barlow felt that Secondary Schools and Further Education offered good services but was also concerned about the stigma in society, despite the fact that mental health illness was commonplace and should not be something to be ashamed of.

RESOLVED:

That the work that had been undertaken to commence the procurement of the redesigned service, and its progress to date, be noted.

23. Work Programme

Councillor Morris-Cook requested a report on Cultural Entitlement be referred to the Committee in February 2015.

Councillor Ojetola requested than a report on the Admissions Forum be referred to the Committee in February or March 2015.

Democratic Services advised that a report on the Early Officer of Help Commissioned Services be added to the Work Programme of Children's Services Overview and Scrutiny for the 2015/16 Municipal Year, following Members request during the earlier item.

Democratic Services recommended that a number of to be confirmed items be supplied in the form of a briefing note to Members, as there was only two meetings left in the current municipal year and a number of outstanding items.

In response Councillor Ojetola requested that the Grangewaters item be brought to the Committee in the form of a formal report as it was an important issue.

Councillor Halden sought clarification regarding the budget item and questioned whether the budget report on the previous agenda, which had been deferred due to the purdah period, was now defunct or whether a further budget update report would be provided.

The Director of Children's Services explained that the report which had been deferred was now out of date and the report had already been referred to Cabinet. Members were advised that the a more up-to-date budget proposal had been presented to the Committee this evening on the Libraries savings proposals and a further budget report would be presented to the Committee in February 2015 specifically focusing on Nurseries.

Democratic Services clarified that a standing budget update and savings proposals item was included on the work programme for each meeting, however that this would be themed appropriately nearer to the time of each meeting depending on the nature of proposals. As a result a general budget update would not be provided but detailed savings proposals on particular relevant issues, for example the library service or nursery provision.

The Director of Children's Services confirmed a number of amendments to the work programme which included:

- That the Grangewaters Alternative Delivery Model be brought to the Committee in March 2015.
- That the Annual Report of the Local Safeguarding Children's Board and the Youth Cabinet Report be brought to the Committee in February or March 2015.

- An update on the YOS annual report be supplied to the Committee in the form of a briefing note before the end of the current municipal year.
- That the Local Government Ombudsman report had been completed at the previous meeting.
- That the report of the next SCIE review be paired with the Jay Report and an update report be referred to the Committee in February 2015.

RESOLVED:

1. **That an additional item on Cultural Entitlement be added to the work programme for February 2015.**

2. **That an additional item regarding the Admissions Forum be added to the work programme for February or March 2015.**

3. **That a report on the Early Officer of Help Commissioned Services be added to the work programme for the 2015/16 Municipal Year.**

4. **That the work programme be noted, subject to the amendments detailed above.**

Councillor Morris-Cook sought an update from the Director of Children's Services regarding a number of issues raised at the previous meeting, including any old cases of child exploitation and children missing from education.

In response, the Director of Children's Services explained that a recent audit of schools had so far not highlighted any cases which had not been brought to children's social care attention previously and that the service was regularly monitoring any cases where children were missing from school and following these up with other services and departments.

Reverend Barlow commended the success of the Education Awards and congratulated all staff and professionals involved which was echoed by Members. Reverend Barlow added that he would have liked to have seen more Further Education categories or entrants given the growth in this sector in Thurrock.

The Director of Children's Services highlighted that there had been one Further Education winner and agreed that it had been an excellent evening in bringing the community together.

The meeting finished at 9.13 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

10 February 2015	ITEM: 5
Children's Services Overview and Scrutiny Committee	
Commissioning of Local Authority Day Nurseries in Tilbury	
Wards and communities affected: All	**Key Decision:** Key
Report of: Ruth Brock	
Accountable Director: Carmel Littleton – Director of Children's Services	
This report is Public	
This report is Public	

Executive Summary

This report sets out the recommendations for the commissioning out of the two local authority day nurseries in Tilbury. There is high demand for early education and childcare places in the local area however the nurseries are not sustainable in the long term with their current operating model. The Childcare Act 2006 places a duty on the local authority to secure sufficient early education and childcare and the recommendations included in this report aim to ensure this duty continues to be met. All other early education and childcare nurseries in Thurrock are operated through the private and voluntary sector and that sector operates sustainably. The recommendations to proceed to tender will be considered at Cabinet on 11 February 2015.

1. Recommendation(s)

1.1 That the committee note the contents of the report, including the recommendations set out below to be agreed by Cabinet on 11 February 2015.

- **That it be agreed to commission out the two local authority run day nurseries in Tilbury as one unit, subject to the service specification, in order to maintain the number of places and service quality.**
- **That a full range of early years and childcare services continues to be offered in Tilbury including provision for funded early education for two, three and four year olds.**
- **That it be agreed to proceed to tender, as outlined in the commissioning report included at appendix 1.**

- **That authority be delegated to the Director of Children's Services in consultation with the relevant Portfolio Holder to proceed to tender and award the Contract to the successful provider.**

2. Introduction and Background

2.1 The local authority has a statutory duty as a part of the Childcare Act 2006 to secure sufficient early education and childcare locally. This does not have to be operated by the local authority and the majority of early years and childcare in Thurrock is provided through the private and voluntary sector.

2.2 In Tilbury two day nurseries, Little Pirates and Neptune Nursery are operated by the local authority and, these are the only ones in Thurrock to be managed in this way. There is high demand for places at the nurseries and they are of high quality with Little Pirates rated as good by Ofsted and Neptune Nursery rated as outstanding.

2.3 Neptune Nursery in Tilbury Riverside and Thurrock Park ward is accommodated in Tilbury Children's Centre as an integral part of the building; it is registered for a maximum of 37 early education and childcare places. Little Pirates is a stand-alone building based in Tilbury St Chads ward and is registered for a 52 early education and childcare places with additional provision for after school care.

2.4 The nurseries, whilst working towards becoming traded units, have been supported through shared management and also through the local authority funding backroom support functions and training. Recent changes in funding levels and the re-organisation of the children's centres mean that this is no longer possible in the long term.

2.5 Officers have been working to identify a suitable method to secure the long term sustainability of the nurseries to ensure that the provision of high quality early years and childcare provision continues for parents and that the local authority continues to meet its duties under the Childcare Act 2006.

2.6 In the report to Cabinet on Shaping the Council and Budget Progress presented to Cabinet in August 2014 proposals to consult on the commissioning out of the local authority run nurseries in Tilbury were presented and agreed.

2.7 Consultation has now taken place with staff and parents and this is outlined in this report. The feedback has been used alongside officer recommendations based on the statutory duty and knowledge of the sector. Consideration has also been given at Children's Overview and Scrutiny.

3. Issues, Options and Analysis of Options

3.1 In undertaking consultation, all parents of children using the nursery were made aware of the opportunity to feedback on the proposals and a meeting

was held with staff to consider their feedback. In addition, as the majority of families with children under five years old are registered with the Children's Centre all families were notified of the consultation.

3.2 Feedback from staff indicated that the main concern was to maintain high quality nursery provision and for future job security. This would be protected under TUPE rights and the service specification. Managers of the two nurseries also put forward a proposal to manage the nurseries differently however analysis of the proposal indicated that they would not achieve sustainability within the timeframe required.

3.3 Feedback from parents highlights the main concerns were in ensuring the provision remains in place and with maintaining the high quality of provision. If the decision to commission out the nurseries is agreed, the nurseries would be more sustainable in the long term thus protecting the places and the quality criteria will be written into any service specification. It should be noted that response numbers from parents were low and therefore officers arranged meetings with parents alongside the web based consultation.

3.4 Considerable work has been undertaken with regard to the financial sustainability of the nurseries over recent years with the aim of developing an operating surplus to cover the costs currently subsidised by the local authority. From this work officers have determined that the long term sustainability of the nurseries is not secure and that in order to protect services for parents they would be best provided through commissioning them out to the private or voluntary sector as this sector has a proven track record of managing early years and childcare services on a sustainable basis.

3.5 An estimate of the projected income and expenditure for 2015/16 based on the current year has been produced to provide an outline of the financial position for both nurseries as funding for support functions reduced, this is as follows:

Nursery	Expenditure (£)	Income (£)	Projected shortfall (£)
Neptune	379,578	317,323	62,255
Little Pirates	361,798	299,665	62,133

Income is received from parental fees, early education funding for two, three and four year olds and for places funded as a part of a support package, for example, where the child is subject to a child protection plan.

3.6 Savings from management and backroom support have already been included in changes to children's centres and locality services however as highlighted in the report to Cabinet in August a saving of £82,000 is anticipated through lease income which would be assessed on a commercial basis in line with other nurseries operating out of local authority premises.

3.7 If agreed, when commissioning the nurseries out the opportunity will be to operate them on a traded basis and therefore the local authority will not provide funding to do this over and above the income that all early years and childcare providers in the borough receive for example through the funding for early education for two, three and four year olds.

4. Reasons for Recommendation

4.1 There is a proven demand for high quality early years and childcare provision in the Tilbury area. Securing sustainable provision supports parents to work or access training and provides access to funded early education for 2, 3 and 4 year olds. The long term sustainability of this provision is not secure and by commissioning out the two nurseries they can become more viable. This will also ensure that the local authority's duties under the Childcare Act can continue to be met.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Consultation has been held with staff at the nurseries, parents currently using the nurseries and all parents registered with Tilbury Children's Centre.

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6. Impact on corporate policies, priorities, performance and community impact

6.1 This report relates to the following council priorities:

- Create a great place for learning and opportunity
- Encourage and create job promotion and economic prosperity

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager – Children's Services

Considerable work has been undertaken over recent years to improve the financial sustainability of Neptune Nursery and Little Pirates Nursery, whilst this has improved the financial position it has not resolved it. Changes to funding levels mean that the nurseries cannot continue to operate in their current form without financial risk to the Council. By commissioning at no cost the nurseries provision, this risk is mitigated.

7.2 **Legal**

Implications verified by: **Lucinda Bell**

Education Lawyer

The local authority has a duty to secure sufficient childcare for working parents under s6 of the Childcare Act 2006. By implementing measures to improve the sustainability of the childcare currently in place this duty should continue to be met. Delegated authority to proceed to tender is requested in the recommendations. S7 of the same Act imposes a duty to secure early years provision free of charge for some children, from the age of 2. If the recommendation is accepted employment advice on the TUPE arrangements for staff must be obtained.

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**

Equalities and Cohesion Officer

Access to good quality early education and childcare is proven to improve attainment levels and development in all children. This is particularly enhanced in areas with high levels of financial hardship. Given the levels of need in the Tilbury area, these proposals will support increasing attainment and a narrowing of the gap in educational outcomes. In addition the area has high levels of child poverty and economic disadvantage and the nursery provides childcare provision to enable parents to access work and training.

The referred commissioning exercise will be completed with due regard to the principles outlined in the council's recently approved social values framework and Commissioning, Procurement and Grant Funding Strategy with the Voluntary, Community and Faith Sector with particular reference to working positively with providers to maximise community benefit attained through the provision of day nurseries in Tilbury.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Report to Cabinet August 2014: Shaping the Council and Budget Progress

9. Appendices to the report

- Appendix 1 - Commissioning Report

Report Author:

Ruth Brock
Interim Strategic Leader School Improvement
Children's Services

THURROCK COUNCIL

FORM B	COMMISSIONING REPORT

To be attached to Approval to Proceed to Tender (Form A) for service contracts above £75,000 and works contracts above £499,999 or Cabinet Report (if over £750,000)

PS/2015/905

Tilbury Nursery Commissioning

1 INTRODUCTION AND BACKGROUND TO THE PROPOSED COMMISSIONING EXERCISE/TENDER

The local authority has a statutory duty as a part of the Childcare Act 2006 to secure sufficient early education and childcare locally. This does not have to be operated by the local authority and the majority of early years and childcare in Thurrock is provided through the private and voluntary sector.

In Tilbury two day nurseries, Little Pirates and Neptune Nursery are operated by the local authority, these are the only ones in Thurrock to be managed in this way. There is high demand for places at the nurseries and they are of high quality with Little Pirates rated as good by Ofsted and Neptune Nursery rated as outstanding

Due to ongoing sustainability issues the intention, subject to agreement, is to commission out these nurseries to the private and voluntary sector. This commissioning report relates to that intention.

Neptune Nursery in Tilbury Riverside and Thurrock Park ward is accommodated in Tilbury Children's Centre as an integral part of the building, it is registered for a maximum of 37 early education and childcare places. Little Pirates is a stand-alone building based in Tilbury St Chads ward and is registered for a 52 early education and childcare places with additional provision for after school care.

2 BUSINESS CASE

The nurseries, whilst working towards becoming traded units, have been supported through shared management and also through the local authority funding backroom support functions and training. Recent changes in funding levels and the re-organisation of the children's centres mean that this is no longer possible in the long term.

Officers have been working to identify a suitable method to secure the long term sustainability of the nurseries to ensure that the provision of high quality early years and childcare provision continues for parents and that the local authority continues to meet its duties under the Childcare Act 2006.

In the report to Cabinet on Shaping the Council and Budget Progress presented to Cabinet in August 2014 proposals to consult on the commissioning out of the local authority run nurseries in Tilbury were presented and agreed, this consultation has now been undertaken.

Considerable work has been undertaken with regard to the financial sustainability of the nurseries over recent years with the aim of developing an operating surplus to cover the costs currently subsidised by the local authority. From this work officers have determined that the long term sustainability of the nurseries is not secure whilst operated by the local authority due to high costs and that in order to protect services

for parents they would be best provided through commissioning them out to the private or voluntary sector as this sector has a proven track record of managing early years and childcare services on a sustainable basis.

An estimate of the projected income and expenditure for 2015/16 based on the current year has been produced to provide an outline of the financial position for both nurseries as funding for support functions reduced, this is as follows:

Nursery	Expenditure (£)	Income (£)	Projected shortfall (£)
Neptune	379,578	317,323	62,255
Little Pirates	361,798	299,665	62,133

Income is received from parental fees, early education funding for two, three and four year olds and for places funded as a part of a support package for example where the child is subject to a child protection plan.

Savings from management and backroom support have already been included in changes to children's centres and locality services however as highlighted in the report to Cabinet in August, a saving of £82,000 is anticipated through lease income which would be assessed on a commercial basis in line with other nurseries operating out of local authority premises.

If agreed, when commissioning the nurseries out the opportunity offered will be the business opportunity to operate them on a traded basis and therefore the local authority will not provide funding to do this over and above the income that all early years and childcare providers in the borough receive for example through the funding for early education for two, three and four year olds.

Access to good quality early education and childcare is proven to improve attainment levels and development in all children, this is particularly enhanced in areas with high levels of deprivation. Given the levels of need in the Tilbury area, these proposals will support increasing attainment and a narrowing of the gap in educational outcomes. In addition the area has high levels of child poverty and economic disadvantage and the nursery provides childcare provision to enable parents to access work and training.

INSERT DETAILS OF CONSIDERATION TO ECONOMIC, SOCIAL OR ENVIRONMENTAL WELLBEING DURING PRE-PROCUREMENT STAGE.

PLEASE SET OUT BRIEFLY HOW ANY SERVICES PROCURED MIGHT IMPROVE THE ECONOMIC, SOCIAL AND ENVIRONMENTAL WELLBEING OF THE AREA OVER WHICH THEY HAVE RESPONSIBILITY AND HOW THE COUNCIL WILL CONDUCT THE PROCESS OF PROCUREMENT APPROPRIATELY TO SECURE THE BENEFITS IDENTIFIED.

Insert details of the estimated previous spend on this Service. Information relating to estimated future financial spend on this Service will be contained in the exempt part of this report to ensure parties to the tender process provide an unbiased estimate of their fees therefore ensuring the council achieves Best Value.

Note – Officers should contact Finance for details of an appropriate Business Case format.

Financial Summary:

2.1 <u>Details of previous spend</u>

An estimate of the projected income and expenditure for 2015/16 based on the current year has been produced to provide an outline of the financial position for both nurseries as funding for support functions reduced, this providesan outline of previous spend and income levels. This is as follows:

Nursery	Expenditure (£)	Income (£)	Projected shortfall (£)
Neptune	379,578	317,323	62,255
Little Pirates	361,798	299,665	62,133

Income is received from parental fees, early education funding for two, three and four year olds and for places funded as a part of a support package for example where the child is subject to a child protection plan.

2.2 Details of Estimated Contract Cost

See Exempt Schedule 1

3 DRAFT SPECIFICATION

Neptune Nursery is accommodated in Tilbury Children's Centre as an integral part of the building, it is registered for a maximum of 37 early education and childcare places. Little Pirates is a stand-alone building based in Tilbury St Chads ward and is registered for a 52 early education and childcare places with additional provision for after school care.

The specification will set out the expectation that the current levels of places are maintained as a minimum for 48 weeks per annum with operating hours a minimum of 8am - 6pm.

Quality standards set by Ofsted will provide the specification with regards to quality used and it will be a requirement of the contract that the standard is maintained as good or better as judged by Ofsted. .

4 DRAFT TIMELINE

KEY EVENT	DATE
Publication of Contract Notice	Est 18/03/15
Issue PQQs *[Omit if not applicable]*	Est 18/03/15
Evaluation of PQQs *[Omit if not applicable]*	Est 04/05/15
Issue of Invitation to Tender	Est 25/05/15
Pre-Submission Clarification Meetings *[Omit if not applicable]*	N/A
Closing date for Tender submissions	Est 08/07/15
Post-Submission Clarification Meetings*[Omit if not applicable]*	N/A
Interviews *[Omit if not applicable]*	Est 03/08/15
Notification of result of evaluation	Est 21/08/15
Standstill period	Est 24/08/15 - 07/09/15
Expected date of award of Contract	Est 08/09/15
Contract Commencement	Est 01/12/15

The proposed timetable above is in draft form only; it is subject to change and is provided by way of guidance only. The Council's Responsible Officer will be updating and developing this working with Procurement Services.

The timeline is set to ensure that the changes are achieved in the next financial year whilst maintaining continuity of care for the children and parents using the nurseries.

5 PROJECT MANAGEMENT ARRANGEMENTS

5.1 Users/Stakeholders involvement and Communication Plans

Consultation has been undertaken regarding the changes with staff and parents

5.2 Risk and Opportunity Assessment and Register

See Exempt Schedule 3

5.3 Contingency Plans

See Exempt Schedule 3

5.4 Project Management Record Keeping Procedures (which must comply with the Council's documentation retention policy)

The record keeping procedures will comply with the Councils Document Retention Policy. In line with this, the procedure for procurement documentation which will be held by and managed by procurement as a a part of this project is as follows:

Tenders:
Pre tender advice - destroy 7 years after contract let or not proceeded with
Tender for contract under seal - destroy 12 years after the term of the contract has expired
Unsuccessful tenders - destroy 1 year after start of contract

Contracts:
Ordinary contracts - destroy 7 years after the term of the contract has expired
Contracts under seal - destroy 12 years after the term of the contract has expired
Post tender negotiation - destroy 1 year after the the term of the contract has expired
Service level agreements, compliance reports, and performance reports - destroy 2 years after the term of the contract has expired

New contracts will be registered by procurement and retained by the legal department

6 CONTRACT MANAGEMENT ARRANGEMENTS

6.1 Users/Stakeholders involvement and Communications Plans

User feedback will be sought as part of the ongoing monitoring of the contract

6.2 Risk and Opportunity Assessment/Register

See Exempt Schedule 4

6.3 Contingency Plans (including Civil Contingency Plans)

See Exempt Schedule 4

6.4 Proposed Arrangements for Post Contract evaluation

Post contract evaluation will be undertaken jointly through the Commissioning team and School Imporvement team as an integral part of the contract management process

6.5 Proposed Contract Management (including Monitoring arrangements)

This will include regular reviews of quality standards, consideration of Ofsted reports and an annual review of the service offered.

6.6 Contract Management Record Keeping Procedures

The provider will need to comply with the Data Protection and Freedom of Information legislation and the Councils Document Retention Policies. In addition clear requirements of the level of information to be collected to support the contract management process will be provided.

7 Procurement Implications

Procurement

Implications verified by:	Susan Isaac
Telephone	01375 652750
email	sisaac@thurrock.gov.uk

The estimated value exceeds the EU threshold for Services, consequently requires an EU compliant competitive tendering process to be followed, alongside the Council's constitutional and best value duties.

Procurement Services recommend that this contract be awarded on the basis of MEAT i.e. awarded to the most economically advantageous tender, taking into account both price and qualitative responses.

EXEMPT SCHEDULE 1

8 Financial Summary

Estimated Total Cost:	This is an opportunity to trade for five years with an estimated business value of approx £650,000 per annum. There is no contract cost to the Council therefore budget has not been identified.
Recommended Tenderer :	A full procurement exercise will be undertaken Costs not shown below as there is no cost to the Council

Breakdown of Estimated Contract Cost	14/15 £000's	15/16 £000's	16/17 £000's	Later £000's	Total £000's
Contract	0	0	0	0	0
Fees	0	0	0	0	0
Other (Specify)	0	0	0	0	0
Total Cost	0	0	0	0	0

Is the proposed Tender budgeted In the current Approved Capital and Revenue programme? ☐ Yes ☒ No

Funding Identified	14/15 £000's	15/16 £000's	16/17 £000's	Later £000's	Total £000's
1. Revenue Budget <Specify Code>	0	0	0	0	0
2. Capital Budget	0	0	0	0	0
Supported Borrowing	0	0	0	0	0
Unsupported Borrowing (*see note below*)	0	0	0	0	0
Grant 0	0	0	0	0	0
Capital Receipts	0	0	0	0	0
Other 0	0	0	0	0	0
Total	0	0	0	0	0

Note: If supported borrowing is to be used, please show under other financial implications how revenue savings can be made to fund the financing costs.

Other Financial Implications:

None

EXEMPT SCHEDULE 2

9 DRAFT EVALUATION CRITERIA

The evaluation will be based on financial planning / price 30% and quality 70% (5% od which will be interview based

Please note that the above evaluation criteria is in draft form only; it is subject to change and is provided by way of guidance only. The Council's Responsible Officer will be amending and developing the evaluation criteria in conjunction with Procurement Services as the tendering exercise progresses.

EXEMPT SCHEDULE 3

10 RISK AND OPPORTUNITY ASSESSMENT AND REGISTER
Relating to the proposed tendering exercise

Risk	Likelihood A. Very High B.High C.Significant D.Low E.Very Low F.Almost Impossible	Impact I. Critical II. Significant III. Marginal IV. Negligible	Level of Risk. High or Lower High – AI,BI,AII,BI,BII, CII Lower = Other	Potential Negative Impact	Management and Mitigation of Risk
Time - procurement timeline not met	D	II	Low	Financial implications due to delays	Clear project plan with slippage built into timeline
Limited response from potential providers	C	II	High	Nurseries become unsustainable	Provider events to be held to reduce risk

Contingency Plans

As the current provision is managed and operated through the local authority any risks to childcare place availability will be managed by continuing to operate with the current model in the short term. Finacial risks will be managed by close monitoring.

EXEMPT SCHEDULE 4

11 RISK AND OPPORTUNITY ASSESSMENT AND REGISTER
Relating to the ongoing provision of works/services under the contract

Risk	**Likelihood** A. Very High B.High C.Significant D.Low E.Very Low F.Almost Impossible	**Impact** I. Critical II..Significant III.Marginal IV.Negligible	**Level of Risk. High or Lower** High – AI,BI,AII,BI,BII, CII Lower = Other	**Potential Negative Impact**	**Management and Mitigation of Risk**
Quality levels not maintained	D	II	low	Poor quality early years and childcare	Monitoring and quality arrangments in place to identify problems early
Nurseries become unsustainable	D	II	Low	Nursery closes	Monitoring of take up of places will identify issues early and enable support to be offered

Contingency Plans

Support will be offered through the school improvement processes already in place with all providers across Thurrock. These have proven to be effective in maintaining high quality provision, in addtion the Childcare Sufficiency Officer can provide support and advice regarding sustainability issues.

EXEMPT SCHEDULE 5

12 CONFIRMATION FROM LEGAL, FINANCE AND PROCUREMENT

Commissioning Report **(Responsible Officer should sign section 13 below, and then pass to Legal, Procurement and Finance services to sign off below that they have been consulted an agree with the Commissioning Report insofar as it relates to their respective areas)**	
Confirmed by Legal insofar as it relates to Legal implications	
Officers Name Angie Willis	Date 15-1-15
Signature	
Confirmed by Finance insofar as it relates to Finance implications	
Officers Name SEAN CLARK	Date 15/1/15
Signature	
Confirmed by Procurement Services insofar as it relates to Procurement implications	
Officers Name Susan Isaac	Date 15/01/2015
Signature	

EXEMPT SCHEDULE 6

13 CONFIRMATION BY THE RESPONSIBLE OFFICER THAT RULE 5 OF THE CONTRACT PROCEDURE RULES HAS BEEN/WILL BE MET

The Responsible Officer Insert Name confirms that Insert Project Name has been carried out in accordance with Rule 5 of the Councils Contract Procedure Rules (Chapter 9, Part 2 of the Constitution) and in particular the following duties have been/will (as appropriate) be met by the Responsible Officer

The Responsible Officer has or will ensure duties have been met (Re 5.3 of the Contract Procedure Rules)	*Responsible officer must tick this box and sign below to confirm compliance*	☒ Yes ☐ No *If no, please explain here*
IN PARTICULAR:		
Compliance will occur with all regulatory or statutory provisions and the Councils decision making requirements		☒ Yes ☐ No *If no, please explain here*
Inclusion on Council's Contract Register	*Responsible Officer must inform Procurement Services of the contract so that Procurement Services can update the Register*	☒ Yes ☐ No
Value for Money will be achieved	*Give details eg most economically advantageous tender awarded?*	☒ Yes ☐ No *The tender that best provides a sustaibale high quality early years and childcare environment will be awarded*
Advice has or will be sought from Director of Finance & Corporate Governance as to appropriate security (bond/guarantee) required	*Please provide details of any bond/guarantee required*	☒ Yes ☐ No *If no, please explain here*
Document Retention Policy has/will be complied with	*Council's Document Retention Policy (ie for tender and contract documents) is available on in-form*	☒ Yes ☐ No

Financial evaluation will be made of the proposed tenderers including the winning tenderer/proposed contractor	*Required for all tenders over £75,000*	☒ Yes	☐ No
Advice has been and will be sought and followed from Procurement, Finance and Legal Services	*If no, this request will require reconsideration*	☒ Yes	☐ No
The Responsible Officer confirms that this project will be carried out in accordance with Rule 5 of the Councils Contract Procedure Rules (Chapter 9, Part 2 of the Constitution) and in particular the above duties have been/will (as appropriate) be met by the Responsible Officer	*Responsible Officer* *(Responsible Officer should sign here and then pass to Legal, Finance and Procurement to sign it off in section 6 above)*	**Name** Ruth Brock **Signature**  **Date** 15/1/15	

10 February 2015	ITEM: 6
Children's Services Overview & Scrutiny Committee	
Thurrock Local Safeguarding Children Board Annual Report 2013-2014	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Report of: David Peplow , Independent Chair Thurrock LSCB	
Accountable Head of Service: Andrew Carter, Head of Children's Social Care	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is Public	

Executive Summary

Thurrock Local Safeguarding Children Board (LSCB) operates within a legislative and policy framework created by the Children Act 2004 and Working Together 2010 (as amended by Working Together 2013).

This Annual Report, included at appendix 1, is required under the above legislative arrangements and reflects the priorities set within the LSCB Business Plan for 2013/14, the progress against these priorities, and areas for further development during 2014/15.

The report was deferred at the 11 June 2014 LSCB Board meeting at the request of partner agencies to include additional single agency contributions and was ratified at its meeting held on 17 September 2014.

1. Recommendation(s)

1.1 That the progress made on children's safeguarding for the 12 month period April 2013 to March 2014 be noted.

1.2 That the Committee consider and comment upon the report.

2. Introduction and Background

2.1 Thurrock Local Safeguarding Children Board's (LSCB) Annual Report for 1st April 2013 to 31st March 2014 provides an account of what activity it has conducted to oversee safeguarding services within Thurrock and to assess their effectiveness.

2.2 The Board was set up in order to make sure that key agencies work together to safeguard and promote the welfare of children and young people in Thurrock.

2.3 The LSCB operates within a legislative and policy framework created by the Children Act 2004 and Working Together 2010 (as amended by Working Together 2013).

2.4 This Annual Report is required under the above legislative arrangements and reflects the priorities set within the LSCB Business Plan for 2013/14, progress against these priorities, and areas for further development during 2014/15.

2.5 The report was deferred at the 11 June 2014 LSCB Board meeting at the request of partner agencies to include additional single agency contributions and was ratified at its meeting held on 17 September 2014.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no analysis option.

4. Reasons for Recommendation

4.1 It is a statutory requirement for Local Safeguarding Children Boards to produce an Annual Report. It is best practice for this to be considered by the Overview and Scrutiny Committee. This report is for monitoring and noting.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The document was circulated in draft format for consideration and comment by the LSCB and Children's Partnership (CYPP) committees.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The aims and priorities contained within the Annual report influence the refresh and development of both new and existing strategies and plans of both the Council and LSCB partner organisations.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager – Children's Services

No specific financial implications. The delivery of the LSCB Business is undertaken within budgets established through annual partnership funding.

7.2 **Legal**

Implications verified by: **Christine Ifediora**

Senior Solicitor

There are no direct Legal implications.

Thurrock LSCB is required to publish an Annual Report on the effectiveness of safeguarding in the local area. The report fulfils the requirements of the Children's Act 2004 to report on the effectiveness of safeguarding in the local area and to ensure that the appropriate agencies receive a copy.

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**

Equalities and Cohesion Officer

The annual report covers the safeguarding needs of all children in Thurrock. The plans and policies of its board and sub committees reflect the diverse needs which are supported through implementing and developing equalities impact assessments as appropriate.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- LSCB Business Plan 2013/14
- Minutes of Board meetings

9. Appendices to the report

- Appendix 1 - Thurrock LSCB Annual Report 2013/14

Report Author:

Alan Cotgrove

Business Manager

Local Safeguarding Children Board

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THURROCK LOCAL SAFEGUARDING CHILDREN BOARD

Thurrock Local Safeguarding Children Board Annual Report 2013-2014

Forward by Dave Peplow, Independent Chair,

I am pleased to introduce the LSCB Annual Report for 2013-2014. LSCB's are required to publish an Annual Report on the effectiveness of safeguarding in their area, including an assessment of local safeguarding arrangements, achievements made and the challenges which still remain. This report sets out the progress and achievements over the last year and those priority areas which the Board will focus on over the next 12 months.

Our Business Plan continues to develop, responding to new challenges as they arise. There is still work to be completed and this forms part of our forward plans for the coming year to enable our targets and aspirations to be achieved and acknowledged.

Our vision remains clear - that every child and young person in Thurrock should grow up safe from maltreatment, neglect and criminal activity. Keeping children safe requires a culture, across all agencies, where staffs are open to challenge and new ideas. That ethos has again been tested during the year. I am privileged to work with partners who share my commitment to this vision and are willing to analyse their performance to ensure it improves outcomes for children. We now need to build on a safeguarding system where the focus is firmly on the voice and experience of the child or young person's journey from needing, to receiving information, help and support.

As we move forward in 2014, there will be a strong emphasis on early help and prevention. We will see the development of a Multi-Agency Safeguarding Hub (MASH) and greater focus on our early help provision to ensure that we do all we can to prevent children and young people meeting crisis point before interventions are available.

I would like to thank the members of the Board for their work during this reporting period and particularly to all the front line practitioners and managers in Thurrock for their dedicated work in safeguarding children.

Dave Peplow

Comments by the report author

I write this report on behalf of the Board as a reflection of the progress made in improving safeguarding for the children and young people of Thurrock during 2013/14. It takes into consideration the views of Board members, data and some personal reflections. The report provides evidence and examples from the 2013 Business Plan, the progress and activity the Board is making across safeguarding and the way it works to support and challenge our partners in safeguarding our children and young people.

The aim to deliver 'more for less 'and make best use of contributions from partner agencies continues to be a challenge. A tight reign has been maintained on LSCB finances again this year which has enabled the Board to maintain a standstill financial contribution position for the fourth year running as we move into 2014/2015.

As part of our continuous improvement, we commissioned an independent review of the Board which reported back in November 2013. The review highlighted the need for some change and reflection on our current governance and practice. Some changes have already started to take place and we shall continue to develop our approach and processes as we move into 2014.

The Board was pleased to see Children's Social Care conduct a mock inspection on its services in readiness for future Ofsted inspections and to ensure that learning takes place to improve outcomes to safeguard Thurrock's children and young people. The Board commend the Local Authority for this approach and will be looking to see the benefits for our children and young people.

This report will show that overall the Board is carrying out its duties to a good standard and effectively carrying out its statutory functions, as well as identifying areas where it can make an impact. There are always areas for development, which the Board acknowledge and form the basis of our future work.

It is not practical to capture in words all activity within this report, in particular the mind-set and culture that is developing across agencies, but the report aims to highlight and evidence the main aspects.

As you read through this report whether a Board member or interested party there are three questions I ask you to consider:-

Question 1: Are we doing the right things?

Question 2: Are we doing things right?

Question 3: Are we making a difference?

A P Cotgrove

Alan Cotgrove

LSCB Business Manager

Background to Children's safeguarding in Thurrock

Thurrock lies to the east of London on the banks of the River Thames and within the Thames Gateway growth zone. The Borough is host to one of the biggest growth and regeneration programmes in the UK which over the next few years will create 26,000 jobs and 18,000 new homes. The programme includes the creation of the Grays Campus for South Essex College (opening September 2014) which will mark a change in the town's economy and future prospects, providing a learning centre for local young people to gain the qualifications and develop the skills for the new jobs being created in the Borough.

Thurrock's population is 157,700, having grown by over 22.5% since 1990. The population is projected to rise to 207,000 by 2033. Thurrock has a young population by national standards.

The population is increasingly diverse. According to the 2011 Census the non-white ethnic population was 15.7% – a significant increase from the 2001 Census of 4.7%. Among school-age children, more than one in four (26.5%) are from a black and minority ethnic group. Recent data indicates this rate has now increased to 30% (Education Commission Report 2013). Much of this change is being driven by the new homes that have been, and continue to be built across Thurrock. Three-quarters (75%) of the working age population are in employment. Unemployment among young people has risen steeply in recent years and supporting young people into employment and minimising long-term unemployment is a key challenge and agenda for both Children's Services and the Children's Partnership. This work is now starting to impact with a downward trend beginning to show.

Average house prices in Thurrock are historically lower than both national and regional averages. The council manages its own stock of over 10,000 homes. The availability of affordable housing and its inclusion in new housing developments is a focus for the Council to ensure sustainable growth.

Overall levels of deprivation in Thurrock are consistent with the national average however, Thurrock experiences significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England.

Just over one in five children in Thurrock is growing up in poverty (21.9%) – just slightly above the national rate (21.1%). The gap between the highest and lowest areas of deprivation in respect of child poverty is wide. For example, in Tilbury 55% of children are living in poverty, 25 times the level of child poverty in the least deprived ward of Corringham and Fobbing. The areas in Thurrock with the highest levels of child poverty also experience the lowest educational attainment and have more people in poor health or with disabilities which prevent them from working; higher proportions of workless families and higher numbers of adults with poor basic skills or who lack qualifications.

Infant and child mortality rates in Thurrock are consistent with national averages.
Children in Thurrock have average levels of obesity. 10.0% of children aged 4-5 years and 21.1% of children aged 10-11 years are classified as obese (9.2% and 19.2% nationally respectively).

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About the Thurrock LSCB

Thurrock Local Safeguarding Children Board exists as a statutory body and has a range of roles including developing policies and procedures and scrutinising and challenging local safeguarding practice. Section 14 of the Children Act 2004 sets out the Objectives for the LSCB as:

• To co-ordinate what is done by each person or body represented on the Board for the purposes of

safeguarding and promoting the welfare of children in the area and;

• To ensure the effectiveness of what is done by each such person or body for these purposes.

While the LSCB do not have the power to direct partner agencies, they have a role in making clear where improvement is needed. Each Board Partner retains their own existing line of accountability for safeguarding (Working Together to Safeguard Children, 2013). The role therefore of the Board is to have an independent co-ordinating and challenge role around safeguarding practice across its partner agencies. This is carried out through the Full Board and each of the sub groups, details of which are outlined later in this report.

For 2013-14, membership of the Board and representation from all agencies on each of the sub committees was good and we saw a number of changes over the year of individual representatives and a welcome improvement of education engaging in both sub groups and the Board. We reviewed the way meetings were run, how information was shared and how the Board can more effectively challenge practice. The commissioned review of the Board provided an independent view of our governance and procedures to ensure that we were “fit for purpose” and work has begun on the outcomes of that review to improve our systems and structures even further.

Those changes have included:

- New governance structure of the Board
- More direct challenge of services to individual organisations
- Greater focus on outcomes for children

The LSCB continues to participate in the local planning and commissioning of children’s services to ensure all members implement their duty to safeguard and promote the welfare of children in the delivery of all their services and reflect on practice and policy.

These are the main areas the Board have been involved in

- Policy development and refresh of the Pan Essex Child Protection Procedures
- Development of the Early Offer of Help and a member of the EH Project Board
- Development and supporting the implementation of the Multi Agency Safeguarding Hub (MASH)
- Developing a new threshold and pathways to service document.
- Development of joint working protocols

The LSCB also contributes and continues to works closely with the Children and Young People Partnership (CYPP) developing local policy and procedures.

Our Business plan for 2014-2015

A review of the Business Plan in March 2014 showed that in most key areas progress had been made against the actions set. Where any actions were delayed or not completed within the predicted timescale a review was undertaken to challenge why this was the case and they were actioned, accounted for or carried forward to the current year.

It was felt also that new and emerging themes needed to be incorporated into the plan moving forward to reflect the priorities in the Borough, in particular child sexual exploitation as well as identifying local impact and trends emerging nationally arising from Serious Case Reviews and Independent Management Reviews. These approaches will form the basis of individual work plans for the Serious Case Review Group and where local issues arise, the Audit Group and the Performance Panel in 2014 will focus on achieving better outcomes for Thurrock children.

Key highlights and achievements 2013-14:

- The 2013 Conference on Voice of the child
- Managed Review on fabricated illness
- a responsive and reflective multi agency learning and development programme that has been cost effective
- Business Plan on target and flexible to reflect emerging issues
- Continued focus on improvement and challenge by looking at business processes in the Board and challenging agencies and practice where needed
- Launch of new LSCB website

- significant progress with engagement and links with Faith Groups across the borough
- Continued links and sharing practice with other Boards, both within Essex and throughout the region

Areas reviewed and actions

- Thematic review process for Section 11 implemented for all partners through the Full Board
- Refreshed approach to child sexual exploitation, new training provided, intelligence network implemented,
- Focus on links with young people

Reports reviewed

- Private fostering
- Local Authority fostering
- Children's Partnership activity and policy development
- Child Death Review
- CAF
- Ofsted Inspection 2012 action plan outcomes
- Sexual health service and response to sexual violence

Areas for development in 2014-15

- Greater involvement of children and young people in the work of the Board
- Review how Working Together 2013 is embedding across practice
- Inspection frameworks and findings – there is a need to ensure that the Board maintains its position as being fit for purpose to meet the challenges it faces.
- Greater focus on outcomes
- Monitor the impact of the transformation processes across a number of agencies e.g. Probation, Local Authority, Police, Health and Education with Academies and Free Schools and any potential impact on safeguarding practice
- Focus on Sexual Exploitation following the Children's Commissioner Report and local intelligence
- Need for continuous review of smarter working and better use of resources
- Consideration of more "Pan Essex" and regional working and sharing of practice in some key areas such as training and learning provision and child sexual exploitation where boundaries do not apply to perpetrators.

- Making best use of action plans, data and case examples to continue to robustly challenge areas of concern
- Improving administration and support to the Board through cloud based technology

Working with others

This year has seen the development of a joint protocol co-ordinated through the Health & Well Being Board between the LSCB, the Adults Safeguarding Board and Community Safety Partnership. This has strengthened the cross working activities and provided clarity to all three areas.

The LSCB has maintained and developed further its links with the Children and Young People Partnership (CYPP). The CYPP manage and commission the delivery of the Interagency Training element of the LSCB and also provide a number of sub groups in support of safeguarding which are intrinsically linked into the work of the LSCB. It could be debated where various support groups sit within the children's safeguarding structure in Thurrock. The LSCB recognise the most important fact is that we have the right groups with the right people and regularly review practice through reporting processes to the Board, which ensures that all elements of children's safeguarding is in place to meet the needs of Thurrock's children.

Agencies Voice

This year we have added a new section to show how our partner agencies have contributed to safeguarding Thurrock children and young people. We asked each agency to respond to four key headings.

1. **What did your agency do in 2013/14 which promoted safeguarding and how can you evidence the impact on improved outcomes for children and young people as a result. Please include data where possible.**

Children's Social Care

Children's Social Care has successfully implemented a new format for Children & Family assessments combining the Initial and Core Assessment process. Following the challenge of the mock inspection undertaken in November 2013 , one of the areas for improvement was the need for more focussed and clear plans for both Child Protection and Children in Need, linking with better outcomes for children. Workshops have been held with staff to support them with this.

Independent case audits are being undertaken with action plans linking with better and timely outcomes for children. Placement stability for our LAC has improved with fewer children having 3 or more moves in placement.

As part of the transformation of the council, all of Children's Services are transferring into the refurbished Civic Centre, with new mobile technology which will have a positive impact on their efficiency.

Essex Police

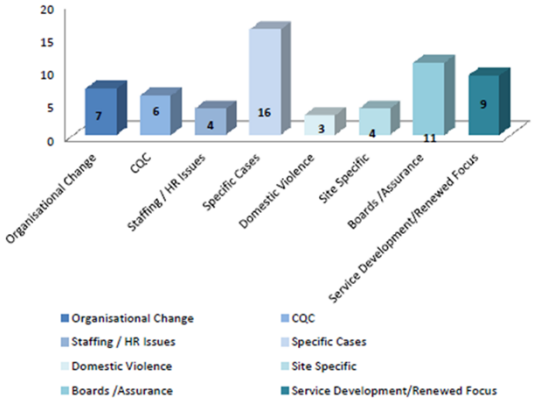
Essex Police has undertaken significant work to further embed early information sharing following domestic abuse incidents where children and young people have been present. This has enabled the partnership to consider and respond to safeguarding at the earliest opportunities, ensuring that risk to children is managed and mitigated. This work is supported by the Domestic Abuse Strategic Partnership Working Group to that is working to identify meaningful and sustainable solutions to the domestic abuse agenda, including those that involve children. Significant work has been undertaken to further embed quality victim management and process to respond to young people who are victims of crime, ensuring that Essex Police works in partnership to safeguard while progressing investigative lines of enquiry.

Significant work continues in the field of 'missing' children and links to child sexual exploitation. Essex police have set up a triage team to consider and develop intelligence and information sharing to identify and protect young persons who may be at risk. Significant work has been led by Essex Police in support of development of a CSE multi-agency risk assessment and notification process.

Thurrock CCG

During 2013, meetings were held quarterly by the Designated Nurse with five healthcare professionals, resulting in a total of 20 meetings across the year (these do not include adhoc unannounced visits for discussions). This included health professionals working for providers including Basildon & Thurrock University Hospital (BTUH), North East London Foundation Trust (NELFT) and the Sexual Assult Referral Centre (SARC) together with CCG employees.

From these meetings, eight themes emerged as dominant topics for discussion as displayed in the chart below:-



As might be expected specific cases were the most discussed topic where actions, timeframes, advice, challenge, escalation and learning were covered. Assurance and understanding of reporting to and the function of various Committees and Boards emerged as the next concern, ensuring that they received an accurate picture of local safeguarding issues was delivered. Organisational change and new service development/renewed focus (eg, Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) and Section 11) emerged equally as the third most popular theme for discussion.

SEPT

Compliance with Safeguarding Training at three levels remained at over 95% for the year.

A presentation was given to the LSCB in March to evidence that there are improved outcomes for children attending CAMHs services. Feedback from young people included:-

- *That I could talk about anything"*
- *"I have been listened to and my thoughts and feelings are always taken into consideration"*
- *"I feel like I am making progress"*
- *"I felt listened to and I have been offered other services as needed"*
- *"I felt for the first time someone understood what I was going through and knew how to help. They have been very understanding and made me feel better about myself"*
- *"Everyone listens, I feel comfortable with who I talk to, everyone's really friendly, kind and welcoming"*
- *"I feel like the people here have made a significant change in my life*

A conference was held for 189 staff in February on safeguarding. This included a number of workshops on Domestic Abuse and Parental Mental, drug & alcohol misuse and the effects on children's welfare.

A three month follow up showed that clinical practice has improved for example- safeguarding has become a standard agenda items at adult team meetings. Risk assessments on the adult include child's welfare etc.

NELFT

Safeguarding Children Training – this is mandatory and is provided to all staff working for NELFT. Compliance reports are completed monthly by the training dept.
On 02.06.14 uptake of level 1 training was 91.6%, level 2 uptake was 87.04% and level 3 uptake was 89.52%.

Dissemination of learning events from local and national SCR's are held quarterly through 2013/2014. NELFT evidence how training has had an impact on practice and improved outcomes for children and families by use of post evaluation questionnaires.

Following completion of an LSCB Multi Agency Case Review (MACR) for a suspected case of fabricated or induced illness in May 13, NELFT took part in delivering an FII workshop across the local health economy with Social Care. This has raised staff awareness of FII and has led to staff identifying and bringing further cases for discussion in safeguarding supervision and a further case has also been taken to Social Care and identified as FII.

Safeguarding Children supervision is mandatory for all NELFT staff that comes into contact with children and young people and they must receive one to one or group supervision, dependant on their roles and responsibilities.
Compliance in May 2014 1:1 was 91.7% and group was 100%. A supervision audit was completed in February 14 to monitor the quality of supervision and staff compliance with the safeguarding children supervision policy. The voice of the child is discussed and recorded in all supervision sessions.

Voice of the Child - A Mapping exercise was completed in August 13 to identify how the voice of the child was being captured across children's services. A voice of the child action plan has now been developed and is being progressed across NELFT to ensure the wishes and feelings of children and young people are heard and involved in service provision .The voice of the child is now captured and recorded at all core contacts.

Audits - Section 11 self-assessment audit was completed to assess the effectiveness of safeguarding arrangements across NELFT and to evidence improved outcomes.

A NELFT wide audit was completed in December 13 to assess the quality, timeliness and outcomes of Multi Agency Referral Forms (MARFS's). Going forward this audit will be completed bi yearly and will enable NELFT to identify learning, improve the quality and future referral rates and improve outcomes for children.

Probation

Essex Probation seeks to Safeguard children in Thurrock in three main ways: firstly by managing the small number of Offenders who, by their offending, pose a High Risk of Harm to children and young people; secondly and more broadly, as an agency working with a large number of adults in Thurrock, many of whom are parents, influencing their behaviour so as to improve the Safeguarding, wellbeing and future life-chances of their children; and thirdly, as an active member of a range of statutory partnerships in Thurrock, working jointly to improve the safety of children.

East of England Ambulance Service

The Trust continues to work in partnership with the Local Safeguarding Children Board (LSCB) and the Local Safeguarding Adult Boards (LSAB) around the Eastern Region. The assistant general managers with safeguarding responsibilities have started to attend these meetings supported by the Head of Safeguarding, in order to strengthen local area networks. In some area this has been more imbedded than others as some senior managers have been undertaking this role longer than others, there are still gaps within some localities which presents a risk to statutory duties in attending meetings.

The Trust continues to support Child Death Overview Panels (CDOP) around the Eastern Region, again this is varied dependent on the area. Form Bs (a form completed by agencies who may have accessed the child prior to or at the point of death) are complete on request and attendance where invited to support CDOPs in understanding the nature and cause of the child death. The Trust has encouraged the Safeguarding Assistant General Managers (SAGMs) to participate in the CDOP meetings and to support any member of staff who may be invited to a rapid response meetings (a meeting undertaken by the CDOP multiagency professionals within 24 - 48 hours after the child death, this meeting is for practitioners from all agencies to share information regarding the child and family).

The Trust Head of Safeguarding takes responsibility to work with NHS England Area teams (X3), National Ambulance Safeguarding Forum and the Department of Health and Royal Collages regarding policy deigns, National standards and uniformity within safeguarding processes.

The Head of Safeguarding also attends the Quality Governance and Risk Directors Group (QGARD) and Ambulance Service Safeguarding Forum (NASF). The Trust Head of Safeguarding is currently Chair of this National Ambulance Safeguarding Forum.

South Essex College of Further & Higher Education

The College has a broad approach to child protection and safeguarding and this includes the following:

- Senior staff with designated child protection training, experience and skills
- A dedicated team of Safeguarding Advisers
- Online safeguarding training for new and existing staff
- General safeguarding training
- Designated Child Protection Officer Training
- Designated Child Protection Officers on main campuses
- Policies and procedures
- Staff DBS, employment and identity checks
- Multi agency working
- In-house counselling service

South Essex College have spent 2013/14 developing the way Safeguarding has been approached and also viewed across the College. A new team has been recruited and the focus they have been given is on preventative work as well as the crisis management. They have spent time ensuring they are well known across the College and staff is referring cases to them. Safeguarding Training is provided through an online tool which all new and existing staff completes. The Safeguarding Team have promoted Awareness Days regarding specific Safeguarding issues that may be occurring within the college.

The College was inspected in November 2013 and received an overall grade of 'Requires Improvement'. The full report is available here: http://www.ofsted.gov.uk/inspection-reports/find-inspection-report/provider/ELS/130672

The quote in the report regarding safeguarding is very good and clearly shows that the College is meeting its statutory requirements, if not going above, to safeguard children and adults at risk. The feedback given from the lead inspector for 'Effectiveness of Leadership & Management' was very complimentary of the working relationship between Student Services and HR which showed a very joint-up approach in the College.

"The college meets its legislative requirements for safeguarding well, including those that provide training on behalf of the college. Managers also provide a good duty of care for adults such as support for those who encounter hardship. They are implementing robust arrangements that reflect the importance of students' and apprentices' well-being and safety. These include improved centralised records and a governor with specific responsibility for safeguarding who links closely with a dedicated senior management team. They respond effectively to safeguarding concerns that arise and are constantly looking to improve their systems."
(Ofsted, November 2013)

Thurrock is currently the smallest campus and does result in the lowest number of cases. The Campus currently has a student population of 1391; the Safeguarding Team have worked with 75 students, this equates to 5% of the student population and this percentage is reflective of our other campuses too. The most common reason for intervention is Mental Health and housing/home life concerns.

The Safeguarding Team have worked extensively with Social Workers and the Local Authority to ensure that all Looked after Children are supported whilst at college. We have supported in arranging PEP and LAC reviews between the teaching teams and Social Workers to ensure all are aware of continued progression of the student and any issues arising that are putting them at risk of not achieving their target grade.

The Team have worked extensively with specific students who have been at high risk in terms of their needs both from a college and Local Authority perspective. We have ensured that with high needs students, we have developed links with their previous school, created a 'hand over' whereby the college is informed of the supported needs of the learner and transition between school and college is easier. The student and their support needs (pastoral, academic, etc) are known to the college prior to enrolment and in place ready for the start of the course. Staff, when relevant, is notified of any safeguarding concern and know to refer to a Designated Child Protection/ Safeguarding Officer if a safeguarding concern presents itself.

2. What challenges as a single agency have you faced in trying to achieve improved outcomes and how have you addressed them?

Children's Social Care

There has been a steady rise in the number of children subject of a Child Protection Plan and Looked After. For both CP and LAC this is 75 per 10,000 populations, significantly higher than statistical neighbours and all England. This places increasing pressure on case allocation and budget. There is

a need to understand and gather effective and relevant data to understand the reason for increased CP and LAC numbers.

We have put in place CP and CIN surgeries to ensure appropriate thresholds are applied and that children do not drift in the system and there are effective step up and down processes in place, undertaken in a timely way. A similar tracking process will be put in place for all LAC to ensure that permanency is achieved.

As with all agencies there are considerable pressures on reducing spend and considerable savings to be achieved across the service to meet the council's budget pressures.

Essex Police

Essex Police in a similar vein to other police forces has continued to see an increase in the report of sexual offences, including those against children. This largely amounts to those of a historical nature following the high profile media cases and national attention to such issues. Significant progress has been made to embed the new Victims Charter to ensure that all those who report such offences are fully supported and provided with regular and relevant information. This also supports the expectation to listen to the voice of the child Robust supervision and management processes have ensured that enquiries have progressed as required, achieving an increase in persons charged and convicted for sexual motivated offences.

SEPT

With the many changes within the NHS there was a need to refresh the way SEPT work with other NHS colleagues in Thurrock. As such a project 'Integrated Family Working' was initiated by SEPT and there are now regular meetings between Adult Mental Health Services, Named Safeguarding Nurses and representatives from the Community Health Services for Perinatal, health visiting and School nursing services. The meetings involve raising awareness of how services operate, contact sheets and joint working processes.

NELFT

Evidencing improved outcomes - Being able to evidence that the health intervention provided has had a positive outcome on the child's health and wellbeing can be a challenge. All children subject to Child Protection/CIN plans have care plans that are SMART and are reviewed regularly to ensure risks to children are monitored and reduced.

There is a need for NELFT to further develop safeguarding children outcome measures.

Ensuring a child centred approach " the child's journey"– Effective safeguarding services must be based on a clear understanding of the needs and wishes of children and young people .Staff need to ensure the child / young person is seen, heard, their views taken seriously and recorded, and staff need to work in collaboration to support the child/ young person's needs. The work we have progressed so far to capture the voice of the child needs to be further embedded in practice.

Probation

The greatest significant challenge for the Probation Service as a whole and Essex Probation as part of it, for 2013-14 – and for the first two months of 2014-15 – resulted from the changes as part of the Ministry of Justice "Transforming Rehabilitation" initiative, which have led to the dissolution of all Probation Trusts and their replacement by two new organisations.

The extent and speed of these changes has been very significant, but on 31st May 2014, Essex Probation ceased to exist and on 1st June 2014 it was replaced in Southend, Essex and Thurrock by two new organisations: the Essex Community Rehabilitation Company (ECRC) and the National Probation Service.

The statutory responsibilities laid upon the two new organisations by the Children Act and its amendments remain unchanged and both of these new organisations, therefore, will be statutory members of Safeguarding Children's Boards and a key part of Safeguarding arrangements in their area.

East of England Ambulance Service

The Safeguarding Annual Report reviews work across the whole of the East of England Ambulance Service NHS Trust (EEAST) geographical area over the last year in relation to safeguarding children, young people, and adult's identified to be at risk, the Mental Capacity Act and also reflects multi agency partnership working and partnerships across the wider health economy. Safeguarding has continued to remain high on the agenda for all statutory organisations in relation to both adults and children. The Trust has a statement of commitment to Safeguarding on the Trust's website.
The Trust continues to be registered with the Care Quality Commission and in order to remain registered it is required to demonstrate on-going compliance to the "Essential Standards of Quality and Safety". Outcome 7 relates to safeguarding vulnerable people who use services from abuse. The Trust has taken steps to implement suitable arrangements to ensure service users are safeguarded against the risk of abuse by identifying the possibility of abuse and preventing it from happening and

by responding appropriately to any allegation of abuse. This information is monitored through the Trust's governance arrangements and through the quality schedule incorporated within the standard ambulance contract by the Clinical Commissioning Group of Great Yarmouth and Waveney.

The Trust has seen an escalation in safeguarding activity through SPOC; this increase is identified as 85% within the last 12 months. This seems to be consistent with Ambulance Trusts Nationally; it is not clear as to why this steep activity increase and especially within the last 12 months. It is, however, identified that the increase represents a more appropriate monthly figure of concerns and better representation of the needs and concerns of the local communities. This insight is informed by the Head of Safeguarding's work with the CCGs and Local Authorities in the Eastern Region.

South Essex College of Further & Higher Education

The challenges we have faced would be collaboration with specific agencies within the Local Authority. We have contacted specific groups within Thurrock (e.g. Thurrock Social Workers, Young Carers Groups, and Family Mosaic) to help develop our understanding of the support these agencies provide and ensure we can make accurate referrals and draw upon the resources within the local authority. We still need to further develop our links with local agencies and this will be furthered during the summer period.

We will be expecting an influx of students over the next few years at the new Thurrock Campus and there is a predicted increase in the amount of students who will attend the college. It is therefore important that we further develop our partnership with Local Authority agencies working together to improve our practice.

Thurrock CCG

This first year of CCG has been a year of significant change for the National Health Service, with pressures of budget reductions, service and structure reviews and developments in national and local policy agendas. NHS TCCG and health partners have risen to the challenges and continue to provide effective support and safeguarding services to the most vulnerable children and families in the health community.

As these challenges continue within the NHS, TCCG Safeguarding Team will continue to support the health economy with their statutory safeguarding responsibilities and maintain a focus on the quality and effectiveness of children safeguarding practice across the partnership, ensuring robust arrangements are in place to ensure good outcomes for the children in South West Essex and will continue to hold commissioned providers and partner agencies to account.

3. What challenges around multi agency working have you faced to achieve improved outcomes and how have you addressed these?

Children's Social Care

The understanding and application of threshold by partner agencies into Children' Social Care continues to be an area for attention and could explain the high numbers of CP and LAC in Thurrock. Threshold document re-launched.

On occasion there has been a lack of attendance at multiagency meetings from some partner agencies. There have been further challenges to meet the new timescales as set out and required through the implementation of the FJC reforms with considerable pressure to reduce timescales.

Essex Police

A regular process of partner communication at all levels has ensured that there is a clear understanding of responsibilities, which has led to effective working arrangements and support for young people.

SEPT

To continue to provide substantial assurance that there is effective safeguarding children process in place using audits including Section 11.

To ensure partnership working is effective for example

- The Integrated Family Working project will continue
- Thurrock LSCB minutes are standard agenda items on the Trust Safeguarding meeting

NELFT

Ensuring SMART CP/CIN plans - Front line staff sometimes needs to challenge other agencies to ensure CP / CIN plans are robust and SMART enough to ensure actions are progressed to improve outcomes for children and families. Staff are reminded, through supervision and training , to ensure actions agreed have achievable time frames and effective multi-agency plans are developed and monitored by the group to ensure children are effectively protected.

Regular Multi-agency network meetings are in some cases not always being held and CIN plans are not being effectively monitored to ensure the safety and welfare of the child. Staff advised to discuss concerns with Social Worker and ensure an agency is always available to chair the meeting.

Acceptance of referrals to Social Care - Referrals are sometimes not being accepted by Social Care, staff advised to discuss referral with safeguarding team to review quality of referral and reasons not accepted .Future MARF audits will identify any learning and establish if referrals were appropriate or CAF assessment / early help required. Staff to be referred to escalation process where appropriate.

Probation

In the course of 2013-14, Essex Probation also reviewed our internal Inspection and Quality Assurance arrangements and to focus our Inspections into practice more directly to lessons learned from Serious Case Reviews and similar reviews– in order that we are better able to check if the lessons we learn as an organisation are making a difference to the front-line Safeguarding work of our staff.

East of England Ambulance Service

Significant progress was made in 2013/14; this continued to build on the work undertaken in 2012/13.

The last year has seen regular involvement of the safeguarding team in supporting Trust staff to focus on holistically assessing the need of a patient and their lived experience, identifying concerns to ensure early help is identified, enabling staff to pathway patients to their GP via Trust systems and understanding the Toxic Trio (Mental Health, Drug and Alcohol problems and Domestic Abuse).

Monitoring of the safeguarding referral line has remained consistent over the last year; this work ensures the quality of data leaving the Trust and the pathway choices are evaluated no more than 3 days after the referral is made. This is to ensure patient concerns are received and managed by the correct agency.

Further training has been undertaken to support all Trust staff in using the Consent and Capacity Policy and paperwork complete of the Capacity to Consent Form. The Trust issued further guidance regarding restraint and how to use restraint, how to document the use of such procedures and what the Trust expects of Trust staff. Further work will continue over the next year as this topic is integral to PU for 2014/15.

South Essex College of Further & Higher Education

Within Thurrock, multi-agency working has been overall very good. Any issues we have had regarding a Looked after Child, we have communicated directly with their allocated Social Worker and issues have been raised and addressed. This has allowed a consistent approach to the students support. There have been occasions whereby we have looked into arranging counselling for a student known to the Local Authority and it has been made apparent that the student already receives counselling support outside of college. In this respect, it would be useful to know exactly what other external support the student is receiving arranged by the Local Authority so we can direct specific queries to that agency as well as informing Social Care.

4. What are your safeguarding priorities for this year 2014/15?

Children's Social Care

- Implementation of MASH from July 2014.
- Additional changes to the model for Early Offer of Help to ensure that children with additional needs are supported at an earlier stage via CAF
- Plans are in place to reintroduce peer auditing across Children's Social Care to drive up quality and evidence improvement.
- Introduction of strengthening families' model for CP conferences.
- More rigour to address drift on CP plans / roll this out quarterly tracking meeting and involve partners agencies.

Essex Police

Essex Police continue to work to increase all staff awareness of child safeguarding while considering learning from other law enforcement agencies and partners. This will ensure that our response to risk and safeguarding issues will be strengthened through early identification, intervention and partnership working in contribution to early help obligations and prevention opportunities.

SEPT

To continue to provide substantial assurance that there is effective safeguarding children process in place using audits including Section 11.

To ensure partnership working is effective for example

- The Integrated Family Working project will continue

- Thurrock LSCB minutes are standard agenda items on the Trust Safeguarding meeting
- Staff will be fully skilled in using the MASH system in Thurrock
- Ensure safeguarding learning via SCR etc. is tabled at the Trust Lessons Learnt Group

NELFT

Ensure the voice of the child is considered and responded to across all service areas
Ensure our services are aware of the indicators for CSE, FGM and harmful practices, and referral pathways.
Support the implementation of the MASH and ensure staff have the skills to assess and identify children and YP who would benefit from early intervention and early offer of help.
Develop safeguarding children outcome measures
Increase the number of and improve the quality of referrals to Children's Social Care
Increase the number of NELFT referrals to MARAC

Probation

Having introduced in the course of last year a new and updated Practice Instruction to staff in relation to safeguarding children, Essex CRC will also need further to the changes stemming from Transforming Rehabilitation and its embedding in practice in Thurrock, to assure ourselves that our focus on safeguarding remains as strong as ever.

As part of our commitment to the Whole Essex Community Budget Reducing and further to the publication of the last iteration of Working Together, Essex CRC have committed ourselves to developing the offer of 'Early Help' in relation to the children and families of offenders. We are looking to roll that 'offer' out in concert with our partners in the coming year.

East of England Ambulance Service

The Trust will be focused on the following priorities of the next year. These have been highlighted from Government initiatives and new legislation, SCR outcomes and ongoing monitoring of Trust systems to ensure the Trust keeps up to date on all changes as the NHS and Safeguarding restructures take place nationally.

- Trust training – review of training standards to ensure trust compliance to Intercollegiate Guidance
- Trust training – ensure that there is a consistent approach to safeguarding training throughout the trust during this year of heavy recruitment

- Adult safeguarding – evaluate compliance to statutory obligations when issued in October 2014
- Trust Locality leads – ensure that lead managers are identified in each area and have clear responsibility regarding safeguarding expectations
- Mental capacity – review capacity documentation
- Mental Capacity – support the PU programme to ensure this topic is identified to all staff undertaking PU and the train the trainers are supported in delivering the discussion regarding legislation on legal requirements

South Essex College of Further & Higher Education

Looked After Children

- Each Safeguarding advisor will be allocated a 'case load' of LACs to work with and will be a direct point of contact for the allocated Social Worker and LAC.

Staff Training

- The College are looking to increase staff confidence in dealing with a range of safeguarding issues as well as the pastoral care after any disclosure. Training across college will be taking place in the first term of 2014/15.

Training & Upskilling of Safeguarding Team

- This will always be a priority due to the changing landscape of safeguarding. Staff must be equipped with the appropriate skills and knowledge so we can effectively support all cases.

Policies and Procedures

- A new Safeguarding Policy has been developed and this will be promoted to staff and students over 2014/15. The next phase will be to bring all College policies in line with the Safeguarding Policy and ensure there is a joined up approach for example to behaviour and bullying & harassment.

Self-esteem

- This is an area of interest for our team this year that needs development across all colleges. Increasing self-esteem for students will help to develop students capacity to problem solve situations, develop their independence and empower them to make better decisions. We will be doing this through self-esteem workshops and through peer-support within the Student Union.

Young Carers

- Continued development is needed in this area. We are speaking with the Young Carers Group in Thurrock and will be arranging a time to meet up and discuss how the college can help support Young Carers and work collaboratively.

Substance Misuse Awareness

- The Safeguarding Team piloted a Substance Misuse event in Southend using the Local Authority agencies within the town. This provided largely successful with a template that we hope to replicate in Thurrock. We will develop relationships with the local YPDATs in Thurrock as well as Police and rehabilitation services, ready to roll out a similar provision next academic year at the Grays Campus.

Thurrock CCG

Priorities identified for the year 2014-15 will be monitored through the CCG and Providers CQRG Meetings and will be based on the standards outlined in "Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework" (March 2013) namely: -

1. Maintain CCG membership of the Thurrock Local Safeguarding Children Board (TLSCB) and fully engage with the Local Authority to fulfil safeguarding responsibilities including reviewing and reporting on the progress and quality outcomes.
2. Maintain robust processes to learn lessons from cases where children die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) and other Alternative Reviews which are commissioned by TLSCB.
3. Ensure representation and effective contribution to the newly established Joint Children's England to influence the commissioning of high quality integrated pathways of care for all children and young people from maternity and right through to adult services.
4. Gain assurance from commissioned services that they have effective safeguarding arrangements in place and that the views of children and young people and frontline staff inform service development.
5. Demonstrate that designated clinical experts are embedded in the decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice.
6. Work with primary care commissioners and local CCG clinical leaders to develop effective arrangements for the employment and development of named GPs (and other primary care expertise) within the local area.
7. Work with the Local Area Team of the NHS England to contribute to the continued development of Safeguarding Clinical Forums
8. Ensure CCG staff induction programmes incorporate safeguarding requirements and that

CCG staff attendance is evidenced and reported to the Safeguarding committee.

9. Continue to support and improve the quality of primary medical care by continuing to offer PLT events and GP safeguarding lead training to all CCG's across the County

The Childs voice

Following the success of the LSCB Conference in December 2012 on child sexual exploitation, greater engagement with young people and their involvement in the Board was an area acknowledged for further development and still continues into 2014. The Board recognised that work to involve young people was not as advanced as it could be and actions were put in place to rectify this. Such actions included a conference for professionals on the voice of the child in November 2013, which provided the opportunity for young people to openly express their experiences to those that provide the services to children. Key note speakers and workshops with young people reinforced the message. Through the close working with the CYPP we now have a youth forum set up at a local school whose focus is on E- Safety which has helped shape our understanding and obtain a young perspective on the needs and use of young people and the internet .

Walk Online Road Show

The Board undertook what is probably its biggest challenge in recent years to raise awareness and gain greater insight into child sexual exploitation through the voice of the child. Partners from across different agencies supported an ambitious project which took place over six days during March 2014 targeting 5,000+ years 5, 6 & 7 pupils from across the whole Borough.
This event was organised based on feedback received from schools, Serious Case Reviews and identified local needs to meet concerns around pupils awareness to sexual exploitation and in particular e-safety and its many facets e.g., cyber bullying, sexting and grooming. The programme was led by Essex Police Online Investigation Team and cases and examples used in this event were based on real life examples and the content was hard hitting, but age appropriate, reflecting the nature of the investigations Essex Police are coming across within these year groups.

The Board took this rare opportunity of having such a large group of young people together to conduct an anonymous survey using electronic keypads, asking eight questions about their use of the internet. The questions were aimed to complement the NSPCC survey conducted this year on CSE so comparisons could be made from a local to national perspective. The results of the survey have highlighted some interesting facts. The full report on the events is available on request from the LSCB.

LSCB Business Unit

The Business Unit of the Board has continued to grow following the appointment of a dedicated Business Manager and restructured support team to oversee the work of the Board. This has helped to streamline processes and look at new ways of working. The need to appoint further support resources will be assessed over the coming year as part of the independent review findings. Further development of the new LSCB website as well as taking on a more proactive safeguarding awareness role with professionals and the community are two areas of work currently being progressed. Further streamlining of process including cloud based technology will be developed during 2014.

Relationship with the Health and Well-Being Board

The LSCB continues developing its relationship with the Health and Well-Being Board reporting activity and supporting partnership working. There is still significant transformation taking place across the Health community, including commissioned services, early offer of help provision and Clinical Commissioning Groups (CCGs) and these changes continue to be assessed to enable agencies to acclimatise to new ways of working.

Full Board

The Full Board met on four occasions with good attendance from all statutory and member organisations. Some of the areas reviewed, discussed and challenged included

- Who's Looking After the Children – our response and position to the report was agreed. Police provided information and data on its procedures. A further report requested and response received following HMI inspection of Essex police custody facilities for young people
- 157/175 Audits on education establishments
- Budgets
- Annual Independent Review Officer Report was discussed. A number of challenges made to the Local Authority around case loads and content of the report.
- Childrens Commissioner Report – "If only someone had listened" Action plan to be developed through the CSE sub group
- Child Death Review – Some of the content was challenged and tasked to the Management Executive to action. Awareness campaign agreed on safe sleeping and the risks of water (pools & ponds)
- Joint protocol with Heath & Well-Being Board signed by Chair
- The activates and reports of the sub groups were provide to the Board
- Reflective learning by Board members

The Independent Chair has led the Board through a series of Thematic Section 11 processes. These have included to date:

- Selection & Recruitment
- Voice of the child
- Governance

Board members were required to account for their agencies processes and outcomes within the themed areas and were challenged by members who found the process both insightful and a refreshing approach.

The Local Authority Lead Member with responsibility for children and young people sits on the Board as a participating observer, allowing them to participate in discussion but does not have a voting right. This enables another context of the communities' voice to be heard within the LSCB communications framework.

As part of our Learning Improvement Framework we ask members of the Board to complete feedback and reflection after meetings under eight subject headings to ensure that we have made best use of the time and productively of members

Management Executive

The Management Executive met on eight occasions during this reporting period.
The Boards sub groups report direct to the Management Executive who are the custodians of the LSCB Business Plan and ensure that allocated objectives are actioned by the groups.
The focus and purpose of this group is to ensure that the LSCB are able to be satisfied that children are being appropriately safeguarded across Thurrock.

The Executive reviewed

- Health Action Plan
- Update and progress of the VAWG strategy
- Update and progress on Local Authority Self-Assessment
- Childrens workforce strategy
- Report on impact of welfare reform
- Report from Basildon Hospital on safeguarding
- Report from Essex Police on safeguarding
- Report from Probation

- Report on children who are home educated
- Update and progress on response to CSE & Childrens Commissioner paper
- Review of the threshold document
- Monitored progress of the early help changes
- Annual reports
    - Private Fostering annual report
    - IRO report
    - E-Safety report
    - EDT report
    - Missing children report
    - UAS

Sub Groups

The Boards sub groups are the key mechanism for challenging practice and any gaps or areas for development in service provision, ensuring that the Board is contributing to make a difference to safeguarding practice across Thurrock. The groups are well supported by partner agencies and all elements have shown considerable progress against objectives set by them as part of the Business Plan. They are all functioning well and their work areas and terms of reference continue to be reviewed to ensure they remain fit for purpose.

Scrutiny and challenge

For this reporting year the groups of the LSCB comprise of:-

- Child Death Review Sub Group
- Serious Case Review and Audit Group
- Performance Management Sub Group
- Interagency Training Sub Group

Each sub group has its own terms of reference and business priorities set within the 2013-14 plan and reports into the LSCB Management Executive. The groups are accountable through an action matrix but have also been given the flexibility to adapt these priorities to meet emerging priorities, for

instance, new legislation/guidance or serious case reviews that affect safeguarding in Thurrock. Where appropriate they can implement task & finish groups to compliment the work undertaken.

Child Death Review

All child deaths are reviewed as part of the LSCB responsibilities to support learning outcomes. This process is undertaken jointly though the Southend, Essex and Thurrock (SET) procedures at both strategic and operational level. There is a pan Essex Strategic Child Death Overview Panel which aims to identify any lessons to be learned from the death of a child in order to improve the health, safety and wellbeing of all children and to identify modifiable factors which may, when addressed, prevent further such deaths in the future. It provides multi-agency, sub-regional awareness raising sessions around the child death review process and ensures that parents/carers are supported following their loss and are given the opportunity to contribute any comments or questions that they might have to the review of their child's death.

An Annual Child Death Report is presented to the Thurrock LSCB and Children's Partnership Board which provides an account and overview of the child death cases reviewed, makes recommendations in relation to further actions and ensures that all recommendations are accounted for and disseminated to relevant partner agencies and stakeholders. This quality assurance scrutiny by the Board of the report provides reassurance that partners are doing all they can in assessing modifying factors and implementing strategies to reduce those risks. From their findings the Board implemented a safer sleeping awareness programme in November 2013 and water safety information in readiness for an awareness campaign over the coming spring and summer months.

Geographically based are Local Child Death Review Panels which for Thurrock are placed within the South West Essex group. This group assesses the response at a more local level and detailed level. This group is tasked to review all child deaths in the SW Essex area to identify any modifiable factors and make recommendations to the Strategic group and appropriate agency to address any issues.

Serious Case Review and Audit Group

As part of streamlining LSCB business, the process for conducting serious case reviews and audits changed in the previous year 2012-13 resulting in the Serious Case Review Group and Audit Group being amalgamated to one group. This followed a long period where no serious case reviews had been presented for consideration to the Board and partner representatives time was not being well utilised. In hindsight and as fate often plays its part, this year saw both the need to consider and implement a serious case review and also a separate managed review. This identified a number of

weaknesses in the structure and has resulted in the groups re-forming back to two groups, with greater focus and direction.

Lessons from Serious and Managed Case Reviews

Thurrock commissioned one serious case review for this reporting period the case of "Julia". The SCR findings and publication will fall into the next reporting period. Other national serious case reviews whose findings had an impact on safeguarding in Thurrock were reviewed during the year and disseminated to the respective agencies for the learning outcomes to be embedded into practice.

A further case was presented to the Panel for consideration of a SCR which did not meet the threshold criteria – this was in relation to fabricated illness.
Having reviewed the case the panel felt that although it did not meet the threshold for a SCR, there was learning to be obtained from agencies. The Board commissioned a light touch managed review which was undertaken by the NSPCC. The Board during this process identified the importance of transparency of its work and agreed that all reviews undertaken (subject to any reporting restrictions) will be published.

The future work programme of the group in its new format will be determined by the action plans arising from serious case reviews which will form part of the standing agenda and any local cases submitted for consideration of a SCR.

The group's priority will be to ensure that all the recommendations are implemented in a timely manner and monitor for impact of change. Briefing staff on the lessons learned from SCR's will continue to be a key activity in the coming year and work is in progress to develop our website to incorporate better information. The group will also be reviewing the SCR process undertaken considering the feedback from staff involved in managed reviews to continue to improve the process of supporting staff involved in the DCR process.

The Audit Process

The LSCB Audit Group includes representation from Police, Health, YOS, Probation, Housing, Social Care and commissioned providers. The members are middle managers or professionals with a specific safeguarding brief. The group met on seven occasions.

The activity and case categories selected for audit and review are selected at random and an audit tool used for consistency of practice tailored to the type of audit being conducted. Our audits include single and multi-agency audits which are notified in advance to each representative before the meeting. Each agency representative is then expected to review its own records in relation to the case and the identified practice point e.g. S47 Child Protection. Where relevant, notes and case files are brought to the meetings and shared with the group. The focus of the group includes the appropriateness, quality and timeliness of each agency's involvement, not just in the immediate period but also over a longer timeframe where this is relevant. Prime concerns are whether children appear to be safe / have been safeguarded, whether they have been the main focus of activity and particularly – when age appropriate – that they have been spoken to and their views elicited. The emphasis during the early part of the year has been much more focused on whether policy and procedures had been followed and any learning has a systems approach. This is still considered important, but the theme has shifted its focus to outcomes of practice and the voice of the child.

Audit Outcomes

Minutes of the meeting are recorded with comments on each case made by the group. These identify good practice and joint working as well as noting any concerns about the work completed. If serious concerns about the safety of a child are identified, these are immediately notified to the appropriate agency and the group requests and receive updates on any such case.
The findings and outcomes of the audit group meetings are reported to the LSCB regularly through the executive meeting and there is an annual summary of activity for the full board, so that the overall quality of local safeguarding practice can be evaluated and any lessons for improvement taken forward at both an operational and strategic level.

A forward plan has been agreed for future audits' to ensure all safeguarding elements are considered taking into account equality and diversity.

Each representative has been keen to ensure that the investment of their time has been an effective means of assessing how well local partners are working together to safeguard children. All members of the group have reported that they have found the audit process a learning opportunity to broaden their own understanding and knowledge of the roles and responsibilities of every agency. The group has gradually developed a shared, appropriate expectation of what they would expect to see from safeguarding responses not just from their own agency but also from other agencies.

Audits undertaken 2013/2014

Criteria - Section 47 cases audited that have been closed as no further action.

Learning outcomes:

Concern identified over one case reviewed where case closed whilst police investigation still taking place. Further review of similar cases then tasked and identified that this was not normal practice and details fed back to team concerned.

Criteria - Child Protection case where parents have learning difficulty.

Learning outcomes

Audit identified a shortfall in service provision of support to the parents as agreed by Adult Social Care. Action taken by adult representative to implement support.

Criteria – Appropriate use of CAF process

Learning outcomes

- The Adult and Child Protocol is to be refreshed.
- An action plan has been put in place to review Core Assessments and ensure that the Voice of the Child is captured.

Criteria - Examination of the early help provision

Learning outcomes:

- Identified that some health colleagues were not clear on the pathways
- EH services and pathways forwarded to health colleagues
- EH needs to be acknowledged as a multi-agency programme of services

Performance Management Sub Group

The Performance Management Sub Group met on two occasions. The group supports the LSCB in the monitoring, promotion and planning of high quality practice in line with the interagency performance management framework. This group will be changing to a Performance Panel approach during 2014.

The group developed a framework called the “Thurrock Wheel” which has received regional recognition as good practice in monitoring the effectiveness of what is done by the Board Partners, individually and collectively, to safeguard and promote the welfare of children. Although this process has been very effective, it is recognised that further development of performance indicators is required and these are in the course of being agreed.

Continuous performance management is at the core of Thurrock LSCB ethos, ensuring the effectiveness and impact of interagency safeguarding activity makes a difference. Areas of concern, practice, performance issues or areas requiring development are identified and evidenced through the performance management framework. The chair of the sub group reports directly to the LSCB Executive in respect of the progress and impact of safeguarding in Thurrock.

The group examined performance in the following areas during 2013-2104
Child Death Review process

- Examined the CDR Annual Report and feedback provided to the CDR Coordinator
- Identified data that would support better understanding of neo natal deaths where maternal age is under 20
- Missing children - The group reviewed the Children's Partnership multi-agency Missing Children Panel performance, which tracks individual cases but has also contribute to identifying patterns of absconding and behaviour to minimise the impact of child sexual exploitation. In one case presented, the Missing Children Panel were able to find a reported missing person though its intervention who would otherwise not have been located through other enquiries and illustrated the value of this group. During 2014 having recognised the significant links to CSE the group will join with the CSE group infrastructure.

Training Sub Group

The Training Sub Group met on eight occasions and has a key role in ensuring that each agency delivers effective child protection training of professionals and volunteers who work with children, young people and their families or services that affect the safety and welfare of children. It is the responsibility of the LSCB to ensure that multi-agency training on safeguarding and promoting welfare that meets local needs is provided. The purpose of the training is to develop and promote shared understanding amongst safeguarding partners around the tasks, processes, principles, roles and responsibilities for safeguarding children promoting their welfare to result in better outcomes for children and young people in Thurrock.

The group successful sought to identify an individual who has an overarching involvement with schools and education and can provide a valuable insight to training and development needs for education.

Training Provision

A review of training provision was conducted and presented at the February 2014 meeting. This was a detailed review of both the provision and attendance of agencies to the different programmes offered by the Board to enable to the group to assess future needs. The data in this year's report will cover this review period which was from January 2013 to January 2014. An extract of the report has been included in this annual report.

Training Programmes

Throughout the last year we have ran three courses; Inter-Agency Child Protection Training, Online Exploitation of Children and Young People, and the Six Steps of Child Sexual Abuse Behaviour Module. A total of twelve courses overall.

Inter-Agency Child Protection Training:

This training was delivered on five occasions. There was a high response to this training with a total of 123 staff attending from the 125 positions given across the five sessions.

Online Exploitation of Children and Young People:

This training was delivered on four occasions. There was a medium response to this training with a total of 136 staff attending from the 180 positions given across the four sessions.

The Six Steps of Child Sexual Abuse Behaviour Module:

This training was delivered on three occasions. There was a high response to this training with a total of 135 staff attending from the 150 positions given across the three sessions.

TRAINING ATTENDANCE

Training Event	Number of Courses	Places Available	Total Attended	Total Attended from each Sector

				Health	Education	Private Voluntary	CAFCASS	Local Authority	Police	Probation	Private	Fire	Misc
Inter-Agency Child Protection Training	5	125	123	35	36	23	2	15	11	1	0	0	0
Online Exploitation of Children and Young People	4	180	136	37	19	34	4	35	0	1	6	0	0
The Six Steps of Child Sexual Abuse Behaviour Module	3	150	135	34	14	20	4	36	7	5	10	2	3

The total amount of attendees for the period January 2013 to January 2014 is 394.

Of this 394 the percentage of attendance across the recorded sectors is as follow:

Sector	Percentage of Total attendance recorded in sectors
Health	26.90%
Local Authority	21.83%
Private Voluntary Institutes	19.54%
Education	17.51%
Police	4.57%
Private	4.06%
CAFCASS	2.54%
Probation	1.78%
Misc.	0.76%
Fire	0.51%

Findings

The review identified the current commitment from each agency and identified the number of eligible staff against attendance. This process was welcomed by the group and has enabled each agency to review their commitment to multi agency safeguarding training. The representatives have been tasked to take the report back to their agency and discuss the findings.

Highlights

- New content and model of delivery for Inter-agency Child Protection training has been developed and implemented with positive feedback from participants regarding their learning from the programme
- Since introducing the new programme for Inter-agency Child Protection training demand has increased
- Adult Social Care representation on training group has strengthened the groups capacity to encourage joint working across children's and adults services
- Online Exploitation training has been well received with each training identifying that there is still a significant lack of awareness across the workforce as to the real challenges in this area of work
- Investment in the skills of the training group and an increase in trained facilitators reduce the need to commission external providers and strengthen the effectiveness of local delivery with a local perspective, allowing budgets to be used more effectively.
- Administrative support has allowed for training places in the second half of the year to be more evenly allocated across the partner agencies, ensuring that training truly is "inter-agency"

Challenges

- Long-term evaluation on impact of training continues to remain a challenge due to the vast nature of the workforce of which only a small percentage receive inter-agency training. There are a significant number of other variables which all impact on improvements in practice making it difficult to pinpoint the exact impact of training. We have developed our post course feedback process and split one course to enable learning practice to form the second part of the programme.

FINANCE AND RESOURCES

The LSCB is funded through partner agency contributions and any income generation provision. These monies are used to pay for management of LSCB business. This includes serious case reviews; independent chairing of the LSCB, the LSCB Business Team, and costs associated with LSCB and sub group meetings, multi-agency training, publications and procedures relating to safeguarding.

The budget is managed through the Local Authority budgetary procedures system by the LSCB Business Manager. A breakdown of the financial position for 2013/14 is shown below.

Income 2013/2014			**Expenditure**		**Budget**	**Actual Spend**	**Comment**
Health		15,000.00	LSCB Independent Chair (inc VAT)	AA301-2104-CS410	20,000.00	16,275.00	
Police		15,000.00	LSCB Manager Cost - inclusive	AA301-0001-00000	27,909.00	27,909.00	
CAFCASS		550.00	LSCB Business Team - inclusive	AA301-2104-CS403	9,773.40	20,089.76	Additional staff from Aug 2013
Probation		9,500.00	The Walk On Line Roadshow	AA301-1750-00000	10,000.00	10,000.00	Final bills to be calculated
LA	Business Team	65,591.40	LSCB Training Programme	AA301-2104-CS400	20,000.00	21,293.92	
			Child Death Review Administrator	AA301-2104-CS424	6,000.00	6,000.00	
			Annual Conference	AA301-0380-00000	13,500.00	9,263.27	Final bills awaited
			Serious Case/Mgt Reviews	AA301-2104-CS402	28,000.00	9,107.50	Final bill awaited for SCR
			Promotional/Publications/Marketing		5,000.00	1,067.85	
			Seminars and Courses	AA301-0360-00000	5,000.00	350.00	
			Equipment Purchase	AA301-1400-00000	4,000.00	1,375.23	
			Contingency	AA301-0000-00000	1,000.00	0.00	
			Stationery	AA301-1681-00000	1,000.00	620.76	
Total Income		**105,641.40**	**Total Expenditure**		**151,182.40**	**123,352.29**	
C/F 2011-12		68,641.00					
C/F from 2012-13		37,826.00		Savings made		27,830.11	
Munro Funding		11,000.00					
Total C/F from previous yea		117,467.00					
Total Budget		**223,108.40**			Fixed costs - staffing of LSCB Business Team		
					Disposable Income		
					Fixed costs from disposable income		
Carry Forward to 2014-15		99,756.11					

The Board have managed to maintain a standstill budget for a fourth year in a row, but is reaching the point where it is proposed to apply a slight annual increase for 2014/15 to offset additional costs being necessary both as demand increase for outcome based learning as well as changes in infrastructure affecting meeting costs.

Troubled Families Programme

Thurrock Council and its partners are participating in the Troubled Families Programme. This is a national programme developed to address issues of crime and anti-social behaviour, children not engaged in education and worklessness. The initiative for Thurrock targets 360 families over three years to help them to turn their lives around and in particular the lives and prospects of their children. Families will be offered intensive interventions to address the difficulties that they have. The LSCB is interested and involved in this work at a strategic level as the success of the programme will have positive benefit around the safety and wellbeing of children in Thurrock. The work links with the early help provision of service, providing a mid and long term saving both financial and the point intervention takes place. The programme is just reaching end of year one and of its target of 120 families 100 payment by results submissions will have taken place. The next phase over the coming year targets 180 families. In addition to specific family intervention, through the payment by results approach, the programme has been able to offer financial support to support Children's Social Workers. Social Workers can apply for small amounts of money for basic items or commissioned services to resolve easy to fix low level family issues which would have otherwise escalated.
The Board receive progress reports throughout the year from the Programme Lead on outcomes achieved. The impact on those families supported as well as the financial benefit to children's safeguarding has been significant, with many excellent examples where families in crisis have been turned around. The Board fully support the continued work of this very worthwhile programme.

Sexual Exploitation

The majority of children in the UK grow up safe from harm however there are a small number of children who are being sexually exploited and it is thought that this is an area which is under-reported. Research has shown that this abuse can be perpetrated by individuals from all sections of society and can be targeted at boys and girls from all sections of society. There are certain factors in a child's life that can make them more vulnerable to being sexually exploited, for example the links between children who go missing and those who are sexually exploited are well documented.
Thurrock LSCB has made substantial progress in working to improve outcomes for children who go missing from home or care or who are at risk of sexual exploitation. We are part of the Essex Strategic CSE group which examines and delivers activity across Essex to support victims and bring offenders to justice. Through the Children's Partnership Missing Children Panel the Board has oversight of the picture of children who go missing in Thurrock. They also review individual cases and have highlighted some children who are at risk of CSE and take positive action to meet their safeguarding needs and provide a report to the LSCB for scrutiny.
The Government has also made sexual exploitation a priority and has produced a

'Tackling Child Sexual Exploitation Action Plan' and also a cross-Government strategy on missing children and adults. The LSCB has been reviewing the Children's Commissioners Report and has been working on its own action plan to quality assuring its systems and processes against the reports recommendations and making sure that those who come into contact with children and young people are aware of possible signs of sexual exploitation and how to respond. Further work in this area is seen as a priority for the LSCB in the coming year.

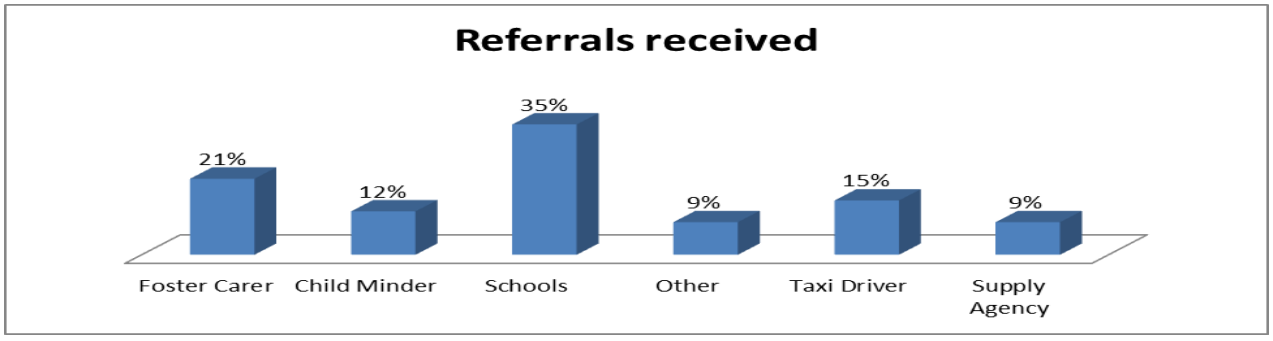
Lay members

Thurrock LSCB have been very fortunate in having a lay member who is well known within the community which has proved invaluable in assisting with community awareness and supporting events. Unfortunately during this year due to other community commitments our lay member resigned which has left a gap of providing the 'community voice' to the Board. We have since been actively engaged in a recruitment campaign and we did have another member for a short period but it is disappointing that we have been unable to find a community member to pick up this important role. We continue to actively seek lay members to be a part of the Board.

Allegations Management

The Local Authority Designated Officer (LADO) has close links with the LSCB who monitors the recommendations and outcomes of allegations of abuse against those who work with children ensuring completion within timescale.

The LSCB has a duty to ensure that all allegations of abuse or maltreatment of children by a professional, staff member, foster carer or volunteer will be taken seriously and treated in accordance with consistent procedures. The Board needs to ensure that there are effective inter-agency procedures in place for dealing with allegations against people who work with children. During this reporting period there are have been 34 referrals to the LADO, this is consistent with the previous years reporting.



The outcomes from allegation investigations in Thurrock show that the proportion resulting in no further action is 47% this may be due to the fact that schools are reporting all allegations that are made. The LSCB will continue to monitor this.

The Board will make recommendations to the Inter-Agency Training Group to provide further awareness training and the roles of agencies in disclosing to the LADO.

Good examples of safeguarding practice

The LSCB are pleased to acknowledge some of the excellent work undertaken in safeguarding children and young people by the Children's Partnership, Community Safety Partnership and local community and voluntary organisations that contribute to making Thurrock a safe place and supporting Thurrock overarching vision

Highlights

- Positive alcohol strategy and proactive operations to combat and reduce underage drinking
- Violence against Women Strategy and implementation plan
- Honour based abuse - The LSCB has been a sponsor of the showing over 5 sessions of a documentary "BANAZ" to 236 professionals from multi agencies in support of understanding the impact and response to HBA. The film chronicles the life and death of a young British Kurdish woman killed in 2006 in South London on the orders of her family in a so-called honour killing.

SAFEGUARDING PERFORMANCE OVERVIEW

THRESHOLDS

Thurrock continues to apply its thresholds rigorously. With a steady increase in Child Protection Plans Children's Social Care commissioned an independent audit of CP plans during 2013 to ensure that thresholds to intervention were being appropriately applied. The outcome of the sample audited confirmed that risk assessments were being appropriately applied.

Referrals

Referrals have seen an increase on the previous year with a 2% increase in repeat referrals (19%). Despite this trend, Thurrock over the last three years still remains consistently below the national and statistical neighbours' benchmark average. This suggests Thurrock is accurate in determining what kinds of cases need to come into the service and understanding of this threshold is very well understood by partners. The implication of the Early Offer will help to strengthen the interface between Children's Social Care and partner agencies in terms of cases that do not meet the threshold for Social Care involvement. Nevertheless the referral rate into the service remains an area for vigilant attention.

Rate of Referrals per 10,000	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
National rate	497	548	555	534	521	Not available
Stat Neighbours	525	560	550	555	608	Not available
Thurrock	**1046**	**671**	**416**	**361**	**449**	**497**

Initial & Core Assessments

During this reporting period the process of Initial and Core Assessments changed with the introduction of the Single Assessment. This area of performance is at an early stage and will be monitored over the coming months and will be reported on further in the 2014/15 report.

Child Protection Plans

The rate of children subject to Child Protection Plans is high; Comparable data with national and statistical neighbour were not available at time of this report. The actual number of children subject of a plan in Thurrock is 288 which are anticipated to be significantly higher. Child Protection thresholds are consistent in Thurrock; the percentage of children becoming subject to a Child Protection Plan measured against the number of Section 47 investigations undertaken has remained consistent at about 50% for a five year period. This is largely in line with national and statistical neighbours' figures for the same period.

The Board are concerned on the number of Child Protection cases which fall under the category of neglect and that recording of cases of CSE are correctly reflected and recorded. This will be a focus for the Board during the coming year.

Children in Care

The rate of Children in Care continues to rise Thurrock - 68 per 10,000; national - 60; statistical neighbour - 67 (the actual number of children in care March 2014 is 291).We have seen a steady increases over the year and a particular rise in young people 18+ moving from 0 to 7 . Its needs to be acknowledged that as part of this increase the method of data recording changed during the year and now young people who are placed on remand are also classified as LAC and although not tested , likely to be in the higher age bracket. The outcomes for children in care, as measured by the performance indicators, are on the whole good, and in some areas very good.

Challenges and next steps from the Independent Chair

This reporting period has seen further progress to continue to improve the Boards challenge to maintaining and improving safeguarding practice across the Borough. There are some gaps and areas for improvement that have been identified through the activities of the Board, the independent review and the need for continuous improvement.

The Board continues to develop an ethos of ongoing challenge and improvement not only of its partner agencies but also of itself. With this in mind, the LSCB will continue to challenge the way we do business – complacency in this important area of work of safeguarding children and young people is clearly not an option. We would like to thank all those members who have committed to the sub groups and activities of the LSCB during this period. Can I thank the Business Support Team for their dedication and commitment to making a difference to the Board's business processes. We will continue to seek out what we can do better to support the community we serve and ensure that the message that 'safeguarding is everyone's business' continues to be promoted.

Dave Peplow

Independent Chair

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10 February 2015	ITEM: 7
Children's Services Overview and Scrutiny Committee	
Youth Consultation – alternative ways of working to support young people across Thurrock	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Thurrock Youth Cabinet and Michele Lucas, Interim Strategic Lead Learning and Skills.	
Accountable Director: Carmel Littleton, Director or Children's Services	
This report is Public	

Executive Summary

To enable young people to contribute and inform the decisions around proposed reductions and the potential ways in which youth activities could continue over the next three years, the August Cabinet meeting requested that the Youth Cabinet oversee the development of a consultation to determine current provision and what young people see as the key priorities over the next three years.

With the Council currently facing difficult choices around where services can be reduced the Youth Cabinet were asked to develop a questionnaire that could be utilised to ask Thurrock young people a range of questions to gain a greater understanding of where youth activities were needed and how to continue to deliver the youth offer across Thurrock with a key emphasis of ensuring that young people are in a position to access the regeneration opportunities that are available locally.

In September 2014 a presentation was undertaken with the Youth Cabinet outlining the proposed savings and introducing an alternative delivery model for youth activities across Thurrock. In response to this presentation a small task and finish group was established to design a questionnaire (See Appendix One). The Youth Cabinet set a target of **200 r**esponses – at the close of the consultation **383** had been completed.

1. Recommendation(s)

1.1 That the consultation feedback be noted and the Youth Cabinet formally recognised for the good work they undertook in developing and analysing the feedback.

1.2 That Members endorse the work of the Project Team, supported by members of the Youth Cabinet, to explore alternative delivery models for Youth Related Activities.

1.3 That the findings of the youth survey be used to inform services for young people.

2. Introduction and Background

2.1 In August 2013, the Cabinet received proposals for a reduction in the youth offer across Thurrock; to ensure that young people's views were sought in making these decisions they requested that the Youth Cabinet develop a questionnaire to seek young people's views.

2.2 The questionnaire was developed by a small task and finish group of the Youth Cabinet and was signed off in September by the full Youth Cabinet – the consultation went live on 8th October 2014 and closed on 14th November 2014.

3. Youth Services Survey Findings

3.1 The Youth Services Survey was completed by 383 young people; the age range was 11-19 with the highest response rate of 19% attributed to fifteen year olds.

3.2 The highest level of responses came from South Ockendon at 21%, Grays at 17% and Tilbury at 15% with the rest spread across a range of other wards within Thurrock.

3.3 The gender split was 61% young men and 39% young women.

4. Issues, Options and Analysis of Options. (Top Issues identified by young people who completed the survey)

3.1 Young people were asked if we should offer a more targeted approach to work across Thurrock, over 75% of the responses agreed that services should be targeted, in analysing this further the young people identified the following target groups:-

- NEET – young people who are not engaged in education employment or training
- Young people with a disability – many of the responses identified the need to provide more opportunities for young people with disabilities
- Young people living in poverty – one of the ways in which young people felt this could be addressed is by providing food in the youth hubs across Thurrock

3.2 The questionnaire also asked what young people believed the benefits were to accessing youth activities – the top three responses to this are outlined below:-

- Confidence – young people felt that gaining confidence and working as part of a team was a key benefit in accessing youth provision and that it was important that you learned skills which would equip you for work, the following is a quote from a young person accessing provision

- ‘*’well where do we start, firstly the youth centre has helped me in building my confidence also it has made me a better person’’*

- ‘Staying off the streets’ and keeping out of trouble, as well as undertaking something positive was a key benefit for many young people who completed the survey – the following is a quote from a young person who completed the survey

- ‘*’Made friends. Stopped thieving’’*

- Keeping active/healthy – many young people commented on this and the importance of a healthy lifestyle – the following is a quote from a young person who completed the survey.

- ‘*’I think the youth centre is amazing, it helped me learn about drugs and alcohol and I did water rafting’’*

3.3 The questionnaire also looked at what the top issues were facing young people in Thurrock, the top three are listed below:-

Lack of youth provision (lack of things to do, places to go and being bored – one of the many ways in which we are looking to address this is the up skilling of the local communities to provide a more universal approach, this has meant that we have offered a number of Level 2 youth work programmes to colleagues from the community and have increased the universal provision locally.

Smoking & drugs – initial discussions have taken place with the Drug awareness teams across Thurrock to look at providing a more systematic approach to raising awareness, this area of work will be discussed at the Thurrock Education Alliance to consider whether this could form part of the work commissioned.

Crime ‘not feeling safe’ with a particular reference in relation to bullying – this is work that the Youth Cabinet have been campaigning on – one of the solutions identified is more police on the streets, this feedback will be given to the Crime & Disorder Partnership to look at the strategic deployment and perhaps campaign around young people’s safety.

The final question looked at whether young people would be prepared to pay for some activities, the majority of young people agreed that they would be prepared to pay a small fee, but referenced the fact that if young people struggled to pay then this should not stop young people accessing services.

4. Reasons for Recommendation

4.1 The Youth Cabinet have developed a questionnaire that clearly outlines some of the key priorities over the next three years, and are supportive of the opportunity of taking youth activities out of the Council into an alternative model for delivery – this will enable young people to access high quality services and ensure that they are in a position to participate in and be part of the exciting regeneration agenda, with a view to promoting the Council's key target of ensuring Thurrock young people access the future managerial jobs.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The Children's O&S Committee wish to establish a task and finish group make up of members to support the development of an alternative model of delivering youth related activities across Thurrock.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The youth activities directly contribute to Thurrock Council priorities 1 and 2:

- **Create a great place for learning and opportunity**
- **Encourage and promote job creation and economic prosperity**

7. Implications

7.1 **Financial**

Implications verified by: **Kay Goodacre**

Finance Manager – Children's Services

With the potential to develop an alternative model of delivery for youth activities we would need to work closely with finance to look at a financial model going forward – this would include some financial modelling of services, recognising the need for the Council to realise the savings that have already been agreed by Cabinet.

7.2 **Legal**

Implications verified by: **Lucinda Bell**
Education Lawyer

The Committee is asked to note the report content, and make decisions that are within the remit of the Committee's terms of reference and powers.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**
Community Development Officer

In giving young people the opportunity to fully engage in the decision making around the current provision and the ongoing development over the next three years recognising the need to reduce budgets we have ensured that we have undertaken both the consultation and some focus groups attended by members of the Youth Cabinet. In the development of proposals we will need to ensure that we address the issues of engaging with vulnerable groups to ensure that they have the opportunity to contribute to the debate, this will be achieved by using a number of our networks within the community to ensure that we give vulnerable young people the opportunity to inform the decisions made around services.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

- Appendix 1 Questionnaire
- Appendix 2 Survey report

Report Author:

Thurrock Youth Cabinet

Michele Lucas, Interim Strategic Lead Learning and Skills

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Youth Services Survey

Thurrock Council needs to hear from young people. The Council has to save a lot of money over the next few years but is committed to supporting young people in Thurrock. We need your views to help this happen so please fill out this survey openly and honestly!

How old are you?
(please select one answer)

11 ..... ○
12 ..... ○
13 ..... ○
14 ..... ○
15 ..... ○
16 ..... ○
17 ..... ○
18 ..... ○
19 ..... ○

Where do you live?
(please select one answer)

Aveley ..... ○

Bulphan ..... ○

Chadwell St Mary ..... ○

Chafford Hundred ..... ○

Corringham ..... ○

East Tilbury ..... ○

Fobbing ..... ○

Grays ..... ○

Horndon on the Hill ..... ○

Linford ..... ○

North Stifford ..... ○

Orsett ..... ○

Purfleet ..... ○

South Ockendon ..... ○

Stanford Le Hope ..... ○

Tilbury ..... ○

West Thurrock ..... ○

West Tilbury ..... ○

Outside of Thurrock ..... ○

Please state

Male or Female?
(please select one answer)

Male ..... ○

Female ..... ○

What is the most important issue for young people in your area?

How do you think you, other young people and Thurrock Council can improve this issue?

Do you currently take part in one or more of the following?
(please select all that apply)

Local Youth Club ..... ☐

Duke of Edinburgh Scheme ..... ☐

Princes Trust Programme ..... ☐

Thurrock Youth Cabinet ..... ☐

Apprenticeships or Training Courses ..... ☐

Careers Guidance from Thurrock Careers (formally Connexions) ..... ☐

Arts, Drama, Music ..... ☐

Sports activities ..... ☐

None ..... ☐

Other ..... ☐

Please state

How has taking part in this benefitted you personally? (e.g. developed confidence, learnt a skill, achieved something)

If the Council was going to set up ONE new activity or service for young people what should be the main aim?
(please select one answer)

Improve health and fitness ..... ○

Giving young people a say in their area ..... ○

Careers advice ..... ○

Getting young people work related skills ..... ○

Developing confidence and social skills ..... ○

Keeping young people out of trouble ..... ○

Supporting young people to gain a job ..... ○

Other ..... ○

Your suggestion

Do you think there should be a focus on young people who are most in need of some extra support?
(please select one answer)

Yes ..... ○ *No* ..... ○

Which young people do you think should be a priority (e.g. young people not in school, young people living in certain parts of Thurrock etc)

Where would you prefer to go to a youth activity?
(please select all that apply)

Local park ..... ☐

Local community building (e.g. community centre, church, village hall) ..... ☐

Local school ..... ☐

Youth hub (one site in Thurrock that young people would travel to) ..... ☐

Mobile youth bus ..... ☐

Other ..... ☐

Your suggestion

Would you or your parents/carers be prepared to pay a small fee to take part in an activity? (e.g. £1 to attend a youth club)
(please select one answer)

Yes ..... ○ *No* ..... ○

Would you like to be further involved in helping to plan young people's services in Thurrock?
(please select one answer)

Yes ..... ○ *No* ..... ○

Please provide your email address or contact number

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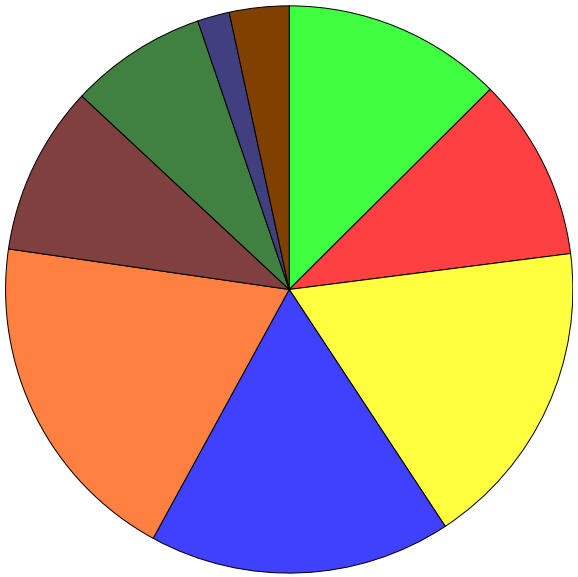
Report Settings Summary

Event	**Youth Services Survey**
Total Responses	**383**
Total Respondents	**1**
Questions	*Custom selection (see Table Of Contents)*
Filter	*(none)*
Pivot	*(none)*
Document Name	Youth Services Survey
Created on	2014-11-19 15:12:57
Created by	Patrick Kielty

Age

Question responses: **383 (100.00%)**

How old are you?

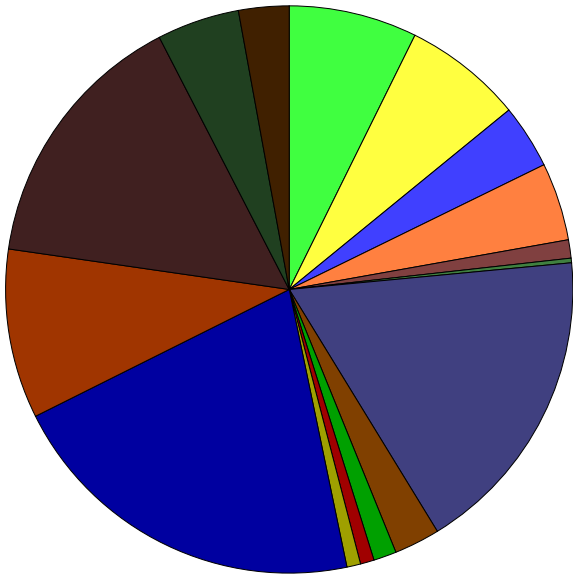


	% Total	% Answer	Count
11	12.53%	12.53%	48
12	10.44%	10.44%	40
13	17.75%	17.75%	68
14	17.23%	17.23%	66
15	19.32%	19.32%	74
16	9.66%	9.66%	37
17	7.83%	7.83%	30
18	1.83%	1.83%	7
19	3.39%	3.39%	13
Total	100.00%	100.00%	383

Area

Question responses: **383 (100.00%)**

Where do you live?



	% Total	% Answer	Count
Aveley	7.31%	7.31%	28
Bulphan	0.00%	0.00%	0
Chadwell St Mary	6.79%	6.79%	26
Chafford Hundred	3.66%	3.66%	14
Corringham	4.44%	4.44%	17
East Tilbury	1.04%	1.04%	4
Fobbing	0.26%	0.26%	1
Grays	17.75%	17.75%	68
Horndon on the Hill	2.61%	2.61%	10
Linford	0.00%	0.00%	0
North Stifford	1.31%	1.31%	5
Orsett	0.78%	0.78%	3
Purfleet	0.78%	0.78%	3
South Ockendon	20.89%	20.89%	80

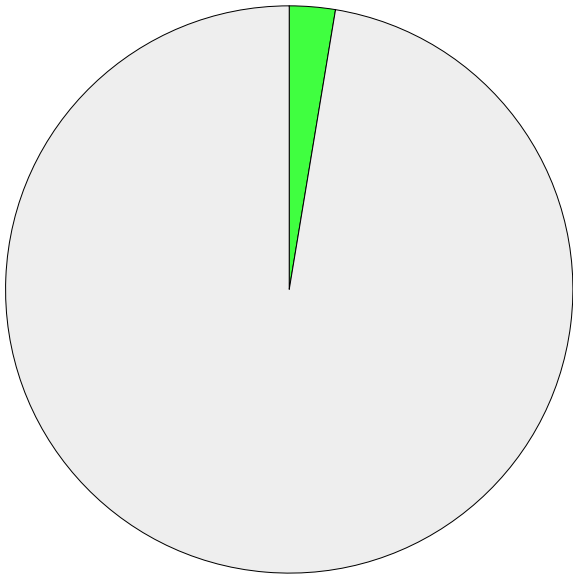
Area

	% Total	% Answer	Count
Stanford Le Hope	9.66%	9.66%	37
Tilbury	15.14%	15.14%	58
West Thurrock	4.70%	4.70%	18
West Tilbury	0.00%	0.00%	0
Outside of Thurrock	2.87%	2.87%	11
Total	100.00%	100.00%	383

Live Other

Question responses: **10 (2.61%)**

Please state

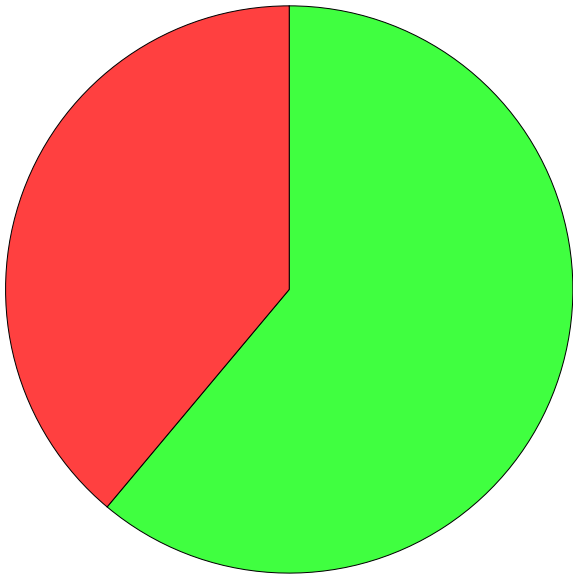


	% Total	% Answer	Count
[Responses]	2.61%	100.00%	10
[No Response]	97.39%	--	373
Total	100.00%	100.00%	383

Gender

Question responses: **383 (100.00%)**

Male or Female?

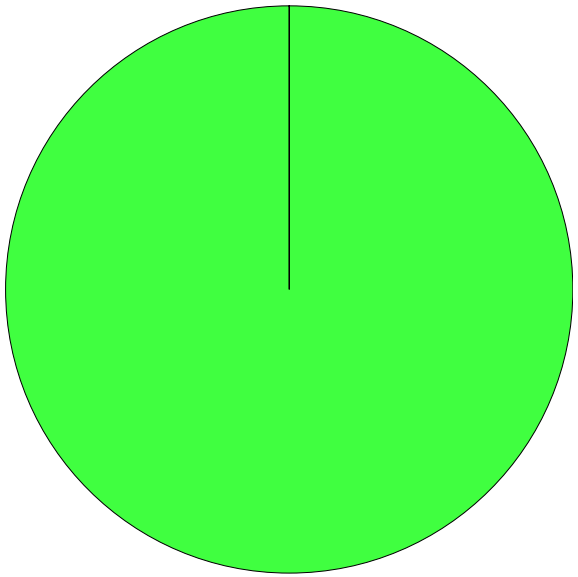


	% Total	% Answer	Count
Male	61.10%	61.10%	234
Female	38.90%	38.90%	149
Total	100.00%	100.00%	383

Top issue in area

Question responses: **383 (100.00%)**

What is the most important issue for young people in your area?

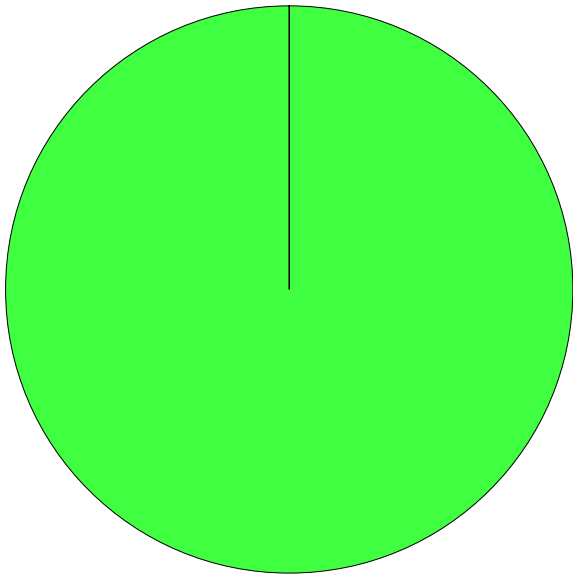


	% Total	% Answer	Count
[Responses]	100.00%	100.00%	383
[No Response]	0.00%	--	0
Total	100.00%	100.00%	383

Solution to issue!

Question responses: **383 (100.00%)**

How do you think you, other young people and Thurrock Council can improve this issue?

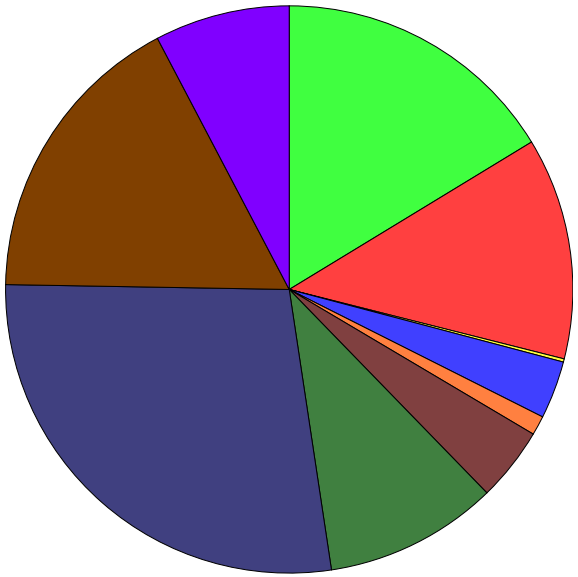


	% Total	% Answer	Count
[Responses]	100.00%	100.00%	383
[No Response]	0.00%	--	0
Total	100.00%	100.00%	383

Activity list

Question responses: **383 (100.00%)**

Do you currently take part in one or more of the following?

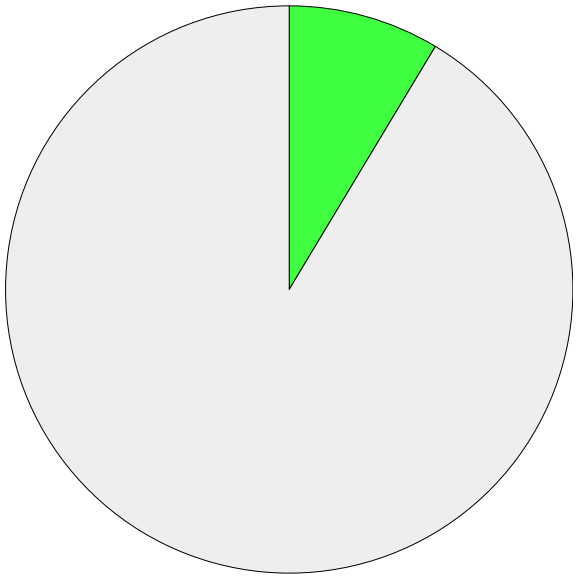


	% Total	% Answer	Frequency	Count
Local Youth Club	16.30%	16.30%	23.24%	89
Duke of Edinburgh Scheme	12.64%	12.64%	18.02%	69
Princes Trust Programme	0.18%	0.18%	0.26%	1
Thurrock Youth Cabinet	3.30%	3.30%	4.70%	18
Apprenticeships or Training Courses	1.10%	1.10%	1.57%	6
Careers Guidance from Thurrock Careers (formally Connexions)	4.21%	4.21%	6.01%	23
Arts, Drama, Music	9.89%	9.89%	14.10%	54
Sports activities	27.66%	27.66%	39.43%	151
None	17.03%	17.03%	24.28%	93
Other	7.69%	7.69%	10.97%	42
Total	100.00%	100.00%	0%	546

Other Activity

Question responses: **33 (8.62%)**

Please state

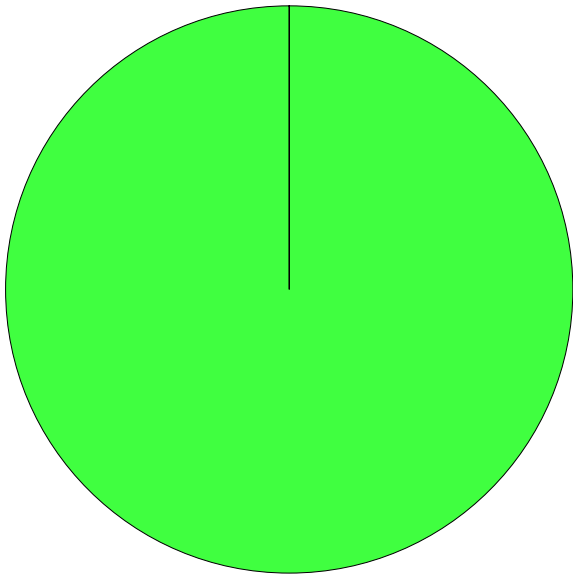


	% Total	% Answer	Count
[Responses]	8.62%	100.00%	33
[No Response]	91.38%	--	350
Total	100.00%	100.00%	383

Benefits

Question responses: **383 (100.00%)**

How has taking part in this benefitted you personally? (e.g. developed confidence, learnt a skill, achieved something)

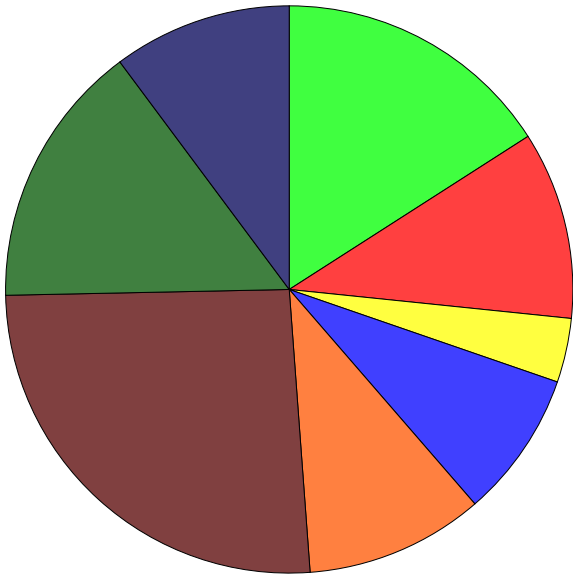


	% Total	% Answer	Count
[Responses]	100.00%	100.00%	383
[No Response]	0.00%	--	0
Total	100.00%	100.00%	383

New activity

Question responses: **383 (100.00%)**

If the Council was going to set up ONE new activity or service for young people what should be the main aim?

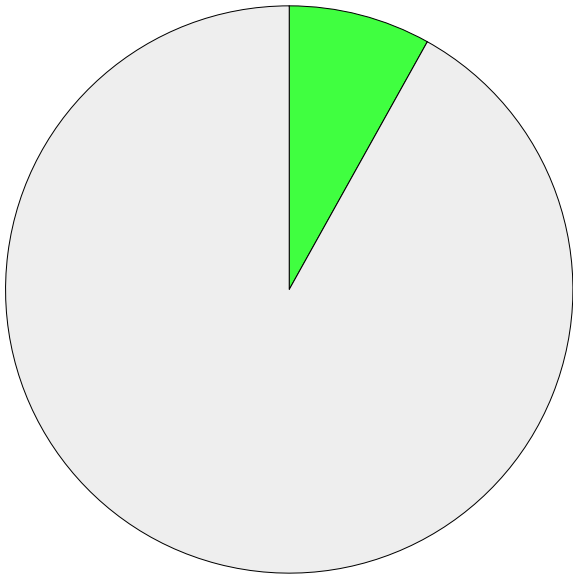


	% Total	% Answer	Count
Improve health and fitness	15.93%	15.93%	61
Giving young people a say in their area	10.70%	10.70%	41
Careers advice	3.66%	3.66%	14
Getting young people work related skills	8.36%	8.36%	32
Developing confidence and social skills	10.18%	10.18%	39
Keeping young people out of trouble	25.85%	25.85%	99
Supporting young people to gain a job	15.14%	15.14%	58
Other	10.18%	10.18%	39
Total	100.00%	100.00%	383

Suggested New Activity

Question responses: **31 (8.09%)**

Your suggestion

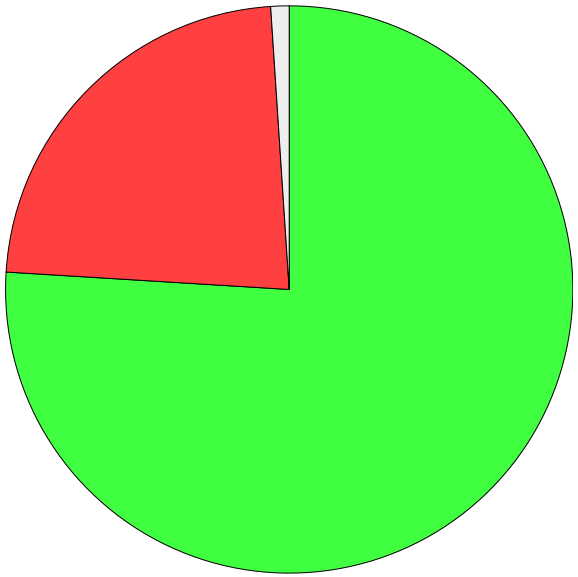


	% Total	% Answer	Count
[Responses]	8.09%	100.00%	31
[No Response]	91.91%	--	352
Total	100.00%	100.00%	383

Targeted work

Question responses: **379 (98.96%)**

Do you think there should be a focus on young people who are most in need of some extra support?

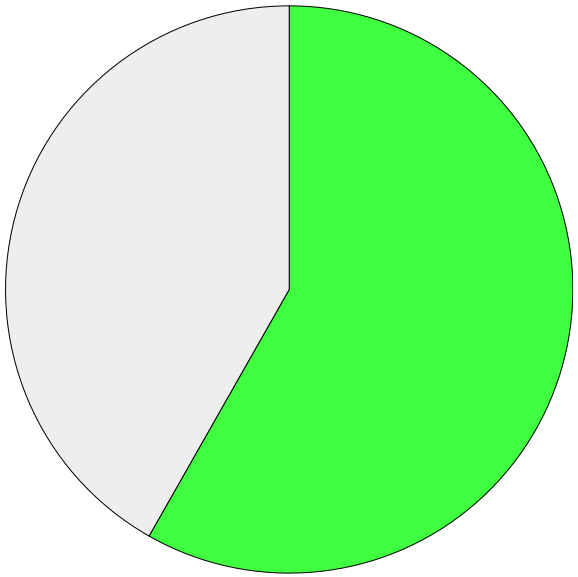


	% Total	% Answer	Count
Yes	75.98%	76.78%	291
No	22.98%	23.22%	88
[No Response]	1.04%	--	4
Total	100.00%	100.00%	383

Targeted groups

Question responses: **223 (58.22%)**

Which young people do you think should be a priority (e.g. young people not in school, young people living in certain parts of Thurrock etc)

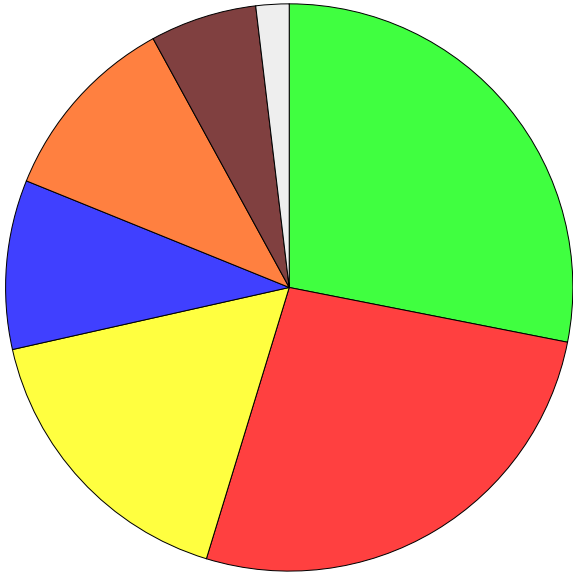


	% Total	% Answer	Count
[Responses]	58.22%	100.00%	223
[No Response]	41.78%	--	160
Total	100.00%	100.00%	383

Location of YW

Question responses: **374 (97.65%)**

Where would you prefer to go to a youth activity?

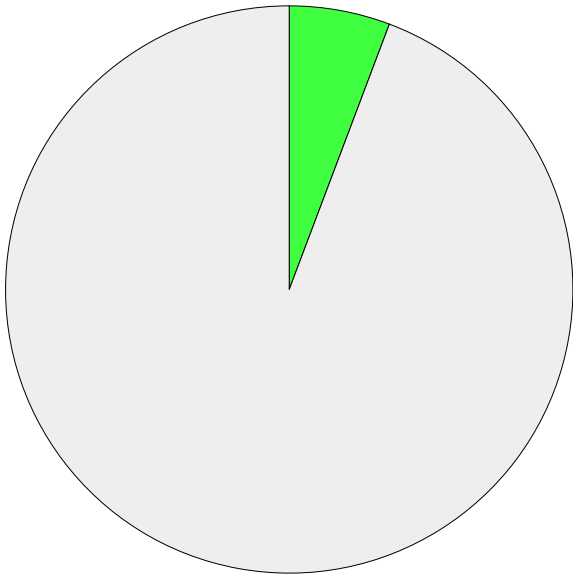


	% Total	% Answer	Frequency	Count
Local park	28.09%	28.63%	34.99%	134
Local community building (e.g. community centre, church, village hall)	26.62%	27.14%	33.16%	127
Local school	16.77%	17.09%	20.89%	80
Youth hub (one site in Thurrock that young people would travel to)	9.64%	9.83%	12.01%	46
Mobile youth bus	10.90%	11.11%	13.58%	52
Other	6.08%	6.20%	7.57%	29
[No Response]	1.89%	--	2.35%	9
Total	100.00%	100.00%	0%	477

suggested YW Other

Question responses: **22 (5.74%)**

Your suggestion

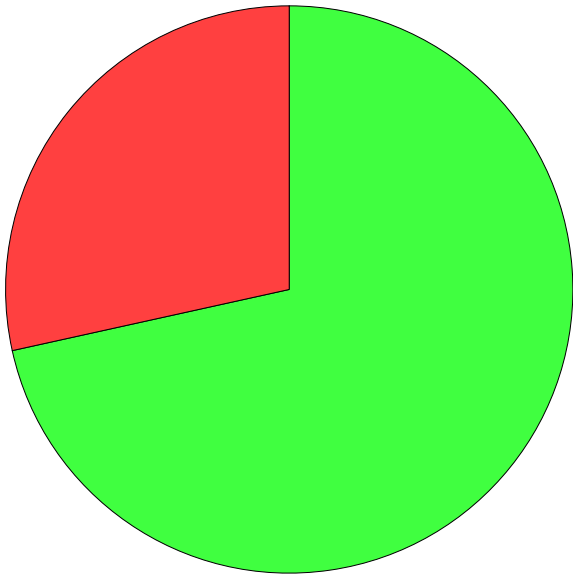


	% Total	% Answer	Count
[Responses]	5.74%	100.00%	22
[No Response]	94.26%	--	361
Total	100.00%	100.00%	383

Payment

Question responses: **383 (100.00%)**

Would you or your parents/carers be prepared to pay a small fee to take part in an activity? (e.g. £1 to attend a youth club)

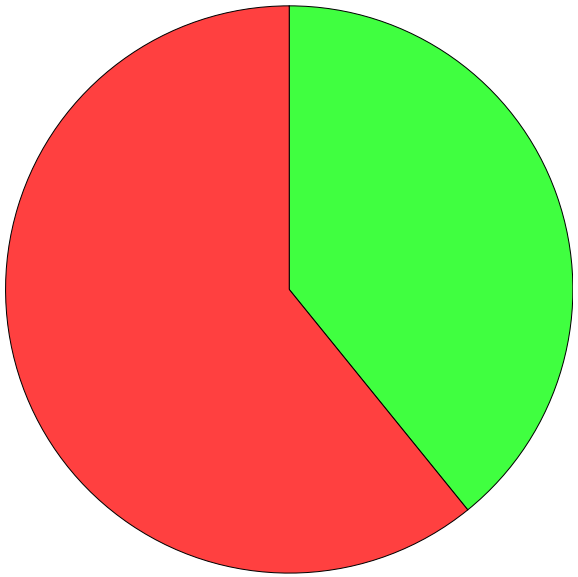


	% Total	% Answer	Count
Yes	71.54%	71.54%	274
No	28.46%	28.46%	109
Total	100.00%	100.00%	383

Further involvement

Question responses: **383 (100.00%)**

Would you like to be further involved in helping to plan young people's services in Thurrock?

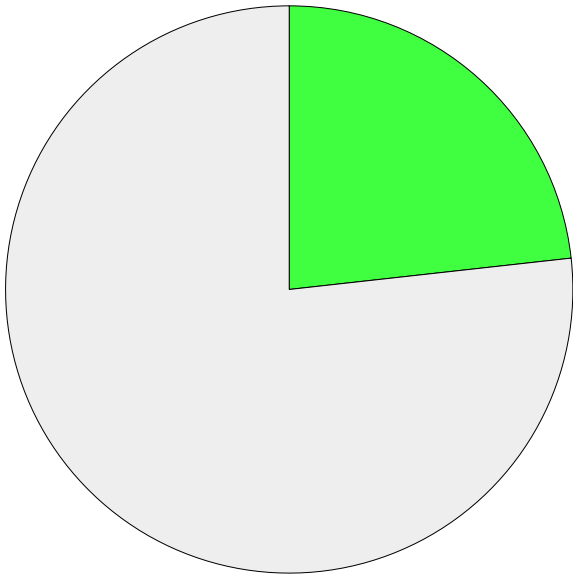


	% Total	% Answer	Count
Yes	39.16%	39.16%	150
No	60.84%	60.84%	233
Total	100.00%	100.00%	383

Email

Question responses: **89 (23.24%)**

Please provide your email address or contact number



	% Total	% Answer	Count
[Responses]	23.24%	100.00%	89
[No Response]	76.76%	--	294
Total	100.00%	100.00%	383

10 February 2015	ITEM: 8
Children's Services Overview & Scrutiny Committee	
Learning from the Serious Case Review of "Julia"	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Jane Foster-Taylor, Thurrock LSCB Full Board Vice-Chair	
Accountable Head of Service: Andrew Carter, Head of Children's Social Care	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is Public	

Executive Summary

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:

a) abuse or neglect of a child is known or suspected; and
b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

A serious case review team was established and although Julia and her family had been known to Universal and Specialist Services for many years, the SCR Review Team agreed that the period to be reviewed would be from November 2010 – to February 2013 when Julia became subject to a Child Protection Plan.

1. Recommendation(s)

1.1 That the Committee consider and comment upon the report.

1.2 That the progress made on the review's action plan be noted.

2. Introduction and Background

2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

2.2. This case was referred formally to the Thurrock Local Safeguarding Children Board Serious Case Review Panel to consider the case under Regulation 5. The Panel found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children, 2013.

2.3 A Serious Case Review Team was established and although Julia and her family had been known to Universal and Specialist Services for many years, the SCR Review Team agreed that the period to be reviewed would be from November 2010 to February 2013 when Julia became subject to a Child Protection Plan.

2.4 The review was commissioned in May 2013 and completed in May 2014 and the subsequent findings presented at a series of Safeguarding Board meetings and presented to the recently initiated National Serious Case Review Panel (new requirement) before going before the LSCB Full Board for final ratification and agreement in September 2014.

2.5 The review was officially published on 15th December 2014 and will remain on the LSCB website for a period of 18 months in accordance with guidelines (Working Together 2013).

2.6 The review identified seven findings for the Safeguarding Board to consider.

2.7 The board conducted an initial assessment of progress made during the course of the review and this is reflected within the final document.

2.8 A detailed multi-agency action plan has been developed and agreed by the partner agencies to monitor progress of each of the seven findings and outcomes from this review.

2.9 The governance and monitoring of the action plan has been tasked to the Safeguarding Board's Audit Group and overseen by the Serious Case Review group and subsequently reporting to the LSCB Full Board.

3. Issues, Options and Analysis of Options

None.

4. Reasons for Recommendation

4.1 It is a statutory requirement for Local Safeguarding Children Boards to publish all Serious Case Reviews. It is good practice for these reviews to be submitted to Overview and Scrutiny.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The document was circulated in draft for consideration and comment to all partners of the LSCB and the various LSCB sub committees prior to ratification

6. Impact on corporate policies, priorities, performance and community impact

6.1 The review calls upon the authority to review the findings against existing policies and procedure and to consider making any changes reflected in the review.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager – Children's Services

The delivery of the LSCB Business is undertaken within existing budgets. Those budgets are established through annual partnership funding and specific budgets allocated for training and serious case reviews. All agencies contribute to the LSCB budget.

7.2 Legal

Implications verified by: **Lindsey Marks**
Principal Solicitor

This serious case review fulfils the requirements of Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

7.3 Diversity and Equality

Implications verified by: **Teresa Evans**
Equalities and Cohesion Officer

The annual report covers the safeguarding needs of all children in Thurrock. The plans and policies of its board and sub committees reflect the diverse

needs which are supported through implementing and developing equalities impact assessments as appropriate.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- SCIE Serious Case Review Report "Julia"

9. Appendices to the report

- Appendix 1 - SCIE Serious Case Review Report "Julia"

Report Author:

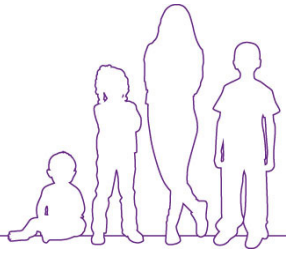
Alan Cotgrove

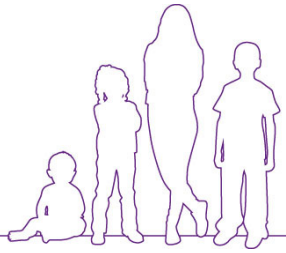
Business Manager

Local Safeguarding Children's Board

Thurrock
Local Safeguarding Children Board

Serious Case Review:
"Julia"





1 INTRODUCTION TO THE REVIEW PROCESS

Reason for the Serious Case Review

1.1 Julia (14) attended Sexual Assault Referral Centre (SARC) in December 2012 after she made a disclosure of rape. When she was medically examined she was found to have a significant sexually transmitted infection. Julia gave a history of sexual abuse at age 6 and 11 and four recent experiences of being raped, which had been investigated. The Designated Nurse also became aware that there was an extensive family history of involvement with specialist services and historical allegations of sexual abuse.

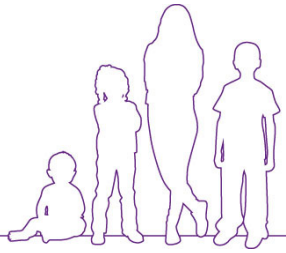
1.2 The Designated Nurse referred the details of Julia's circumstances to the Thurrock Serious Case Review subcommittee where it was agreed that it met the criteria for undertaking a Serious Case Review as outlined in Chapter 8 of Working Together to Safeguard Children 2010 (DSCF 2010[i]).

1.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

1.4 Working Together was reissued in 2013[ii] and provided new guidance for undertaking a Serious Case Review which requires that they should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;

[i] Education Department (2010) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. London
[ii] Education Department (2013) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. London



- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

LSCBs may now use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro[iii]. The Thurrock LSCB agreed to undertake a review using the SCIE Learning Together methodology[iv].

Time scale for the SCR

1.5 Although Julia and her family have been known to Universal and Specialist Services for many years, the SCR Review Team agreed that the period to be reviewed would be from November 2010 – to February 2013 when Julia became subject to a Child Protection Plan.

This review was commissioned in May 2013 and completed in May 2014.

[iii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London RSO.
[iv] Fish, S. Munro, E. and Bairstow, S. (2008) Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews. SCIE. London

Julia's Family – all names have been changed for reasons of confidentiality

1.6

	Relationship to Subject	Age at start of review process – November 2010	Ethnicity	
Julia	Subject of the review	12	White/ British	School
Sophia	Mother	39	White/ British	Working
	Non resident father of Julia - left the family in 2000. (Julia is not supposed to have contact because of concerns about allegations of his sexual offences against children. He now has a new family and Julia has visited them in the past)	39	White/ British	Not known
Natalie	Half sister (her partner also lived in the family home in the period under review)	18	White/ British	College
Courtney	Half sister	16	White/ British	College
Paige	Half sister	15	White/ British	
	Non resident father of Natalie, Courtney and Paige left in 1995 – unclear if there is any current contact.			
Little is known about Julia's wider family, but that Julia remains in contact with her maternal grandparents and her uncle, and Julia's mother said that she has a difficult relationship with maternal grandmother.				

Succinct summary of case

1.7 The background to this case is a long history of contact with children's welfare and child protection services for Julia, her siblings and parents. Julia's mother and her father were known to children's welfare services as children. Julia was assessed as having special educational needs for which she receives additional support at school. Historic health records report that as a child Julia's mother was also considered to have learning difficulties, but no formal assessment has ever been undertaken, so the precise nature of these difficulties remains unclear. There has been long standing concerns about Julia and her half siblings regarding neglect, intra-family sexual abuse, physical abuse, domestic abuse and social exclusion/deprivation. These were addressed by a large number of referrals from Universal Services, Assessments, Child Protection Conferences, Child in Need processes, therapeutic support and police action. Over time there were concerns about the parent's lack of engagement with services, but there was also evidence of sufficient change in the lives of all the siblings, which led to Children's Social Care feeling able to withdraw from involvement with the family.

When Julia was aged 12, in January 2010, she disclosed that she had been raped, she made three further disclosures of rape by boys (aged 15- 18) over a two year period, and despite good police investigation it has not been possible to achieve a prosecution.

Over this period there were also periods when there were concerns about her poor attendance, behaviour and anger at school, and her mother complained about her behaviour and angry outbursts at home. As a result of Julia's disclosure of rape in December 2012 Julia was made subject to a Child Protection Plan in February 2013 and Julia's mother has also engaged with the Troubled Families project.

Timeline of critical incidents

1.8

Earlier contextual information	
Date	**Incident**
January 2010	Children's Social Care received a referral from the police about allegations that Julia had been sexually assaulted by a male friend.
February – March 2010	A Core Assessment was undertaken under Child Protection Processes (Sec 47 Children Act 1989) by Social Worker 1 and concluded that there were concerns about the sexual assault, but Julia was no longer at risk of harm. A Child in Need Plan was formulated and Julia and her family were transferred to a social work team.
June 2010	Police conclude that they do not have enough evidence to pursue a conviction.
July 2010	The Team Manager of the social work team contacted Safeguarding to query why there had been no Child Protection Conference for Julia. The electronic records provide no evidence of a response.
July to November 2010	The allocated Social Worker 2 attempted to contact the family, via numerous texts, letters and unannounced home visits without success.
Review Period Starts	
Date	**Incident**
3 November 2010	School report to Children's Social Care that Julia had told them she had sexual intercourse with a boy who was a friend. The allocated Social Worker 2 tried to make contact with Julia's mother without success, and also contacted the police who visited the family home that evening.
4 November 2010	School contacted Julia's mother and suggested she take her to the GP.

9 November 2010	Julia visited GP 1 with her mother and was prescribed contraception. The concerns about the sexual assault were discussed, and the GP agreed to contact the police. There is no recorded evidence that this happened.
November/December 2010	During November and December many attempts were made to contact Julia and her mother by Social Worker 2 without success. The Social Worker 2 and her Manager agreed a Strategy Meeting should take place, and the police agreed. The Social Worker pursued this without success.
13 January 2011	A home visit was undertaken by allocated social worker 2 and police officer 1. Julia was seen with her mother. The police said that the rape disclosure was not supported by the available evidence, and there could be no further action. A referral to the Sexual Health Advisor and support activities for Julia was taken forward.
February 2011	The Sexual Health Advisor attempted to make contact with Julia without success. Social worker 2 was also unable to make contact despite many calls and home visits.
March/April 2011	Children's Social Care considered closing the case because of lack of engagement, but continued to try and make contact with Julia and her family.
May 2011	A referral to Children's Social Care was completed by the Accident and Emergency Department of the hospital regarding concerns about lack of appropriate parental care and an injury to Courtney. An Initial Assessment was completed about Courtney, by Social Worker 2 and recommended case closure with referrals to parenting support and family mediation to address family conflict.
June/July 2011	Julia's mother sought support from Social Worker 2 regarding Julia's disruptive behaviour and concerns

	about sexual contact with boys. Referrals were made to parenting support and the Sexual Health Advisor by social worker 2. Mother also told GP 2 that she was concerned about Julia's disruptive behaviour and the GP made a referral to Child and Family Consultation Service (one of the services of CAMHS). No other agency was informed of this referral.
8 August 2011 – September 2011	Children's Social Care sent a letter saying the case had been closed, but reviewed this decision because of a referral received in September 2011 which meant that the case remained open until January 2012.
4 September 2011	Julia was given a final warning for an incident where she had thrown boiling water over her sister Courtney. Courtney went to hospital with her mother who told hospital staff that Julia had been sexually active since the age of 11. They appropriately made a referral to Children's Social Care. A Core Assessment was undertaken by social worker 2 and concluded that there were no concerns regarding Courtney, and no need for services, but Julia would need further support which would be provided by the school and Coram would provide parenting support to her mother.
6 September 2011	The social work Team Manager sought advice for a second time from the Safeguarding Team because she thought a Strategy Meeting should be convened and a Child Protection enquiry carried out. There is no evidence in the records of a response to this request, or that any further action was taken.
September 2011	Julia's mother attended three sessions of the parenting programme, but did not complete the programme.
17 October 2011	Julia had her Annual Review meeting for a student with a Statement of Special Educational Needs at school, and concerns about her poor attendance and behaviour were discussed, goals were set in these areas.
November 2011	Julia attended a sexual health drop in session at school

	with the School Nurse. She said she was having sexual contact with a 14 year old boy and her mother was aware of this. She was assessed as Gillick competent and contraceptive advice and support was given, in line with existing health guidance.
December 2011	Social Worker 2 was unable to make contact with Julia or her family and the school and Social Worker shared information. School said they were concerned about Julia's attendance and behaviour/aggressive outbursts.
January 2012	Julia continued to have difficulties at school and support/ counselling was provided by the Learning Mentor. The school struggled to contact mother. The Social Worker 2 made many attempts to contact and visit Julia and her family without success.
31 January 2012	Case closed to Children's Social Care.
February – May 2012	School remained concerned about Julia's anger and behaviour, and made a referral to Children's Social Care regarding bruising to Julia's sister. There is no evidence in the electronic files or school records of a response to this referral.
May 2012	Julia and her mother saw GP 2 twice regarding the contraception pill and once for advice regarding mothers concerns about Julia's behaviour.
June and August 2012	Julia's mother contacted the Duty Social Work Team twice for advice about managing Julia's behaviour, sexual behaviour and her wanting to meet boys. On the second occasion Social Worker 3 visited, but there was no one at home because the family had gone on holiday. A letter was left asking mother to make contact, but she did not.
October 2012	During the course of an investigation of sexual assault of another young woman, the police were told that Julia had also been raped by the same perpetrator. The police interviewed Julia and she alleged that she had

	been raped. When interviewed again by the police she said that it had been consensual and she had previously had sex with six other boys. The police made a referral to Children's Social Care and a Core Assessment was initiated. This assessment was not completed before a further disclosure of sexual assault was made by Julia in December 2012. School were concerned at this time about her poor attendance and disruptive behaviour.
8 December 2012	Julia reported to the police that she had been raped by a 19 year old man. She was seen at the Sexual Assault Referral Centre where she was diagnosed with a sexually transmitted infection by the Doctor who examined her. She was seen by the nurse who made a referral to Children's Social Care because she was concerned about Julia and her mother's attitude regarding the infection.
12 December	Julia was seen with her mother at the Genito-Urinary Medicine Department of Sexual Health (GUM) for treatment, where she told the Doctor that she'd had "*15 to 20 sexual partners*". The nurse at the clinic also made a referral to Children's Social Care. Julia's mother did not take Julia to the follow up appointment to treat the sexually transmitted infection.
14 December/11 January 2012	Julia was seen with her mother at home by Social Worker 4 and the sexual assault was discussed.
December 2012	The Inclusion Leader from the school and Lead from the Troubled Families Project visited the family, they were concerned that the house was in a poor state of repair and the three sisters were huddled in bed because there was no heating.
18 January 2013	Children's Social Care convened a Professionals' Meeting to discuss progress regarding the rape disclosures made by Julia. Three appointments with the police were cancelled by Julia's mother. At this point

	Julia's attendance at school was 50% and there was ongoing conflict with peers at school.
January 2013	The Core Assessment was extended to include the second rape disclosure and was completed by Social Worker 4 in January with a recommendation of Child in Need support from the social work team.
29 January 2013	The case was allocated to Social Worker 5 and she requested (with the support of her Team Manager) that an Initial Child Protection Conference be convened. This was held on 21 February 2013. Julia was made subject to a Child Protection Plan.

Methodology

1.9 This serious case review has been undertaken using the SCIE Learning Together methodology[v]. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper, underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them should contribute to improving practice more widely. Data comes from semi-structured conversations with the involved professionals, and the young person and their family who are the subject of the review, from case files and contextual documentation from organisations. A fundamental part of the approach is to talk with staff to understand what they thought and felt at the time they were involved in the case, avoiding hindsight as much as possible. It is vital to try and make sense of what factors contributed to their understanding at the time and to the decisions they made. This is known as 'local rationality'. Any appraisal of practice is then made in the context of those contributory factors.

[v] Fish, S. Munro, E. and Bairstow, S. (2008) Learning Together to Safeguard Children: developing a multi agency systems approach for case reviews. SCIE. London

The Lead Reviewers

1.10 This review was undertaken by Jane Wiffin (Independent Lead Reviewer) and David Peplow, both of whom are SCIE accredited Lead Reviewers.

Jane Wiffin was the Independent Lead Reviewer. She is a qualified Social Worker who has extensive experience of working in safeguarding. She is an experienced serious case review author and chair, having undertaken 18 reviews. She was accredited as a SCIE Learning Together Reviewer in 2011 and has undertaken a number of reviews using this methodology. She is currently engaged in work developing tools and frameworks for addressing childhood neglect and she is an experienced auditor and safeguarding trainer. She is independent from all the agencies involved in this review.

David Peplow served 25 years as a police officer. He was the Essex Police lead for safeguarding matters and Head of Child Abuse Investigations. He has extensive experience of multi-agency working across three Local Authority areas. He left the police in 2012 and became an accredited Learning Together reviewer in July 2012. He is the Independent Chair of Thurrock LSCB and sits on a fostering panel. David is independent of all the agencies involved in this. Although he is Chair of the LSCB he has undertaken this serious case review from a critical and analytical standpoint.

The Review Team

1.11 The review was conducted by a team of senior representatives from local agencies who has had no direct involvement with the case. They shared in the conversations, the analysis of documents, the identification of key practice episodes and contributory factors. This report is the shared responsibility of the Review Team in terms of analysis and conclusions, but was written by the joint lead reviewers.

Name	Agency
Yvonne Anarfi	Designated Nurse for Safeguarding Children: NHS Basildon & Brentwood CCG /NHS Thurrock CCG
Sandra Bryan	Matron for Disabled Child Team for North East London NHS Foundation Trust
Julie Cole	Lead Consultant for Safeguarding and Quality: Coram
Liz Chapman	Manager – Operational Investigations: Essex Probation
Kathie Clibbens	Professional Lead & Consultant Nurse Safeguarding Children: West Essex Clinical Commissioning Group
Anita Erhabor	Associate Designate Nurse: Basildon and Brentwood and Thurrock CCGs
Lesley Ford	Detective Chief Inspector Head of Child Abuse Investigation & Police Online Investigations Teams / Head of Child Safeguarding
Barbara Foster	Head of Care & Targeted Outcomes, Children's Directorate, Thurrock Council
Cassandra Moore	Named Nurse for Safeguarding Children, Basildon Hospital
Lindsey Marks	Principal Solicitor for Children's Safeguarding; Thurrock Council
Malcolm Taylor	Principal Educational Psychologist

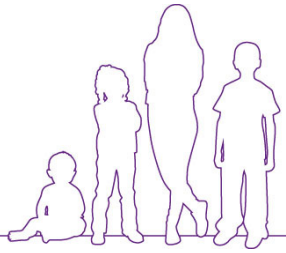
The Case Group

1.12 The members of the Case Group are the professionals who worked with or made decisions about the family, and who had individual conversations with members of the Review Team. The Case Group comprised of over 20 people (although not all these people attended Case Group meetings). Most were briefed on the methodology and then met with the Review Team on four further occasions to share in the analysis, the identification of contributory factors, and to comment and contribute to the report. Individual sessions were held with some professionals, either because they could not make the Case Group meetings or to clarify data.

- Two Social Workers
- Social Work Team Manager
- School Liaison
- Special Educational Needs Coordinators
- School Nurse
- Three police officers
- Two nurse specialists
- School counsellor and school support
- Education Welfare Officer
- GPs
- Practice Manager for GP surgery
- Parenting Workers
- Specialist Doctor
- Inclusion Leader, School

Family Member Involvement

1.13 Julia and her Mother contributed to the Review by meeting with the Lead Reviewer on two occasions, once at the beginning of the process, and once at the end.



Structure of the Review Process

1.14 The Review Team met on six occasions, including four times with the Case Group, and worked with them on the information from the conversations to the identification of the Findings and issues for LSCB consideration.

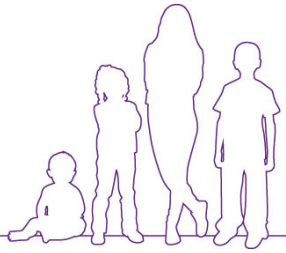
Sources of data

1.15

- The semi-structured conversations between members of the Review Team and 20 members of the Case Group;
- The semi-structured conversations with family;
- Documentation: All necessary documentation was made available to the review ranging from case files, procedures, and police attendance records. This meant that the reviewer did an in depth review of all the relevant information held during the period under review by Children's Social Care, GP surgery, Police, School Nurses, Coram, school, GUM and SARC.

About Thurrock

1.16 Thurrock lies to the east of London on the north bank of the River Thames and within the Thames Gateway, the UK's largest economic development programme. Thurrock has a strong manufacturing and retail focused economy. There is a very significant regeneration programme centred on five growth hubs: Purfleet, Lakeside, Grays, Tilbury and London Gateway. Thurrock has a resident population of approximately 40,200 children and young people aged 0 to 18, representing 25% of the total population of the area. In 2012, 25.7% of the school population was classified as belonging to an ethnic group other than White British compared with 22.5% in England overall. Some 12% of pupils speak English as an additional language. Deprivation levels in Thurrock are consistent with the national average, but there are significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England.



2 APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE

2.1 A Serious Case Review plays an important part in the efforts to achieve a safer Child Protection system. Consequently it is important to consider what happened and why in a particular case, but to then go further and reflect on what this might reveal about underlying gaps and strengths in the child welfare system that may reappear in other cases. This case should act as a "window on the system" and move beyond the case specific. We begin by capturing the appraisal of the practice response to this case, given what was known and knowable at the time. The Findings that follow in the next section then aim to provide an explanation of the "why", outlining what got in the way of professionals being as effective as they wanted to be.

2.2 It is difficult for those professionals who were directly involved with Julia and her family to have practice they were involved in appraised in this way. They were very open to reflecting on practice, but wanted to make clear that some of what took place is historical, and some aspects of the practice reviewed has now changed and developed. The Review Team is grateful to them for being open and helping to make sense of the case and the context in which practice took place. It is clear that all individual professionals cared about what happened to Julia and her family. Many of the professions involved, for example the allocated Social Care Team and the police, were overloaded in the period under review and this had an impact on practice in this case. Less is known about whether there were capacity issues for the other services involved.

2.3 During the timeframe for this review (just over two years) there were four critical incidents, three of which were disclosures of rape and sexual assault by Julia and one related to concerns about the quality of physical and emotional care that Julia and her siblings received. There was an immediate response to most of these incidents. However, on occasions, established policies and procedures were not followed, including a Strategy Meeting/discussion, Child in Need

processes, processes for non-attendance at school and evidence that some health professionals did not make direct referrals to Children's Social Care, although there is also evidence of good multi-agency referrals too.

2.4 Beyond these points of crisis, despite a lot of professional activity and concern, there was little progress in improving the safety and wellbeing of Julia and the professional responses appeared to 'drift'. It is the task of this review to consider why this was so, and what this tells us about the strengths and weaknesses in the multi-agency Child Protection system.

Working with persistent non–engagement

2.5 In part, the lack of progress for Julia was as a result of the passive resistance by Julia's mother to most professional contact and help. Many agencies spent a great deal of time trying to see Julia and her family without success and Julia's mother regularly missed meetings, did not follow up on referrals made for her daughter's well-being and failed to return telephone calls or reply to letters about failed appointments. There was a mistaken belief that Julia could not be seen without mother's permission.

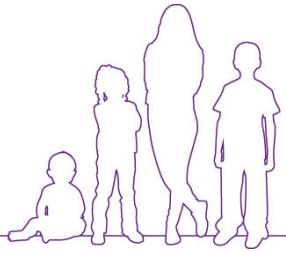
2.6 The only time that contact with mother was possible was when there was a crisis, or she wanted advice about Julia's difficult behaviour as she saw it. As soon as the immediate crisis had been addressed, Julia's mother withdrew, meaning that Julia did not have contact with professionals and was unable to develop helping relationships with them. The cause of this withdrawal by mother was insufficiently analysed or challenged, and no solution was found to address it. The school were aware of Julia's poor attendance at school and held meetings to discuss this with Julia's mother. Although they discussed the potential for taking formal action, none was taken. The health professionals who advised Julia were aware that her mother did not always seek advice for her promptly enough, but did not explicitly challenge her. The consequence of this was that professionals lost sight of the fact that, because of the non-engagement of mother, Julia did not receive the services she needed. Working with chronic non-compliance with services is difficult. **This is discussed in Finding 4 and 5.**

Professional recognition of adolescent neglect

2.7 The lack of engagement by Julia's mother to services designed to promote the wellbeing of Julia and her siblings should have been recognised as an indicator of adolescent neglect. There was evidence that Julia was not sufficiently supported to attend school, and there were times when she said she did not have bus fare because her mother had spent it. This had an impact on her ability to make use of the additional support she was provided with as a child with additional needs, and she was not able to attend counselling support provided at school because of her many absences. When Julia told school that she had been raped they appropriately suggested that her mother take her to see a health professional, which her mother delayed. Julia was not taken for her police interview (Achieving Best Evidence) on a number of occasions, and when a sexually transmitted infection was diagnosed she was not taken for her follow up appointment.

2.8 There were periods when the household she lived in was described as "chaotic" with the siblings being in conflict. This was of concern to the Accident and Emergency Department of the hospital who saw Julia's sister with an accidental injury in May 2011, and when the Coram parenting worker visited in September 2011 she was concerned about the level of conflict at the house and the behaviour of all of the siblings.

2.9 Although most professionals recognised that Julia was a young person who had disclosed a number of rapes, had a difficult family history and at times poor quality parental care, the lack of engagement and resistance by her mother meant that they were not able to form a relationship with her. There was an urgent need for a multi-agency meeting or an assessment to analyse her needs and her mother's response in the context of potential adolescent neglect – neither of which happened. **This is discussed in Finding 6**.



Uneven balance between "troublesome" rather than "troubled" Adolescence

2.10 A focus on Julia being "troublesome" was instigated by her mother and was not sufficiently challenged by professionals. Mother sought help from the GP and asked for Julia to be assessed by a Psychiatrist. A referral was made to Child and Family Consultation Service (one of the services of CAMHS) for Oppositional Defiance Disorder without an analysis of her very real difficulties or contact with any other professional. At school she was often difficult and badly behaved, and these concerns were a strong feature of her Statement of Special Educational Needs reviews'. The school did offer her counselling support, but poor attendance meant that these sessions were rarely attended.

2.11 The focus shifted to Julia as the problem, and this overshadowed the difficulties she was experiencing as young person with additional needs because of her mild learning disability and who had experienced a number of traumatic experiences. This was apparent after the incident when she threw boiling water over her sister. This was a serious incident and needed to be treated as such, but there is no evidence that once the criminal issues had been addressed, that her behaviour was analysed or linked to her recent disclosures of rape and sexual assault. The fact that she could be held responsible for her behaviour, yet none of her disclosures of rape had led to any prosecutions, despite significant and appropriate enquiries being made, was not acknowledged. Julia clearly needed help to make sense of this. There should have been a multi-agency plan to bring these two aspects together – the complex circumstances which were likely to have led to Julia feeling angry and the behaviour that appears to be the consequence. There was a need for a more holistic response. **This is discussed in Finding 3 and Finding 5.**

Lack of assessment

2.12 An Assessment for Julia was carried out nine months before the period under review in January 2010 as a result of a disclosure of sexual assault when she was aged 12. She was next assessed in October as a result of the referral made by the police regarding a disclosure of sexual assault, a gap of two and a half years. In this time there was one further disclosure of sexual assault and there

were concerns expressed about Julia's under age sexual activity. There were also concerns about family chaos and two specific incidents which led to two Assessments, both focussed on Julia's sister rather than Julia. These were comprehensive pieces of work, which gave a good sense of history but which focussed in their analysis on the presenting incident, and did not fully consider Julia and the concerns about sexual assault.

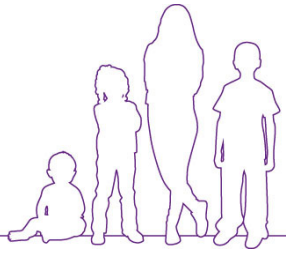
2.13 This lack of Assessment was influenced by existing processes for assessing the primary referred child rather than the whole family, and this is discussed in Finding 3. This meant that the proposals for interventions, made at various points were not connected to a clear understanding or analysis of Julia's needs and circumstances, and success, was unlikely. This is discussed in **Additional Learning.**

Multi-agency meetings and planning processes

2.14 It is striking that in the period under review there was only one multi-agency meeting with regard to Julia and this was held at the very end of the review period in January 2013. It would have been expected that some multi-agency meetings would have taken place given the lack of progress of any of the proposed services offered to Julia and her family. It is easy to place this responsibility entirely onto Children's Social Care, and although they had key worker responsibility, any other agency could have requested or called a multi-agency meeting, although all agencies do not seem to have felt enabled to do so. **This is discussed further in Finding 3 and Finding 6.**

Child in Need Processes

2.15 Julia was considered to be a Child in Need from July 2010 to January 2012 without there being a Child in Need Assessment, Child in Need meeting or Child in Need review. Despite concerns that this case should have been escalated to Child Protection, the Child in Need processes could have developed an effective multi-agency plan. This did not happen. Overall there was reasonable multi-agency information exchange across the period of this review but it was not focussed or part of a clear plan of action. This was particularly noticeable with regard to the school, who were managing concerns about Julia's non-



attendance, behavioural and emotional difficulties, her disclosures about sexual assaults and her special educational needs, without a clear overarching plan. Coram were asked to provide parenting support and provided this, but without it being clear how this fitted into an overall plan for this family. It is clear that the GP surgery was not included in the information exchange and did not also engage with any of the professionals involved with Julia.

2.16 The lack of any multi-agency meetings meant that there was no opportunity to establish goals, set the expectations for Julia's mother and the rest of the family, and review progress. The review would have been an opportunity to reflect on the lack of progress being made and to consider next steps or a change in direction. A face to face meeting in this context might have enabled all professionals to challenge the status quo, but the multi-agency team could also have been a virtual one if there had been a clear plan of action. At no point was information held by all shared in one forum, and so it is not surprising that the response was fragmented. **This is discussed in Findings 3 and 6.**

Effective safeguarding referrals from the multi-agency network

2.17 There were a number of occasions when the school, hospital, GUM[vi] and SARC[vii] and the police made prompt and clear referrals to Children's Social Care about Julia and her sister, and these were responded to quickly. In October 2010 school contacted Children's Social Care to inform them of a disclosure of sexual abuse by Julia. The hospital saw Julia's sibling, Courtney, on two occasions (May 2011 and September 2011) and on both they were concerned about the care provided to all the girls, and on the second occasion mother's discussion of Julia's underage sexual activity. These same concerns prompted GUM and SARC to refer in December 2012. The police made a referral in October 2012 when concerns about sexual assault regarding Julia came to their attention. This was all effective multi-agency practice, but the fact that it did not lead to a multi-agency response **is discussed in Finding 6.**

[vi] Genito-Urinary Medicine Clinic
[vii] Sexual Assault Referral Centre

Difficulties in escalating to Child Protection

2.18 Given the seriousness of the concerns regarding the disclosure of sexual assault by Julia from the ages of 12 – 14 years and her mother's attitude, it would have been expected that Child Protection procedures would have been considered. Julia made four disclosures of rape in a two year period. Rape of a child is sexual abuse, yet somehow this was not recognised. The police undertook extensive criminal enquiries to establish the facts of each case and to seek a prosecution of the perpetrators identified by Julia. The lack of a criminal prosecution should not have meant that there was no Assessment of significant harm and a decision made about whether a Child Protection response under Sec 47 of the Children Act 1989 was required.

2.19 When Julia made a disclosure of rape at the age of 12 in October 2010 there should have been a Strategy Discussion/meeting, as this was clearly an allegation of statutory rape. The Social Worker sought a Strategy Meeting but was hampered by delays in being able to contact the police. The Social Worker pursued this but ultimately it never took place. This appears to have been influenced by the fact that by the time the police officer and Social Worker were able to visit the family home and see Julia (some eight week after the incident) the police could take no further action because they did not have enough evidence to pursue a criminal investigation. As a result there was no Child Protection enquiry and Julia was seen as a Child in Need – not a child in need of protection. There were a number of professionals involved at this point, police, Social Worker, school, GP and School Nurse. All were aware of the seriousness of this incident, but because of the lack of any multi-agency meetings there was no forum to question why the case continued to be held at a Child in Need level. **This is discussed in Finding 7.**

2.20 A Child Protection response should have been considered when Julia threw boiling water over her sister. At this time the hospital raised concerns that Julia's mother had told them that Julia had been sexually active from an early age and there had been recent concerns about sexual abuse. The social work team thought there should have been a Strategy Meeting and Child Protection Case Conference, and sought advice from the Safeguarding Team. They received a

reply asking for clarification of the engagement of other teams, and there was no further recorded response.

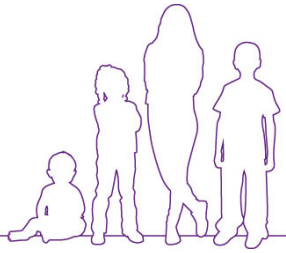
2.21 Julia made a disclosure of rape in October 2012 and this should have warranted a Child Protection response, but was held again at a Child in Need level and a Core Assessment started. A new disclosure of rape was made by Julia five weeks later and it was agreed that a Child Protection enquiry should be initiated and a Child Protection Conference convened. This did not happen. This final disclosure was incorporated into the Core Assessment started in November, and the conclusion was that Julia should once again be held at Child in Need level rather than being escalated to Child Protection, this was subsequently challenged by the social work team and an Initial Child Protection Conference held.

2.22 Over the period of the review the Case Group told the Review Team that adolescents were less likely to be subject of Child Protection processes and the social work team found this frustrating. This has changed over time, and there is now better recognition of the importance of Child Protection processes for this age group. This is discussed in **Additional Learning in section 4.**

The response to disclosures of sexual abuse and rape

2.23 The sexual assault and rape of a 12 year old child is a serious issue. Julia made four disclosures of rape over a three year period from when she was just 12 to 15 years old. It was particular striking how the language used about Julia by her mother such as Julia “had 15- 20 partners”, and the language used by Julia herself such as “she had consented to sex” was recorded across professional records without any clear critique or analysis about what it meant for Julia and her well-being. This language needed to be challenged, and addressed, not recorded without comment. The danger of the lack of challenge and analysis is that it can appear that professionals agree with the negative ideas behind the language used, which in this case they did not, but this needed articulating in the records. **This is discussed in Finding 2.**

2.24 There also needed to be a clearer connection made between the sexual health advice Julia received from a number of professionals and the sexual abuse she



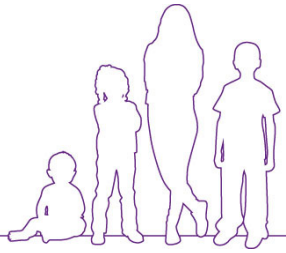
was experiencing. No one agency connected these two issues together so they were considered in isolation of one another. The lack of an assessment or multi-agency meeting meant there was no forum in which this could be discussed.

2.25 The police worked hard to achieve a prosecution. Given Julia's learning difficulties and her difficult early childhood experiences, it was always going to be complex for Julia to provide a clear picture of what had actually taken place, and this was indeed so. The difficulties in achieving a criminal prosecution influenced the practice response at times. When Julia made a disclosure in October 2010, the difficulties of achieving a criminal prosecution led to the belief that a Strategy Meeting was no longer required. This was incorrect. There appears to have been confusion regarding the criminal response, carried out by the police, and the civil response, carried out by the multi-agency team in the context of a disclosure of sexual abuse and Child Protection processes.

2.26 There is now greater multi-agency awareness and response to the sexual exploitation of young people locally (see the section on learning from the fringes page) and nationally. However, over the period of the review Julia was not always understood to be a victim of sexual exploitation by professionals, her parent/siblings and significantly she also did not understand that this was what was happening to her.

2.27 This review highlights the importance of good quality multi-agency working and a shared multi-agency awareness of the importance of and responsibility for ensuring:

- effective holistic assessments
- effective Child Protection and Child in Need processes
- analytical information sharing and particularly the sharing and appraisal of assessments and decision making
- good quality planning and reviews
- an understanding of adolescent neglect,
- an appropriate balance between sexual health advice and sexual abuse/exploitation.



These are all essential elements of an effective response to child sexual exploitation and were often absent for Julia. The challenge for the Board is to reflect on the Findings that follow and to consider how the practice gaps identified in this case can be addressed to ensure that sexual exploitation of young people is effectively responded to in the future.

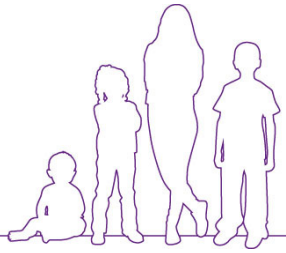
3 THE FINDINGS

Analytic process for establishing systems findings

3.1 The aim of a Learning Together case review is to use a single case as a 'window on the system', to uncover more general strengths and weaknesses in the Child Protection system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case specifics, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the reconstruction of the unfolding case, documentation and an examination of the key practice episodes.

3.2 The second step is to consider whether the issue observed in this case is 'underlying'. That is, that it is not a 'quirk' of the case, but is likely to represent practice in other cases and by other practitioners. The third step is to consider how geographically widespread and numerically prevalent the issue is within the system. Sometimes it is not possible within the scope of a review to collect this data. The sources for these steps will be information from the Review Team and Case Group, any performance data, national research and other reviews in a variety of combinations. In this review, it has not been possible to obtain some of the data requested to populate these steps – this has been highlighted where relevant.

3.3 The last step is to articulate why this issue matters, what are the risks to the safeguarding system. Based on this finding, questions and considerations for the LSCB are formulated.



Categories of underlying patterns

3.4 The systems model that SCIE has developed includes six broad categories of underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change. Not all the typologies will have a finding associated with them but they are designed to allow for structured enquiry as to what the data has revealed:

- Human biases (cognitive and emotional):

Are there common errors of human reasoning and judgement that are not being picked up through current case management processes?

- Family-professional interaction:

What patterns are discernible in the ways that professionals are interacting with different family members, and how do they help and or hinder good quality work?

- Communication & collaboration in responses to incidents:

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents (e.g. allegations of abuse)?

- Communication and collaboration in longer term work:

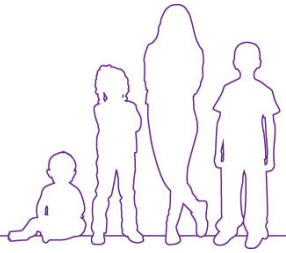
Were any good or bad patterns identified about ways of working over a longer period with children and families?

- Tools:

What has been learnt about the tools and their use by professionals?

- Management system:

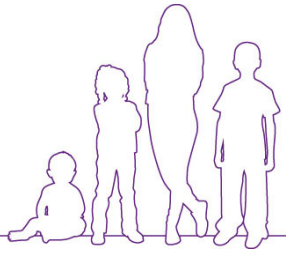
Are any elements of management systems a routine cause for concern in any particular ways?



3.5 This review has prioritised seven findings for the Board to consider:

Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual abuse/exploitation	Communication and collaboration in longer term work
Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection.	Communication and collaboration in longer term work
Finding 3: Is there a pattern whereby the Child in Need procedures are not routinely being used leaving children and young people without formal plans and review?	Communication and collaboration in longer term work
Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response.	Family-professional interaction:
Finding 5: Is there is a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm.	Communication and collaboration in longer term work
Finding 6: Is there a pattern whereby Multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?	Communication and collaboration in longer term work

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by others or themselves as an integral part of the safeguarding network?	Communication and collaboration in longer term work
Additional Learning	
1. The importance of holistic assessments 2. Difficulties in escalating to Concerns about Adolescents to Child Protection	



Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual abuse/exploitation

Why does it matter?

3.6 Nationally there is a clear legal framework with regard to sexual activity regarding children and young people. Children aged less than 13 years are not legally capable of consenting to sexual activity and sexual activity with a young person under the age of 16 is a criminal offence. However, there is some evidence that increasing numbers of young people under the age of 16 are engaging in sexually activity. Guidance from the Crown Prosecution Service states that young people who are of a similar age should not be prosecuted or issued with a reprimand or final warning where sexual activity was mutually agreed and non-exploitative. The law makes clear that children under 13 are particularly vulnerable, so to protect younger children any sexual activity with a child aged 12 or under will be subject to the maximum penalties – whatever the age of the perpetrator.

3.7 It is the task of all professionals to evaluate these early sexual experiences to assess whether they are sexually exploitative. This was raised by the Bichard Inquiry (2003)[viii] into the Soham murders which highlighted the importance of taking a critical approach to young people's early sexual experiences and for professionals to be aware of the potential for exploitation. To support this approach a checklist was introduced into Working Together 2006[ix] and this has formed the basis for all current sexual exploitation frameworks.

3.8 Sexual exploitation has become an important policy objective, and one that is recognised as having been difficult for all professional groups to respond effectively:

[viii] Cabinet Office (2004) The Bichard Inquiry London: The Stationery Office
[ix] HM Government (2006) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children, London: The Stationery Office

"The lack of curiosity about child sexual exploitation shown by all official agencies has been a running theme… professionals did not recognise the existence of the exploitation, were not aware of the scale of the abuse and were not sharing information, this was partly due to assumptions that victims were engaging in consensual relationships and the inability to engage with them.' Beckett, H et al (2013[x])

3.9 Professionals must ensure that young people are not being sexually exploited and have made an informed choice/consented to sexual activity. The issue of consent is important here and is described in Section 74 of the Sexual Offences Act 2003 as:

'if (s)he agrees by choice, and has the freedom and capacity to make that choice'.

3.10 Professionals should consider this in two stages. Whether a young person has the capacity (i.e. the age and understanding) to make a choice about whether or not to take part in the sexual activity at the time in question and whether he or she was in a position to make that choice freely, and was not constrained in any way.

3.11 At the same time professionals are also required to give young people advice and support about sexual relationships, contraception and sexual and reproductive health including pregnancy and abortion.

3.12 The Labour Government developed its Teenage Pregnancy Strategy (Social Exclusion Unit, 1999[xi]) with the aim of reducing teenage pregnancy rates by 50%. In the period between 1998 and 2011 the under 18 conception rate fell by 34% (Office for National Statistics, 2013). Teenage pregnancy and sexual health continue to be prioritised in the policies of the Coalition Government. The Public Health Outcomes Framework 2013-16 (Department of Health, 2011[xii]), against which national and local government will monitor improvements in public health,

[x] Office of the Children Commissioner (2013) *If only someone had listened – the final report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG)*
[xi] Social Exclusion Unit (1999) Teenage Pregnancy Report, London: Social Exclusion Unit.
[xii] Department of Health (2011) Health Survey for England, London: DH

includes reducing under-18 conception rates and late diagnosis of HIV, and increasing Chlamydia diagnoses among 15-24 year-olds as key sexual health indicators. Alongside this, the Framework for Sexual Health Improvement in England[xiii] highlights reducing rates of under 18 conceptions and STIs as two of the five priority areas for improvement (DH, 2013).

3.13 Although this policy guidance now makes clear that all professionals providing sexual health advice must be aware of child protection and safeguarding issues as well as having guidelines and referral pathways in place for risk assessment and management of child sexual abuse, there remains a potential contradiction between the responsibility to address sexual exploitation and promote positive sexual health.

How did it manifest in this case?

3.14 Julia's mother sought advice from the GP when she disclosed that Julia had been raped six weeks before her 13th birthday. This led to contraceptive advice, and there is no evidence that she was assessed to see whether her experiences had been abusive in line with existing policies and procedures and there was no referral to Children's Social Care. The focus was on sexual health advice rather than safeguarding.

3.15 In November 2011 when Julia was 13 she sought advice about sexual relationships from the School Nurse who assessed her as Gillick competent under the Fraser guidelines, and she was provided with condoms. This was in line with existing procedures regarding sexual health support. The School Nurse was not aware of the other concerns regarding Julia's sexual activity, and there was no opportunity or forum for her to contextualise the support for sexual health alongside all the other concerns about this vulnerable young person.

[xiii] Department of health (2013) A Framework for Sexual Health Improvement in England: https://www.gov.uk/government/uploads/system/uploads/attachment data/file/142592/9287-2900714-TSO-sexualhealthpolicyNW accessible.pdf

3.16 The Child in Need Plan developed as a result of the Core Assessment undertaken in July 2010 and which remained unchanged over a period of two and a half years, focussed on sexual health advice and parenting support.

How do you know it is underlying?

3.17 There were numerous occasions on which Julia made allegations and sought sexual health advice, and on each occasion there was a stronger professional focus on advice-giving rather than exploring issues of consent and abuse. It was at the end of the review period that concerns about sexual exploitation were voiced, and this was after four disclosures of rape and numerous allegations of underage sexual activity. The consistency of practice suggests strongly that this was an underlying tension inherent within the different role that professionals play.

How prevalent is the issue?

3.18 No specific work was done by the Review Team to understand the prevalence of this issue in Thurrock, although the Case Group and Review Team both recognised that the imbalance was present in many of the polices regarding early sexual experiences. The extent of sexual exploitation is not well understood nationally, both because of the inconsistencies in data collection and because many young people do not recognise that they are being exploited. When talking about the scale of child sexual exploitation, Sue Berelowitz, the Children's Commissioner told the Home Affairs Select committee[xiv] convened to look at this important issue that "*there is not a town, village or hamlet in which children are not being sexually exploited*." The committee concluded that "*it is obvious that child sexual exploitation is a large-scale, nationwide problem and evidence to the Committee indicates that it is increasing"*. At the same time increasing numbers of young people under the age of 16 are engaging in sexual behaviour under the age of consent.

[xiv] House of Commons :Home Affairs Committee (2014) Child sexual exploitation and the response to localised grooming Second Report of Session 2013–14 : http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/68i.pdf

Finding 1

The principal finding of "*If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG*)[xv] was that despite increased awareness and a heightened state of alert regarding child sexual exploitation children are still slipping through the net and falling prey to sexual exploitation. Research published by Barnardos[xvi]and the evidence provided to the Home Affairs Select Committee[xvii] suggest that gaps remain in the knowledge, practice and services required to tackle this problem. Part of an effective response will be to ensure that there is a professional balance between appropriate advice regarding sexual health and a heightened awareness that this might be an opportunity to consider the potential for sexual exploitation.

Questions for the Board

Does the Board recognise that this is an issue within Thurrock?

Does this Board have any further information about what is getting in the way of enabling professionals to strike a balance between advice around sexual health and an awareness of sexual exploitation?

What are the options available for tackling this issue?

What action would the Board need to take to ensure that they know this has been addressed?

[xv] Office of the Children Commissioner (2013) If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG)
[xvi] Barnado's (2012) Cutting them free: how is the UK progressing in protecting its children from sexual exploitation? London: Barnado's.
[xvii] House of Commons: Home Affairs Committee (2014) Child sexual exploitation and the response to localised grooming second report of session 2013-14: https://www.publications.parliment.uk/pa/cm201314/cmselect/cmhaff/68/68i.pdf

Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection

Why does it matter?

3.19 Finding 1 made clear the legal framework regarding underage sexual activity and the contradiction in policy which makes underage sexual relationships illegal, whilst at the same time recognising the need for support when it takes place in the context of choice and consent. This was not the case for Julia. She made disclosures of rape on four occasions, when she was 12, 13 and 14. This was her language and reflected her experiences. Professionals should have considered what this meant and been clear about making a professional analysis of what had happened, in order to address it effectively. It would have been more accurate for those agencies outside of the criminal justice system to record that Julia had been sexually abused. Sexual abuse is described in the SET[xviii] (Southend, Essex and Thurrock) procedures as

> "*forcing or enticing a child/young person to take part in sexual activities, ...whether or not the child is aware of what is happening*"

3.20 There is growing recognition that child sexual exploitation (CSE) is a form of sexual abuse "*that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things ... and where the abusive relationship between victim and perpetrator involves an imbalance of power which limits the victim's options"*.

3.21 It is a form of abuse which is often misunderstood by victims and outsiders as consensual. (Barnardo's 2012[xix]). This makes it complex because of the power

[xviii] https://www.thurrock.gov.uk/how-we-keep-children-safe/set-child-protection-procedures

[xix] Barnardo's (2012) Cutting them free: how is the UK progressing in protecting its children from sexual exploitation? London: Barnardo's.

dynamics of perpetrators and that young people themselves do not recognise that they are being abused or exploited.

How did it manifest in this case?

3.22 Julia was described by a number of professionals as making "allegations" of rape – this is a phrase more suited to adults where there are legal issues regarding proof. For young people there is a need to consider whether what they are talking about is sexual abuse - which would now need to be seen in the context of sexual exploitation. There is a still a burden of truth here – but one which needs to be seen in the context of significant harm as outlined in the Children's Act 1989 and enshrined in subsequent versions of Working Together. For young people under the age of 13, and for those with a learning difficulty in the older age range, professionals need to be focussed on the harm experienced, as well what actually happened. For Julia, professionals wrongly emphasised ascertaining the 'truth' of the 'allegations' – rather than focusing on what was the harm to her.

3.23 It was recorded that Julia told professionals that she "consented" to sexual activity without there being sufficient analysis or reflection of this statement. She needed professionals to help her understand that it is not uncommon for young people to be confused about this. A recent report, undertaken as part of the Children's Commissioners' review of sexual exploitation, highlighted the extent to which young people are confused about consent[xx]. Julie needed professionals to help her see what had happened to her was not actually consensual, and help her have an accurate understanding of issues of choice and accountability. This was pertinent when she was below the age of 13 and unable to legal consent, but also when she was 14 and 15.

3.24 A number of records across the multi-agency network recorded that Julia's mother had told them that she had "15 - 20 partners" from the age of 12. This word was used without analysis or challenge, and the implications for Julia's

[xx] Coy, M., Kelly, L., Elvines, F., Garner, M. and Kanyeredzi, A. (2013). "Sex without consent, I suppose that is rape": How young people in England understand sexual consent. London: Office of the Children's Commissioner.

well-being were not explored. The use of this word had the potential to make her experiences of sexual exploitation hidden.

3.25 There was some professional confusion about the difference between "risky behaviour" and risk factors. In professionals records Julia was described as engaging in "risky behaviours" something her mother mentioned to all professionals she was in contact with. This phrase was used inaccurately and implies (without professionals actually intending to do so) that Julia might be responsible for what happened to her because of her own behaviour. This needed a clearer analysis and for professionals to distinguish between "risky behaviours" which are part of some adolescent's behaviour and "risk factors" which were those aspects of her life that made normal risk taking more dangerous.

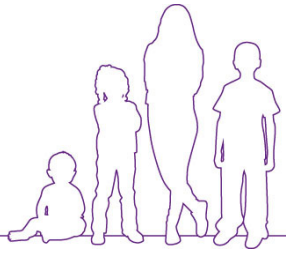
How do you know it is underlying?

3.26 The Review Team and Case Group told us that it was common practice across all agencies to record what children and young people told them uncritically, in the context of early sexual experiences. They considered that professionals understood the importance of recording what young people told them as a way of being child centred.

How prevalent is the issue?

3.27 Although there are no national or local figures regarding the number of young people who are being sexually exploited, research suggest that a significant number of young people are affected by this issue. The complex issue of language and its use in the context of exploitation was something that the Case Group and Review Team recognised affects all professionals. Nationally, the Children's Commissioners Office inquiry[xxi] into sexual exploitation expressed concern about the language used by professionals which led to victims being

[xxi] Office of the Children Commissioner (2013) *If only someone had listened" – the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG*)



blamed for the exploitation with the consequence that they were not effectively safeguarded.

Finding 2

Sexual exploitation is a serious issue and one that has a profoundly negative effect on young people's lives and their wellbeing. It is essential that all professionals feel able to recognise young people who are being sexually exploited and that they are able to respond effectively. This response must be child centred and all professionals must take a critical approach to the use of language in this complex area of practice, so that risks are recognised and young people are not held responsible for the harm perpetrated by others.

Questions for the Board

Do the Board recognise that this is an issue that it should be concerned about?

How can the Board ensure that this issue is addressed within its Child Sexual Exploitation strategy?

Are there other opportunities or lever's at the Boards disposal for changing professional practice and language in this area?

How will the Board know if it is being effective in addressing this issue of language?

Finding 3: Is there a pattern whereby the Child in Need procedures are not routinely being used leaving children and young people without formal plans and review?

Why does it matter?

3.28 The Child in Need processes outlined within the Children Act 1989 further reinforced by the Assessment Framework Guidance 2000 and Working Together 2010[xxii] were instigated to ensure that children and young people who were not subject to safeguarding plans received a carefully planned approach to their needs, which was reviewed over time. The SET procedures for Thurrock make clear that:

"*An initial Child in Need plan is used to support the provision of services by Children's Social Care. The role of other relevant agencies should be considered within this initial plan and their involvement discussed and agreed with them, using a multi-agency meeting to formulate the plan, including parents. The initial plan must be reviewed within three months and thereafter monitored and reviewed at regular intervals, not less than once every six months*. (Section 8.2 SET Procedures)

3.29 The Child in Need plan is an essential next stage after an Assessment has taken place. The purpose is to set a plan of action, based on the assessed need. This makes clear to young people how the Local Authority plans to support them and ensures that parent's/carers know what is required of them to promote their children's outcomes. It also creates the framework for multi-agency work. The ultimate aim is to improve children's outcomes and so the review mechanism is an essential part of the process. This enables progress to be marked, and services provision to be amended if necessary. This process should activate multi-agency support for an agreed plan, and should not be dependent on a pre-existing network.

[xxii] Department for Children, Schools and Families (2010) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. March 2010

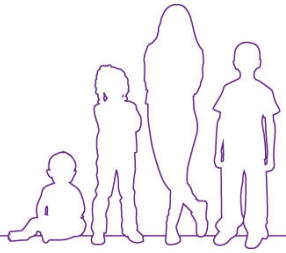
3.30 During this review the Review Team were told by members of the Case Group that Child in Need meetings do not always take place when there are no other agencies involved with the child or young person, meaning that there appears no point in having a meeting. In Julia's case there were times when other agencies were involved and particularly school – who were in fact a cluster of different professionals with differing responsibilities to Julia. This highlights fundamental misunderstanding of the process and the importance of planning for children and young people.

How did it manifest in this case?

3.31 Julia was held from July 2010 to January 2012 as a Child in Need case. During this time there was no new plan made, no Child in Need meeting or review. The services proposed were not engaged with by Julia or her mother in any meaningful way. There was no opportunity for the professionals involved with the family to consider all the information they held about Julia and to consider whether the approach to her needs was working. The Case Group informed the Review Team that the reason there was no Child in Need meetings was because there was not 'multi-agency involvement' in addition to Social Care. However, there was at least two other key agencies involved throughout the review period. The school, for example, was providing counselling support, behavioural support, putting in place a plan for Julia's special educational needs, attempting to address her poor attendance and providing sexual health advice. She was also receiving contraceptive advice from her GP who also acted upon concerns regarding her behaviour expressed by Julia's mother. This work happened in isolation.

3.32 If there had been a plan which was reviewed, the many crises that occurred over the period of the review and the lack of engagement of Julia's mother would have amply demonstrated that the approach being taken was not working, and the analysis of her needs inaccurate.

3.33 No professional involved with Julia and her family asked about the absence of Child in Need meetings or a review of the plan which was made six months before this review started.



How do you know it is underlying?

3.34 It has not been possible to establish how common it is for Child in Need processes not be used in the Adolescent Team or other teams in Thurrock. The Case Group members told us that pressures during the period under review led to difficulties in maintaining Child in Need planning and review processes. The fact that no agency involved with Julia asked about why a Child in Need meeting and review was not taking place suggests that Child in Need processes is not firmly established in the multi-agency network. Additionally, there was a belief that the absence of an established multi-agency network meant that Child in Need processes would not be helpful. Statistics are not collected nationally about Child in Need meetings or plans, as the focus is on Child Protection processes. Evidence from Serious Case Reviews suggests that Child in Need processes are not always prioritised.

How prevalent is the issue?

3.35 It has not been possible to establish how prevalent this is as an issue. This is covered by the questions for the LSCB below.

Finding 3

Effective processes to support children, young people and their families are essential. The Child in Need processes are intended to build on good quality assessments, by developing a plan of action , which is owned and developed by the multi-agency group, and is reviewed regularly to see what progress is being made to promote children and young people's outcomes. If these processes are not used, interventions are unlikely to be clearly focussed on children's needs and are unlikely to provide effective help and support.

Questions for the Board

Are the Board aware that Child in Need processes are vulnerable to pressures on Social Work teams, and of a potential misunderstanding of when Child in Need meetings should be convened?

Is there more the Board could do to establish the extent of this issue, e.g. case audit?

What can the Board do to address this?

How will the Board know they have been successful in ensuring that Child in Need processes is embedded in multi-agency practice?

Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response

Why does it matter?

3.36 Local Authority Children Services, other Local Authority departments such as Education and Health Authorities have a duty to safeguard and promote the welfare of children in their area who are in need and to promote the upbringing of such children, wherever possible by their families, through providing an appropriate range of services. In carrying out this responsibility the "client" or primary "service user" is the child or young person. In the Munro review[xxiii] of the safeguarding system, it was re-emphasised that children and young people should be at the heart of the provision of services. The vision of the Convention on the Rights of the Child[xxiv] and the Children Act 1989 is that they are individuals, members of a family and a community, with rights and responsibilities appropriate to their age and stage of development. They are not "the property of their parents" a point made by Baroness Butler-Sloss: '*the child is a person not an object of concern*[xxv].

3.37 There is considerable evidence from research and serious case reviews that children and young people can become invisible to services because of the

[xxiii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London TSO
[xxiv] The United Nations, (1989), The United Nations Convention on the Rights of the Child (available online at https://www.2ohchr.org/english/law/crc.htm)
[xxv] Cm 412, (1998), Report of the Inquiry into Child Abuse in Cleveland 1987, London, HMSO.

needs of their parents or caregivers, and this is apparent when those parents choose not to engage with services targeted at improving the outcomes and wellbeing of their children.

3.38 Recent research by Eileen Munro[xxvi] suggests that "Did Not Attend" should be reconceptualised as 'Was Not Brought' – i.e. failure to attend/engage with appointments should be an indicator of neglect.

How did it manifest in this case?

3.39 There was a long history of non-engagement by Julia's mother throughout the period under review. Julia's mother only responded to contact from services in times of crisis. She was not at home for appointments and home visits organised by the Social Workers, she did not return telephone calls or respond to letters. She failed to follow up on the referral to the Sexual Health Advisor and did not follow through on a number of referrals for parenting support and did not attend planned school appointments regarding concerns about attendance and behaviour. Paradoxically, the lack of engagement, suggestive of a poor level of care for Julia, resulted in Julia receiving less rather than more support from services.

3.40 The Social Workers considered seeing Julia at school, and one appointment was made. A decision was made that because the case was held at a Child in Need level it was not possible to see her without the consent of her mother. The lack of engagement by mother meant that consent could not be sought. Consent is of course important and respecting family life appropriate, but this approach served to allow mother's non engagement to restrict access to a Social Worker for Julia.

3.41 This had clear consequences for the wellbeing of Julia:

- She was not able to form a relationship with her Social Worker - which is essential if effective work is to be done about sexual abuse and sexual exploitation
- Her emotional, educational and physical needs were neglected.

[xxvi] Munro, E (2012) *Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice.* Journal of research in nursing, 17(2). Pp. 193-194.

How do you know it is underlying?

3.42 The Case Group told us that working with parental non engagement, particularly in the context of adolescence, was a regular occurrence and a great frustration. The Biennial Review of Serious Case Reviews[xxvii] highlighted the extent of parental resistance and its negative impact on improving children's outcomes.

How widespread is the pattern?

3.43 There is little information available nationally or locally about the extent of non-engagement in work with families at Child in Need level. Research and serious case reviews suggest that nationally this is a significant issue, which has a profound impact on children and young people's outcomes.

How prevalent is the issue?

3.44 Whilst this review has not established how prevalent this issue is, Ferguson (2010[xxviii]) suggests: "*We have failed to acknowledge the sheer scale of resistance and hostility that professionals have to bear*"**.**

[xxvii] Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., and Megson, M. (2012) New learning from serious case reviews: a two year report for 2009-2011. London: HMSO

[xxviii] Ferguson. H (2010) Walks, Home Visits and Atmospheres: Risk and the Everyday Practices and Mobilities of Social Work and Child Protection. British Journal of Social Work

Finding 4
The non-engagement of parents in services aimed at promoting the well-being of their children/young people is a significant issue. It has an impact on young people's well-being and their outcomes, and causes more pressures on over stretched professionals. It is also costly for services. A lack of recognition of this as a safeguarding issue means that children and young people are not always effectively protected.

Questions for the Board

Are the Board aware of this as an issue facing professionals?

Does the LSCB know if staff locally has been equipped to work with resistant parents both in single agency and partnership working?

How might the LSCB help practitioners overcome this obstacle to effective practice?

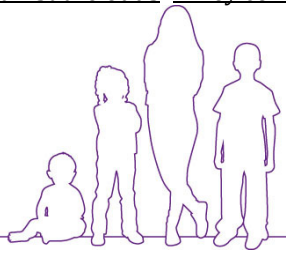
How will the Board know when this has been effective?

Finding 5: Is there a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm?

Why does it matter?

3.45 There is considerable evidence about the developmental world of adolescents (Coleman and Hagell 2007[xxix]). This stage of development characterised for some young people as engaging in risky behaviour such as drugs, alcohol and sexual experimentation. This sense that this is "normal" adolescent behaviour has caused some professional confusion about risk taking behaviour, which is part of adolescence as opposed to "risk factors" which make appropriate "risk taking behaviour" more dangerous. This has been recognised particularly in the context of sexual exploitation, where young people are perceived as engaging in risky behaviours and a causal link is made with sexual exploitation, inadvertently

[xxix] Coleman, J and Hagell, J. (2007) Adolescence, risk and resilience: Against the odds: Wiley.com



making those young people feel like it is their fault – that they are to blame. It is critical that we separate out these two issues and highlight the key issue of the risk factors such as adolescent neglect rather than focus solely on adolescent behaviour.

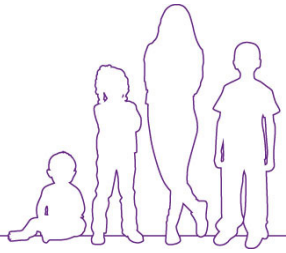
3.46 The recent House of Commons Inquiry into the operation of the Child Protection System in England and Wales[xxx] was presented with considerable evidence that young people aged 14- 18 are not receiving effective protection and support from the multi-agency safeguarding system. This Inquiry found that there was a lack of services to meet the particular needs of adolescents, a failure to look beyond behavioural difficulties, a lack of recognition of the abuse and neglect of teenagers and particularly the long term impact on them.

3.47 The neglect of children and young people is a national concern and is recognised as posing a significant threat to the wellbeing and outcomes of children and young people across the whole developmental spectrum, in the short and long term[xxxi]. Comprehensive help to children and young people has been hampered by professional concerns that it is often poverty and disadvantage which cause neglect and there has been reluctance by professionals to further discriminate against social excluded and disadvantaged communities[xxxii].

3.48 Recent research (Stein et al 2009[xxxiii]) has highlighted the significance of adolescent neglect, and its link to sexual exploitation, early pregnancy, anti-social behaviour, poor mental health and self-harm.

3.49 Despite this there remains concern about the recognition and response to adolescent neglect. This is in part due to differing professionals understanding

[xxx] House of Commons Education Committee (2013) Children first: the child protection system in England Fourth Report of Session 2012–13: children-first-the-child-protection-system-in-england.pdf
[xxxi] Gardner, R. (2008) Developing an effective response to neglect and emotional harm to children. London: NSPCC
[xxxii] Action for Children (2011) Neglecting the issue: impact, causes and responses to child neglect in the UK. London: Action for Children.
[xxxiii] Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) Neglected adolescents: literature review. London: Department for Children, Schools and Families (DCSF).



of what neglect is – and although there is national and local guidance regarding the neglect of children more generally, there is no definition of adolescent neglect.

3.50 The definition in the SET (Southend, Essex and Thurrock) procedures echoes that outlined in National Guidance – Working Together 2013 which provides a much broader framework for understanding neglect, but the issues for adolescents are not explicitly covered.

"Neglect involves the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health and development. Neglect ...may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *Ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment.*
- *The neglect of, or unresponsiveness to, a child's basic emotional needs.*

And Medical Neglect is failure to ensure access to appropriate medical care or treatment".

3.51 One of the difficulties facing professionals who assess adolescent neglect is that many of the outcomes associated with neglect are also associated with young people who are struggling to come to terms with this new stage in their development. This can lead to an underestimation of both the present experience of being neglected and the cumulative impact of past poor quality care. Professionals can come to sympathise with the parents/carers at having to deal with difficult behaviour, rather than recognising that neglectful care can lead to adolescent difficulties. There is some evidence from serious case reviews that in this way adolescents move for being seen as "troubled" to "troublesome" and the service response changes.

3.52 In addition, research suggests that professionals are less likely to feel justified in labelling a young person's experiences as neglectful if they recognise that the family circumstances are characterised by poverty and disadvantage, and if they

feel parents are not deliberately intending to cause children harm – but are struggling with their own issues[xxxiv]. This has led to many children and young people's circumstances not being sufficiently responded to – for adolescents this may mean that the difficulties they experience are seen as a function of who they are – rather than as a function of the care they receive. If professionals do not challenge the quality of care adolescents are provided with , the evidence suggest that they can turn in on themselves, and this can leads to poor self-worth and for some a sense of helplessness about who you can turn to for help. An effective response to adolescent neglect is therefore critical.

How did it manifest in this case?

3.53 There was considerable evidence that Julia had been neglected from her early years, and that this continued thought to adolescence.

3.54 In May 2011 the hospital made a referral to Children's Social Care because Julia's sister, Courtney, had come to the Accident and Emergency Department with suspected concussion after being hit on the head by a falling door at the family home. The hospital said that the injury was accidental, but the reason for the referral was a concern about all the siblings who had reported to hospital staff that there was chaos at home, that their mother took no interest in them and provided no practical or emotional support. The referral from the hospital was responded to with an Initial Assessment of the sibling who received the injury. This concluded that the incident had been accidental and the decision was case closure.

3.55 These concerns about neglect were well supported by the recent concerns that Julia's mother did not enable Julia to seek medical advice when she disclosed that she had been raped, and when a referral for Julia and her sister was made to the Sexual Health Advisor her mother did not enable them to attend and did not follow up on the advisors attempts to contact her. The school found it extremely difficult to make contact with her mother when they had concerns about Julia's behaviour and angry outbursts, and her mother only intermittently

[xxxiv] Action for Children (2011) Neglecting the issue: impact, causes and responses to child neglect in the UK. London: Action for Children.

attended appointments regarding special educational needs. This information was not assessed as part of a pattern of neglectful care.

3.56 Given this background, it was not surprising that Julia presented challenging and angry behaviour. Although it was appropriate that this was addressed, it also needed to be contextualised alongside the quality of care she received and her early sexually abusive experiences. The multi-agency balance for Julia moved to her being viewed as more troublesome than troubled.

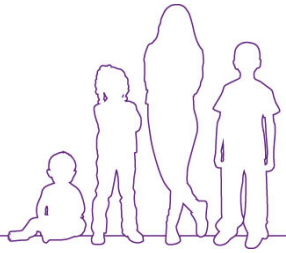
How do you know it is underlying?

3.57 The Case Group considered that adolescent neglect was a significant issue in their work. Research[xxxv] and the Ofsted analysis of serious case reviews[xxxvi] also suggest that adolescent neglect is a significant national issue.

How prevalent is the issue?

3.58 Overall the national evidence suggests that neglect is a significant category of maltreatment both during childhood and adolescence.
In Thurrock during 2012, 61% of children/young people were subject to Child Protection Plans because of neglect and 16% of all plans were regarding young people aged 12 years or older.

[xxxv] Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) Neglected adolescents: literature review. London: Department for Children, Schools and Families (DCSF).
[xxxvi] Ofsted (2011) Ages of concern: learning lessons from serious case reviews: http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews



Finding 5

Adolescent neglect is a significant issue which has a profound effect on young people's lives. Recognising and responding to adolescent neglect is a critical part of addressing sexual exploitation, and an ineffective response leaves young people at risk of significant harm.

Questions for the Board

Are the Board aware that adolescent neglect is a significant issue facing professionals?

How can this be tackled by the Board?

How can professionals be supported to develop a more effective response to adolescent neglect?

How will the Board know its response has been effective?

Finding 6: Is there a pattern whereby multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?

Why does it matter?

3.59 Good quality multi-agency working is essential to the effective safeguarding of children and young people. This has been a core finding of all the public Inquiries regarding serious child deaths (there have been 75 since 1945[xxxvii]) and most of the serious case reviews that are undertaken in England. Poor multi-agency working was a central criticism of practice in the Victoria Climbié Inquiry

[xxxvii] Winter, K (2011) Building Relationships and Communicating with Young Children: A Practical Guide for Social Workers: London: Routledge

and was also highlighted by Munro in her review[xxxviii] of the child protection system. These reviews and inquiries make it clear that effective multi-agency working is about more than effective and timely information sharing, although this is obviously critically important.

3.60 Multi-agency working must be about being prepared to share with others your own professional understanding of a child/young person's needs and circumstances, contributing this analysis to the assessments being carried out by any agency. Research[xxxix] shows that many assessments of children/young people collate information, rather than analyse it. Part of the analytical process is enabling the multi-agency group to comment on the completed assessment or the analysis and conclusion in order to connect with a shared understanding of the needs of the child/young person and to understand their role in any future plan of work. Serious case reviews have suggested that this is not the case and that a belief system has developed which suggest that it is not permissible to share the assessment with other professionals without the permission of the parents. The Guidance issued as part of the Assessment Framework makes it clear that this is not the case.

3.61 Multi-agency working also means multi-agency planning for a child/young person. The research is clear, where there is careful multi-agency planning, the outcomes for children tend to be better and where planning is weak, there is more evidence of drift and poor outcomes.

3.62 Research also suggests[xl] the importance of the multi-agency network coming together to share their thinking and analysis in a face to face meeting. Although much of this work is done and can be done in a virtual way, it is necessary for professionals to meet to review progress, particularly where progress is not

[xxxviii] Munro, E. (2011) The Munro review of child protection: final report: A child centred system. London TSO.
[xxxix] Broadhurst, K et al (2010) Ten pitfalls and how to avoid them: What research tells us: NSPCC: http://www.nspcc.org.uk/Inform/publications/downloads/tenpitfalls_wdf48122.pdf
[xl] J Selwyn, E Farmer, D Turney, D Platt (2011): Improving Child and Family Assessments: Turning Research Into Practice: Jessica Kingsley Press

being made. Reder and Duncan (1998)[xli] have highlighted the complexity of communication across networks in safeguarding practice where all interaction is virtual. Meetings matter to the outcomes for children, young people and their families.

3.63 Multi agency work is also about appropriate professional challenge. Serious case reviews highlight how barriers to effective challenge across professionals group and hierarchies have a profound impact on safeguarding practice.

How did it manifest in this case?

3.64 There was evidence that all agencies (with the exception of the GP's who were not included and did not contribute – something discussed in Finding 8) communicated with each other and kept each other informed of what was happening for Julia and her mother. There was overall some good information sharing between the school and social work team. The school became a mini team of professionals (teacher, school liaison, School Nurse, Attendance Officer, Special Needs Coordinator) and their information was usually amalgamated and passed on to the social work team. The unintended consequence of this approach was that the School Nurse appears to have been unaware that Julia had been in contact with Children's Social Care, and that there had been serious concerns about her.

3.65 A number of agencies made referrals to Children's Social Care regarding their concerns for Julia and her sisters, including school, hospital, SARC, GUM and the police. These were all appropriate and were responded to by Children's Social Care as would be expected, but this did not lead to requests for further analysis and none of these agencies received information about the outcome of the Assessments emanating from these referrals, despite most agencies remaining involved afterwards. Coram explicitly asked to see the Assessment regarding Julia and her family and was told that permission would need to be sought from her mother. Mother's lack of engagement meant this never happened, and that Coram provided services in a vacuum.

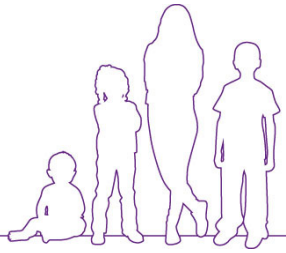
[xli] Reder, P and Duncan, S (1998) Understanding communication in child protection networks: Child Abuse Review: Volume 12, Issue 2, pages 82–100, March/April 2003

3.66 There were no multi-agency meetings over the two and a half years of the review. This meant that the drift in the case was not discussed, that services were provided in isolation from one another and there was no mechanism for reviewing the lack of progress, or deciding on an alternative plan of action. Meetings matter and they mattered for Julia and her outcomes.

3.67 There was evidence across the review that although working relationships were perceived to be good, there was often a lack of effective challenge across the professional network. The delay in seeking a Strategy Meeting in November 2010 caused by the inability to contact the police officer, was frustrating for the social worker and ultimately this delay meant no Strategy Discussion occurred. This was not discussed or challenged. The allocated social care team manager tried to escalate the case to Child Protection, and the emails were not responded to. At the time there appeared no mechanism to address this. The school made a referral to the Duty Team at Children's Social Care which was not responded to and was not challenged. Effective challenge is a critically important part of good multi-agency working.

How do you know it is underlying?

3.68 It is unclear whether this is an underlying issue. The Case Group told the Review Team that there were good working relationships in Thurrock across professional networks, and there were effective working relationships which had built up over time.



Finding 6

Information sharing is a critical component of multi-agency safeguarding practice, but if multi-agency processes are to be effective there is a need to move beyond the provision of information to sharing and exploring a professional analysis of a child or young person's circumstances. Assessments and plans need to be developed and reviewed by the multi-agency network. If this does not happen children and young people are left at risk of harm, and plans become one dimensional. Drift is not challenged, and the lack of progress not noted or addressed.

Questions for the Board

Do the Board accept this finding?

How will the Board establish whether this is a significant issue?

What can the Board do to address it?

How will the Board know it has been successful?

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by others or themselves as an integral part of the safeguarding network?

Why does it matter?

3.69 General Practitioners have a critical role to play in safeguarding children and are vital to inter-agency collaboration in Child Protection processes and to promoting early intervention in families. There is considerable advice to support GPs in their safeguarding roles with children, especially concerning confidentiality and their duties as a GP and doctor, from the regulatory and professional bodies and

Royal Colleges (e.g. GMC, RCGP, RCPCH, BMA). Despite this, research[xlii] and serious case reviews[xliii] have highlighted that it is often problematic to engage GP's in safeguarding processes. This concern is characterised by the difficulties in obtaining information and attendance at key meetings, such as Child Protection Case Conferences.

3.70 Research suggest[xliv] that GP's are aware of their responsibilities regarding the safeguarding of children and young people, but that there are a number of systemic gaps which makes engagement difficult. This research highlights that GP's are concerned about the large reports they receive regarding children, which they do not have time to read or analyse. Where there are medical concerns about children, GP's are used to receiving succinct and focussed reports, which give a clear account of the main issues and the proposed plan of action, including their role. They argue that much of the paperwork they receive regarding safeguarding is lengthy and they cannot get a clear idea of the key issues, or the role that they are required to play. GP's are required to give six weeks' notice to cancel clinics, and find it difficult to attend meetings at particular times of the day, because of patient appointments, yet they feel little account is taken of this when they are asked to attend meetings. Research[xlv] also suggests that some GP's have lost confidence in the safeguarding system because of delays or a non-response to the referral that they make to Children's Social Care.

[xlii] Tompsett, H., Ashworth, M., Atkins, C., Bell, L., Gallagher, A., Morgan, M., and Wainwright, P. (2010) The child, the family and the GP: Tensions and conflicts of interest in Safeguarding Children. DCSF Research Briefing. London: HMSO.

[xliii] Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., and Megson, M. (2012) New learning from serious case reviews: a two year report for 2009-2011. London: HMSO

[xliv] Tompsett, H., Ashworth, M., Atkins, C., Bell, L., Gallagher, A., Morgan, M., and Wainwright, P. (2010) The child, the family and the GP: Tensions and conflicts of interest in Safeguarding Children. DCSF Research Briefing. London: HMSO.

[xlv] Tompsett, H., Ashworth, M., Atkins, C., Bell, L., Gallagher, A., Morgan, M., and Wainwright, P. (2010) The child, the family and the GP: Tensions and conflicts of interest in Safeguarding Children. DCSF Research Briefing. London: HMSO.

How did it manifest in this case?

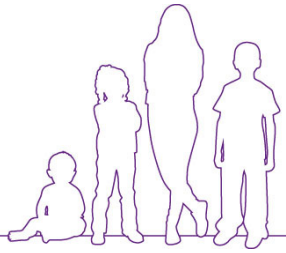
3.71 Julia was seen on six occasions by the GP's at her local Health Centre regarding under age sexual activity, the need for sexual health advice and concerns expressed by her mother regarding Julia's behavioural difficulties. The GP surgery made no contact with any of the other agencies involved with Julia or her siblings. The Assessments carried out regarding Julia acknowledged the GP, but the GP surgery has no record of any contact with Children's Social Care, they did not know Assessments were being undertaken and did not receive a copy or a summary of the analysis, or proposals for sexual health advice and support. No other agency made contact with the GPs, despite, for example, the school knowing that Julia's mother was seeking GP advice and support. The GP surgery was unaware that Julia was a Child in Need and therefore they were not able to inform anyone of their referral to Child and Family Consultation Services. During the period under review they worked in isolation. They did not seek to connect with the multi-agency network charged with promoting the welfare of Julia and they were not ever engaged in that network. This meant that important historical information that they held, particularly about Julia's mother learning difficulties, got lost and they provided sexual health advice without ever contextualising this alongside the other concerns regarding Julia.

How do you know it is underlying?

3.72 The Case Group told the Review Team that they considered that there were often difficulties engaging GP's in safeguarding work. The GP's who work in the Health Centre raised similar issues about their work in safeguarding to those highlighted in the national research.

How widespread and prevalent is the pattern?

3.73 It has not been possible to gather data about how widespread this issue is, but the Case Group suggested that this is a significant issue. The GP surgery was clear that the issue raised by them were replicated in other GP surgeries and national research suggest that this is an important issue to address.



Finding 7

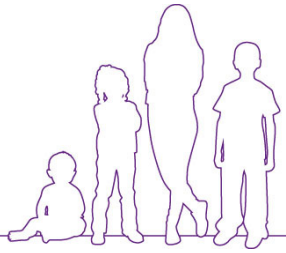
GPs are a critical part of the safeguarding network. It is essential that any barriers to their effective engagement in safeguarding processes are actively addressed. This is particularly important in the context of underage sexual activity and sexual exploitation, where GP's are likely to be a key point of contact for young people.

Questions for the Board

How will the Board establish whether this is a significant issue and which needs addressing?

How will the Board explore the engagement of GPs in the safeguarding network?

What are the options for addressing this issue?



CHAPTER 4 – ADDITIONAL LEARNING

1. The importance of holistic assessments

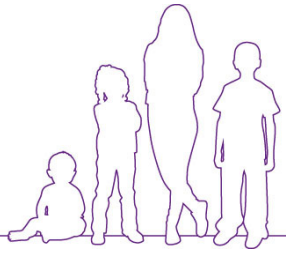
4.1 Historically national guidance regarding Initial and Core Assessments encouraged Social Workers to be incident focused and only analyse the circumstances of the referred child, leaving other children in the same family without a clear analysis of their needs or a plan

4.2 There were two referrals regarding Julia's sibling during the period under review and both focussed on the sibling rather than Julia. The Review Team recognised that the existing processes regarding Assessments did not support a holistic whole family approach. This is in the process of change with the development of the Single Assessment process.

4.3 In September 2011 Children's Social Care received a referral from the hospital regarding Courtney who had been seen in A&E with burns caused by her sister throwing water from a boiling kettle on her back whilst she was in the bath. The referral also said that the hospital was concerned because Julia's mother had told them that Julia "*had been sexually active since she was 11- 12 years old*". A referral was opened regarding Courtney, but not Julia.

4.4 The completed Assessment contained a lot of information and family history. The focus was on Courtney and her circumstances, but there was also information provided about Julia. Information was provided about Julia not having contact with her father because her mother said that he is a risk to children and was allegedly involved in the sexual abuse of a child. The School were said to have raised concerns about Julia who was refusing to follow instructions, truanting from class, being disruptive and had hit another student in class. In the context of the two previous disclosures of rape and the allegations made in the referral, these were worrying issues, which indicated that Julia had significant needs.

4.5 Crucially the conclusion of the assessment focussed almost exclusively on Courtney and the incident which led to the referral. This meant that the referral



was not considered to have met the threshold for services because the incident had been dealt with. Julia's needs were not analysed and no formal plan of action was put in place, beyond continued support from school for her.

4.6 The lack of any Assessment of Julia's needs during the majority of the period under review meant her needs were not well understood, the issues of sexual abuse not explored fully and the need for Child Protection processes to be put in place not fully discussed.

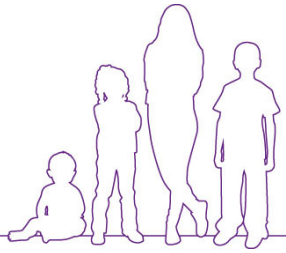
Issues for the Board to consider:

- Does the Board recognise that the quality of assessment in Thurrock is an issue for the safety and wellbeing of children and young people?
- Does the introduction of the Single Assessment provide an opportunity to improve the quality of assessments, and ensure that a holistic approach is taken?
- Does the Board have any evidence about the quality of Assessments locally and what the barriers to effective practice might be?
- Does the Board have an awareness of the key issue for effective assessment of young people who are being sexually exploited and what needs to be put in place to optimise assessment practice in this area?
- How will the Board know it has been successful?

2. Difficulties in escalating to concerns about Adolescents to Child Protection

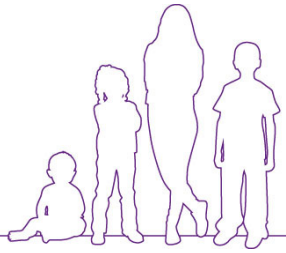
4.7 Over the period of the review the Case Group told the Review Team that adolescents were less likely to be subject of Child Protection processes and the social work team charged with meeting the needs of teenagers found this frustrating. This has changed over time, and there is now better recognition of the importance of Child Protection processes for this age group.

4.8 Given the seriousness of the concerns regarding the disclosure of sexual assault by Julia from the ages of 12 – 14 years, and her mother's unresponsiveness, it would have been expected that she would have been subject to Child Protection procedures. Julia made four disclosures of rape in a



two year period. Rape of a child is sexual abuse, yet somehow this was not recognised. The police undertook extensive criminal enquiries to establish the facts of each case and to seek a prosecution of the perpetrators identified by Julia. The lack of a criminal prosecution should not have meant that there was no assessment of significant harm and a decision made about whether a Child Protection response under Sec 47 of the Children Act 1989 was required.

Issues for the Board to consider:
• How will the Board know that these changes have occurred and are embedded in practice?



Thurrock Local Safeguarding Children Board Initial Response to the Serious Case Review

Introduction:

The publication of the Serious Case Review of "Julia" has learning for all organisations involved both locally and nationally.

The SCR is 52 pages in length and covers the period between November 2010 and February 2013. The report contains seven findings and specific challenges to which the LSCB will seek reassurance of change.

The case was referred formally to the Thurrock Local Safeguarding Children Board (LSCB) on 10th January 2013 and their Serious Case Review Panel met on 4th February 2013 to consider the case under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The Panel found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children, 2010

At the time of this referral Working Together 2013 was about to be implemented which allowed LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology.

After considering the options for the review, it was decided to hold off the commissioning of the review under the "old" IMR procedures pending the guidance implementation to enable the board to commission a systems based approach for this SCR. In May 2013 the Board formally commissioned an independent and co reviewer using the SCIE methodology.

The findings within the report have been agreed by the LSCB Full Board on 19th May 2014 and service improvements are already in hand.

Since the period in question most agencies have demonstrated a clear commitment to learn and improve and have provided evidence to this effect to the LSCB and its sub structures.

With regard to the specific challenges of this serious case review, the LSCB has sought answers to the questions and supporting evidence from all agencies. Having agreed the findings the SCR Group met on 6 June 2014 and each agency has agreed an action plan of the challenges and where changes have not yet been effected, the commitment to make such necessary changes and improvement in practice is detailed within these plans.

Many of the agencies acknowledge that they need to do much better when listening to children and how this is reflected in the actions they take to safeguard and protect.
The Board is focusing on this as a priority area for improvement over the coming year.

This detailed response will be actively monitored by the Board, through its Audit Group to provide continuing evidence of impact.

The LSCB will continue to maintain focus on how agencies are managing organisational change and ensuring safeguarding remains a priority.

LSCB key actions going forward:

The Board will carry out its responsibilities to co-ordinate and monitor the safeguarding arrangements in Thurrock and aims to ensure agencies are transparent within their own organisation, with its partners and the public and the children and young people with whom they work, by requiring that:

The LSCB will:-

- via its Audit sub group provide an evaluation of the progress of the responses by agencies and challenge agencies to produce evidence to determine there has been an impact for children.
- The Board will check that agencies responses have been factored in their improvement process and safeguarding reports to the Board and included in the 2015/16 LSCB Annual Report.
- Coordinate a multi-agency learning event available for all organisations to attend to disseminate the learning from this review.
- Request each organisation to provide details to the Board of the improvements emanating from this SCR within their agencies Annual Report.
- The LSCB training programme will be reviewed to reflect the findings. The Board will produce a presentation (PowerPoint) and briefing notes that can be cascaded to all agencies for use as part of organisational learning and included on its website. Agencies will be encouraged to make available time for their practitioners to access the report and absorb the learning.

Jane Foster-Taylor
LSCB Vice-Chair
14th November 2014

A summary of the response to the findings:

Following the Board meeting where the findings were agreed each agency was asked to respond. This proved to be a longer piece of work than the Board and Serious Case Review Panel originally thought it would be. Some of the findings are phrased as a question to the LSCB and agencies. This is a feature of this method of review and reflects the fact that the hard evidence was not readily available but that the Reviewers, the Review Team and Practitioners had a sense that this was the situation. In formulating the detailed response no evidence to counter the questions completely was found and so they are accepted as areas that need development.

The result is a detailed action plan which is quite long therefore a brief summary of the nature of the responses is below. The plan is being actively monitored by the LSCB and a Sub-Group and is available on request to accompany the serious case review report.

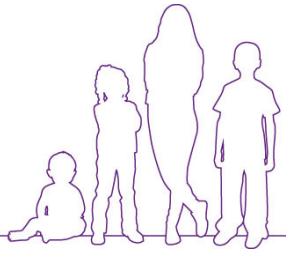
We need to acknowledge that whilst the responses have been put together the Rotherham Report (Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013) by Alexis Jay OBE) was published and we have started work with our neighbouring Essex Boards and the partners to ensure that our previous plans around child sexual exploitation (CSE) are still fit given the issues highlighted in this new report. To help with this a new strategic group has been formed to consider the report and the all Essex CSE group, under a new Police chair, is considering all aspects of CSE. There is also a Thurrock CSE group in place to ensure the local perspective is properly considered.

Tackling the issue of child sexual exploitation was and remains a high priority for Thurrock LSCB and the individual agencies.

The move away from a series of simple recommendations made by a reviewer to findings which need to be worked through by the multi-agency partnership is challenging. It is also a shift in thinking to try and come up with some responses that are more than just “train the workforce”. Whilst we have a detailed response and actions from agencies this is not the end of the response to the findings but a starting point for Workforce Development to address the matters found by this review. The summary below and the full agency response should be read with this in mind.

That said, training the workforce and sharing findings from a review remain important tools. As an LSCB we are looking hard at how we measure the impact of any training that is delivered and our latest full LSCB meeting ran with a theme as to how individual agencies know that training is making a difference to peoples’ practice and therefore making a difference to children.

Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual exploitation



This issue was widely acknowledged by partners and in particular people who work in health and deal with children and young people.

There was already in place a programme of training to help staff recognise when someone might be at risk of being exploited which was happening whilst this review was being done. There is more work to do around this to ensure there is a good understanding of the issue amongst all professionals and that any response is consistent and timely across the partnership.

Thurrock has recently "gone live" with a Multi-Agency Safeguarding Hub (MASH). This puts a number of people from different professions into one place to consider any concerns about children and young people. This model is recognised as being a strong tool to help recognise and deal with child sexual exploitation.

The House of Commons, Home Affairs Committee, Child Sexual Exploitation and the response to localised grooming, Second Report of Session 2013- 14 said:

"We recommend that each Local Children Safeguarding Board be required to set up a Multi-Agency Safeguarding Hub which would house representatives from Social Care, local police, health professionals, education, Youth Offending Teams and voluntary organisations…The police and the CPS should also produce guidance on data sharing via the MASH… "

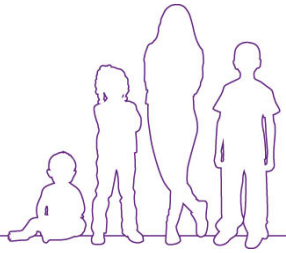
The LSCB will be monitoring the results of this new structure to ensure it is making a difference to the children and young people of Thurrock.

Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection

Unfortunately this is not a new issue and has been highlighted in other reviews. The nub of this is about children and young people using words like "relationship" and adults thinking about that in an adult way without exploring what the child really means.

Again the new MASH will help but there needs to be a broad understanding of this amongst people working with children in many situations. A workshop is planned by some health colleagues. The response from agencies shows a commitment to change and challenge people's use of language.

Individual supervision and the LSCB multi agency audits will consider this issue to ensure that there is a clear analysis of what the professional has been told.



The LSCB ran a conference last year with a theme of hearing the voice of the child and a more recently a themed LSCB meeting in March 2014 asked agencies to report on how they hear the voice of the child and ensure what they hear makes a difference to practice.

The detailed action plan in response to this finding builds on this earlier work.

Finding 3: Is there a pattern whereby the Child in Need (CIN) procedures are not routinely being used leaving children and young people without formal plans and review?

Whilst all agencies are involved in these processes the lead here is Children's Social Care. It was recognised in a mock inspection done is November 2013 that adherence to CIN processes, particularly in regard to regular review was not established, predominantly in the Adolescent Support Team.

Since then action has been taken to address this before this review was finalised. New processes have been put in place including supervision to help discuss and challenge the response to the young person.

In order to conclude this finding the LSCB needs to be satisfied that these new procedures are the normal practice for everyone and those children and young people have appropriate formal plans and reviews. The LSCB will monitor this as part of the Performance Sub Group and report back to the Full Board.

Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response

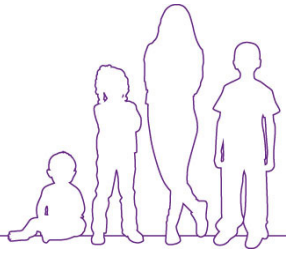
Resistant parents are well known to be a blocker to working with children and young people and this is recognised by all the LSCB agencies. Training has previously been undertaken.

The Early Offer of Help approach of starting work earlier with a family may help, dealing with "missed appointments" of children by health workers may also help. Appropriate early escalation for supervision and a multi – agency response could also assist.

The LSCB needs to closely monitor this finding to be sure that suitable mechanisms are in place to recognise and deal with resistant parents. This is a complex issue for which there is not a "quick fix" such as training alone but needs a range of tactics.

Monitoring the situation is also a challenge and the LSCB and the sub-group will continue to consider what work could be done to assist professionals working in these circumstances so that the best possible outcome can be achieved for children and young people.

Finding 5: Is there is a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm



It is agreed that the impact of adolescent neglect is not always fully understood by professionals and perhaps not dealt with as firmly as neglect in younger children. Some behaviour that could be part of a pattern of neglect could also be seen as part of adolescent behaviours where there is not neglect.

The LSCB is undertaking a new serious case review where neglect of an older child is a feature which reinforces the fact that this is an area of practice that needs to become better developed.

The annual conference, due in the autumn of 2014 has a focus on neglect and adolescent neglect will be part of that. This will help in increasing awareness of this also there is a cross over with child sexual exploitation work where older children, those aged over 16 but under 18, can be particularly challenging for professionals to work with.

Some training is being planned and Children's Social Care are working with a new assessment tool to help recognise the neglect of adolescents.

Finding 6: Is there a pattern whereby Multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?

Put simply this finding was suggesting that people were sharing information as they should but not getting to the heart of the matter by really thinking about what the information was telling them about a situation.

Part of the remedy to this is to make sure each agency shares their information including their own analysis.

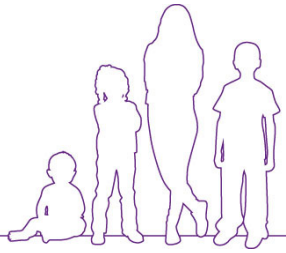
The MASH should assist greatly in this and we are eager to start seeing the performance data that will be produced so we can see what a difference it is making.

A good shared analysis should lead to better planning, the end result being the right children having the best response at the right time, for only as long as it is actually needed. We can determine if this has happened by undertaking audits of cases as part of audit programme.

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by other professionals or themselves as an integral part of the safeguarding network?

Part of the response said that most GP's *did* recognise themselves as being part of the network. So this finding is not fully accepted by all agencies. However it remains a challenge to consistently engage all GP's, this is recognised by some of the practitioners as they have made suggestions as a result of this finding as to how they might better be able to contribute.

The LSCB needs to undertake some work to see how widespread the issue actually is to make sure any effort to correct this is focused in the right way. The reasons could be many and



diverse and it is likely there needs to be a re-think as to how best to work with GP's to ensure their important contribution is included every time.

There is now improved engagement with Primary Care with over 90% of Thurrock's GPs trained to Level 3. There is 100% Board level awareness for Thurrock CCG and currently Section 11 Audits are being undertaken. Also a Named Safeguarding Doctor for Thurrock CCG has now been appointed.

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WORK PROGRAMME
Children's Services Overview and Scrutiny Committee

ITEM 9

Conservative	Independent	Labour	UKIP	Co-opted
Cllr Halden (Vice-Chair)		Cllr Morris-Cook (Chair)	Cllr G Snell	1. Mrs P Wilson (Roman Catholic Church Representative)
Cllr Ojetola		Cllr Kerin		
		Cllr Curtis		2. Reverend D Barlow (Church of England Representative)
Substitutes	**Substitutes**	**Substitutes**	**Substitutes**	
Cllr Coxshall		Cllr Brookes	Cllr J Baker	3. To be nominated (Parent Governor Representative)
Cllr MacPherson		Cllr Gupta		
		Cllr Gray		4. To be nominated (Parent Governor Representative)

Meeting Dates: 15 July 2014, 7 October 2014 (Cancelled), 11 November 2014, 6 January 2015, 10 February 2015, 10 March 2015.

Topic Name	Description of areas to be explored	Why this should be scrutinised	Outcome	Lead Officer	Brought to Committee by (Officer/ Member/ Statutory Reason)	Expected Completion Date / Meeting
Budget Update and Proposals				Sean Clark / Carmel Littleton	Officer	15 July 2014
Education Commission Update				Mike Peters / Carmel Littleton	Member	15 July 2014
Troubled Families Initiative	Assessment of the success of the programme so far	To ensure the programme is on track and making a real difference to the lives of families in Thurrock.	Dissemination of good practice from the programme	Nicky Pace / Teresa Goulding	Officer	15 July 2014
MASH intervention update	Update on the project to date			Nicky Pace/ Chris Wade / Marisa de Jager		Briefing Note - completed
Work placements and the pathway into work for young people in Thurrock				Carmel Littleton	Member	11 November 2014
Children's Social Care – Statutory				Rhodri Rowlands	Officer	11 November 2014

Updated: 21 January 2015

WORK PROGRAMME
Children's Services Overview and Scrutiny Committee

ITEM 9

Topic Name	Description of areas to be explored	Why this should be scrutinised	Outcome	Lead Officer	Brought to Committee by (Officer/ Member/ Statutory Reason)	Expected Completion Date / Meeting
Complaints Annual Report						
Child Sexual Exploitation and the Jay report – implications for Thurrock.				Nicky Pace	Officer	11 November 2014
Budget Update and Proposals				Sean Clark / Carmel Littleton	Officer	11 November 2014
School Results/School Performance	An update on results at KS1, KS2, KS4 and post 16	To determine the progress of Thurrock schools and academies	Updated information and scrutiny of outcomes of national assessments and relative performance of schools	Carmel Littleton	Officer	11 November 2014
Local Government Ombudsman – Report on an investigation into complaint numbers 12 012 268 and 12 005 756 against Thurrock Council	To consider learning. Referred from Cabinet in March 2014.			Rhodri Rowlands	Officer	Completed – 11 November 2015
Budget Update – changes to Library Provision				Sean Clark / Carmel Littleton / Janet Clark	Officer	6 January 2015
Early Offer of Help Commissioned Services					Officer	6 January 2015
Emotional Well Being and Mental Health Services – Project Update					Officer	6 January 2015

Updated: 21 January 2015

WORK PROGRAMME
Children's Services Overview and Scrutiny Committee

ITEM 9

Topic Name	Description of areas to be explored	Why this should be scrutinised	Outcome	Lead Officer	Brought to Committee by (Officer/ Member/ Statutory Reason)	Expected Completion Date / Meeting
Budget Update – Nurseries / Recommendations on the commissioning out of local authority day nurseries in Tilbury				Sean Clark / Carmel Littleton, Ruth Brock	Officer	10 February 2015
Feedback on the consultation with young people on the future delivery of youth services				Michele Lucas		10 February 2015
Annual report of the LSCB	An account of the activity and effectiveness of the Local Safeguarding Children Board over the past year	To ensure that the LSCB is effectively discharging its duties by contributing council scrutiny to the process	Understanding of the effectiveness of the LSCB in undertaking its safeguarding responsibilities	Alan Cotgrove		10 February 2015
Admissions Forum Report				Carmel Littleton	Member – requested at meeting on 6 January 2015	10 March 2015
Grangewaters Alternative Delivery Models	To consider options prior to presenting to Cabinet	To ensure all options have been fully explored	Agreement on recommendations to go to Cabinet	Malcolm Taylor	Officer	10 March 2015
Report of the next SCIE review and an update on the Jay Report.	To ensure that any lessons are learned from a case examined under the Social Care in Excellence Framework. To provide an update on the Jay Report	To ensure that these lessons are understood across Thurrock and shape future provision	Agree recommendations around dissemination of learning and practice	Andrew Carter / Alan Cotgrove	Officer	10 March 2015

Updated: 21 January 2015

WORK PROGRAMME
Children's Services Overview and Scrutiny Committee

ITEM 9

Topic Name	Description of areas to be explored	Why this should be scrutinised	Outcome	Lead Officer	Brought to Committee by (Officer/ Member/ Statutory Reason)	Expected Completion Date / Meeting
Youth Cabinet Report				Michele Lucas / Youth Cabinet		10 March 2015
Pupil Place Planning				Janet Clark / Carmel Littleton	Member	10 March 2015
Cultural Entitlement				Carmel Littleton	Member	10 March 2015
YOS annual report	An account of the activity and effectiveness of the Youth Offending Service over the past year	Members need to be satisfied that the Youth Offending Service is effective and making a positive difference to the lives of those referred to it	An analysis of the effectiveness of measures to reduce youth offending	James Waud	Officer	Briefing Note – to be circulated before 27th February 2015 to enable Members to comment before the March meeting.
School Capital Programme	A review of educational capital building works	Scrutiny will want to be advised of successfully completed projects, progress and other relevant updates	For noting and scrutiny of value for money	Janet Clark	Officer	Briefing Note – to be circulated before 27th February 2015 to enable Members to comment before the March meeting.
Early Officer of Help Commissioned Services	Update on the progress in response to Members request at 6 January 2015 meeting.			Sue Green	Member – request at 6 January 2015 meeting.	New municipal year, date to be confirmed.

Updated: 21 January 2015