Western Bay Safeguarding Children Board

Appendix 1f

Quality & Performance Management Group Work Plan 2016 - Sub group actions from 2016 Business Action Plan

Outcome	Action Needed	Timeline	RAG	Comment/Analysis
1.1 National Assessment Tools are used consistently and effectively to manage neglect in children and young people	1.1b Monitor effectiveness of the use of assessment tools and the impact on how neglect in children and young people is being managed.	December 2016	RED	Waiting on WAG to circulate National Assessment Tools
1.3 There are clear and seamless Step up – step down arrangements between early intervention/prevention resources and statutory chid in need processes	1.3a Local authority Early Intervention and Prevention Strategies across the region have a consistent approach to step up – step down arrangements which are sensitive to local needs and services. 1.3b Cases which appear "stuck" in early intervention and prevention services to be audited and reviewed against local strategies to ensure the right level of intervention is applied.	September 2016 December 2016	AMBER	All 3 LAs have provided early intervention and prevention processes. These differ and are at different levels of being embedded. The SCB agreed that an audit of cases would take place when the processes had been in place for a period so that the audit can be meaningful. The audit will be revisited in the new year for methodology to be agreed and agreed by the Board.

2.2 Members of the local communities are active in identifying and responding to neglect concerns appropriately	2.2a Develop and agree an audit process for neglect referrals from all sources. 2.2b Neglect referrals and their outcomes should be audited and quality assured for neglect referrals made by the community/member of the public	October 2016 February 2016	GREEN AMBER	Work has started with the neglect audit however this has not concentrated on referrals from the community. This will follow on from the ongoing neglect work being completed by the safeguarding leads.
3.1 Children on CPR under neglect have clear protection plans in place to ensure the wellbeing of those children is efficiently improved and maintained	3.1a An agreed % of Children on CPR under the category of neglect should have their protection plans quality assured using a "peer review" process to monitor improvements if registration is continued at the second review conference. The benefits and outcomes should be reported to the WBSCB for information and action.	October 2016	GREEN	**Audit completed by safeguarding leads – report awaited.**
3.3 Children and young people with repeat registrations following an initial CPR registration under neglect do not remain in neglectful households which impact on their long term wellbeing.	3.3b An audit of peer case reviews should be undertaken to ensure change has been effected in cases where long term wellbeing has been impacted.	December 2016	AMBER	**The safeguarding leads have taken a peer review approach to the neglect audit but not in the manner outlined in the South East Wales Safeguarding Children Board Multi-agency Supervision Document. This has been passed to the PPP group for further**

				exploration.
5.2 WBSCB and partner agencies have established operational arrangements and practitioner tools to support the identification of CSE and enable a timely range of appropriate responses.	5.2b Undertake a service analysis of demand and need to include those resulting from risk/impact of CSE 5.2c Review the availability and usefulness of risk assessment processes/tools and improvement action taken as needed	December 2016 December 2016	GREEN AMBER	**This area of work is ongoing across all agencies and the CSE data has given a robust picture of need – being realistic about those hidden areas of concern.** **SERAF tool is widely used. Other tools are developing including the screening questions used by health professionals. CSE work delivered in schools is slightly different – there is a need for an overarching framework.** **The Gwella Project lead has joined the group and a specific working group has been set up to further develop the work stream relating to CSE, MISPERS and Risky Behaviour.**
5.3 WBSCB and partner agencies contribute to a national shared dataset informed through local evidence and intelligence to improve understanding, profiling and response to CSE.	5.3a WBSCB regularly collates CSE data in line with the national CSE data set and report to Welsh Government on prevalence and analysis	April 2016	GREEN	**The group has concentrated on not only gathering the data which was achieved by the set date of April but ensuring it is accurate robust and meaningful. The work quality assuring the data itself was concluded in November 2016.**

7.2 CSE is considered as part of any risk management process/mechanisms	7.2a SCB to be assured that children, young people and their families are supported through a responsive child protection/care and support plan aimed at reducing risk based on individual need	July 2016	AMBER	**Original thematic review was competed but the case review due in January 2017 to follow progress has slipped to March 2017. The review did not specifically cover the action 7.2 so will be carried forward within the work stream.**
7.3 WBSCB and partner agencies have identified a range of services available/needed, to help those children and young people affected by CSE in their locality	7.3a Undertake a needs assessment that enables the Board to understand: - service demand in relation to children and young people at risk of CSE - the impact and effectiveness of the activity and services available to help those affected by CSE in their locality - identify any gaps in service and areas for development	December 2016	AMBER	**This will be taken forward by the Gwella lead work stream where the gap analysis is now being undertaken.**
7.4 WBSCB and partner agencies hold to account for their contribution to the safety and protection of children and young people subject to CSE and challenge practice shortfalls	7.4a Evaluate the differences and/or improvements made by changes in guidance, operational systems and practice reviews makes to outcomes for children and young people	December 2016	RED	**All CPR recommendations from the last 12 months have been taken to the group January 2017 from here the specific audits will be agreed with the CPR group chair. This will form a specific audit work stream not purely for CSE. The CPR group have taken**

				responsibility for the identification of shortfalls. Taking 12 months reviews will ensure that there is time to measure the difference/improvement the subgroup chairs met in November 2016 but work plan still to be agreed.
10.2 Local authorities across Western Bay have made provisions in schools across the region to implement key actions to address GBV, DA and SV within Education functions.	**TBC**	**TBC**		

ACTIVITY LOG (INCULDING LIVE CARRY OVER ACTIVITY FROM 2015)							
The work below aims to give additional information and analysis to the PMF which will be overseen by the group on a 6 monthly basis.							
PRIORITY: Child Sexual Exploitation							
No		**Method**	**Lead**	**Timescales**	**Findings**	**Actions**	**Comments**
1	Missing Children Protocol THE SUBJECT OF MISPERS REMAINS LIVE FOR THE GROUP AS THE WORK CONCENTRATES ON CSE IN 2016 • Police undertaking an audit of children who have been reported missing between 3 & 5 occasions. • Q&PMG will be provided with the findings in relation to any patterns, missed opportunities and reporting processes	To be completed by Darren George	Darren George	Target March 2015	There were no concerns raised by the audit that required remedial action. The findings were it was reassuring that procedures were in place and working effectively.	Quarterly meetings have now been set up in NPT and Swansea to continue the monitoring and sharing of information between Childrens Service and Western BCU. This practise will now be shared with Central BCU. The audit to be kept in a central library of audits for the group	**COMPLETED** Details of all Missing persons aged between 11 and 16 who went missing more than 5 times in the previous 12 months were circulated to Neath & Port Talbot Social Services and Swansea S/S so they could cross reference with their systems, this can be expedited. Approximately 40 names have been shared and gaps/anomalies were identified in relation to processes followed/accurate recording that needed

							follow up but this was in the minority of cases and no concerns arose from the further checks made.
2	Thematic Review of CSE • Commission an independent audit to be undertaken to establish local themes and trends	The group has put forward the possible commissioning of an audit that provides an academic read of all relevant information already available eg PCC research document into CSE, thematic inspections and associated recommendations etc as an effective practice evidence base. Then look at cases across WB identifying what has worked/or not with cases so that this can be brought together with learning from other areas gathered to develop an action plan based on "what works"	Lisa Hedley				July SCB agreed for this piece of work to be held back because of the amount of activity already in place regarding CSE. For now until further notice from the Board, this will be considered as COMPLETED.

3	The Quality and Performance Management Group has been providing quantitative performance information to the Western Bay Safeguarding Children Board on a regular basis since 2014. The management group has recognised that this statistical data is helpful in recognising the prevalence and incidence of child sexual exploitation (CSE). In order to improve our understanding of the operational and practice challenges a sub group was established to undertake a short time limited thematic review of a sample of cases across the Western Bay region. The group consisted of	The group partially based the analytical approach on "Framework" Analysis which was originally established through the work of social policy researchers (Ritchie & Spencer, 2002). This provides a staged process to qualitative data analysis and is probably best categorised as a thematic methodology. The framework comprises themes and sub themes established through immersion in the data; in this case the notes of strategy meetings etc. for the sample of cases. In summary the group followed specific steps in the data management and formal analysis process as follows. The initial step was reading through the data using	LA leads coordinated by Mike Holding	January 2016 for revisiting "where they are now?" in January 2017	<u>"Relationships" with older male peers or adult men</u> <u>The role of the parent/carer</u> <u>Vulnerable Families</u> <u>What we know about the young people vulnerable to CSE</u> <u>New Psychoactive Substances</u> <u>Who can best engage the young person?</u> <u>Characteristics of the perpetrator</u> <u>Social Media</u> <u>Child Abduction</u> <u>Warning Notice</u> <u>What has worked well?</u> The group noted a number of areas of practice that presented as working particularly well with this group of young people. The statutory framework of planning interventions through multi-agency meetings such as strategy meetings represents a consistent	Findings to be shared and group to be revisited in 12 months to see where they are now.	July 2016 SCB reminded of the work undertaken and plan to review. Also reminded to share the work undertaken.

	representatives from the three Western Bay authorities including the local authority safeguarding leads and South Wales Police. **Review Questions** 1. What has worked well in working with these young people? 2. What areas can be identified to develop practice? **3.** What specific practice areas need to be highlighted as essential in working with CSE?	an interactive board as well as paper copies of the written materials. As the data accumulated notes were taken of issues/ characteristics and recurrent themes as they become apparent. The basis for this stage of the early analysis was for the data and emerging themes to be as grounded as possible. A large amount of data accumulated through this process and a revision of the themes and their connections was agreed through discussion in the group. Mason (2002) refers to interpretive readings of data involving researchers developing a representation of the data and giving some inference to it.			structure to identify and manage risk as effectively as possible. The Seraf All Wales assessment tool was regularly used as a helpful measure of risk in conjunction with the statutory planning process. A widening group of professionals are becoming skilled and competent to work with CSE which represents increased opportunities to help young people recognise risk and stay safe. As noted above Child Abduction notices are regularly considered as a mechanism to protect young people		
4	Out of county placements of looked after children	Consider how placements are matched, the management, the	Mike Holding		Swansea has already started a piece of work in this area – how do we ensure that this is	Information to be gathered regarding ToR etc from Powys	PPPMG to hold this.

		management and accountability of placing children in neighbouring authorities and seeking reassurance that safeguarding concerns are being met			covered regionally. Powys has set up a forum where LA meet with private providers.	and the work already started in Swansea and this area to be taken by the PPP group	
5	CSE Data Analysis	Breakdown of data Story behind the baseline to be developed Questions to be answered Are we satisfied with the differentials of CSE across the LA areas? Why does access to sexual health clinics remain low? Who refers and how does that impact on eg SERAF scores and how cases are managed Review CSE National action plan.	BMU and safeguarding leads	ONGOING	Detailed reports are held containing statistical evidence and agency activity to respond to the CSE risk. There is a need to link strategically with MISPERS data the work of the PCC etc Review if the CSE national action plan identified the lack of a prevention strategy relating to CSE and that it is unclear if MASE meetings are taking place as per the recommendation within the national action plan	Specific work stream to be agreed outside of the group. This can take over the monitoring that has been feeding through the quality group and PPP group and develop the prevention strategy	The work for the group is now completed – Nov 2016 and passed to specific work stream.

No		Method	Lead	Timescales	Findings	Actions	Comments
PRIORITY: Neglect							
6	19 Indicators of neglect – Welsh Neglect Project • Suggested area of audit benchmarking cases referred in to services against the 19 indicators focusing on early intervention	Samples of TAF case load from each local authority and applying the 19 point check list the results to be fed into the Q&PMG.	Karen Burrows	Target November 2015 Actual May 2016	An audit was completed of cases referred by early help services to NSPCC matching the family profiles against the 19 indicators of neglect. All referrals were suitable with assessment and planning in place. Of the audited cases against the indicators the strongest indicators were unemployment and mental health problems. Mental health services were being accessed appropriately but unemployment was a huge issue as one would expect. Substance misuse did not feature highly nor did issues of non- school attendance.	No specific action followed. Findings to be shared – strong links confirmed to families in poverty.	**COMPLETED** Delays experienced due to sickness and work load pressures.
7	Re-registration of neglect cases	The number of children initially registered under neglect who have been de-registered but later re-registered under a different category are relatively small. This raised the question "has neglect continued" 9 cases to be re-registered to be audited.	LA Safeguarding leads	Target date May 2016 Extended to November 2016			

		Specific attention to be given to the cases and timescales as one case was re-registered within a month of de-registration. The existing SCB audit tools to be used by a small working group.					
	Education Welfare response to signs of neglect in cases where there is below 80% attendance	Period of audit - Jan 15 to Jul 16 From an alphabetical list of pupils with attendance below 80% select the 1st & last pupil on the list in each of these settings: Biggest comprehensive Smallest comprehensive Biggest primary school Smallest primary school Where a pupil may no longer be on roll at that school, if they were on roll during the scope period the file will still be analysed. This is a qualitative audit where the lead EWO will analyse the files activity, actions & outcomes. For each case provide a short summary of the			Despite the scope being agreed at the group the three LA representatives had undertaken foundation work prior to the scope that differed so the group were not in a position to compare like with like. However each LA reported that there were no concerns raised regarding the referral pathways and no indication that signs of neglect were being missed. The LA's prepared a paper that was presented to the Board outlining process and existing monitoring and reporting.	The audit will be undertaken again with the period adjusted but the scope remaining.	

		background, EWO & agency involvement to date, an analysis of the work undertaken & where applicable, comment upon activity that might have been considered & wasn't at the time. Consider the range of actions/resources available & comment upon the effectiveness of the service provided in this case.					

No		Method	Lead	Timescales	Findings	Actions	Comments
Duty to report and within the PMF:							
8	Professional abuse	During the review of the Performance Impact Framework	Lisa Hedley	Raised in May 2016 to be revisited by Leads and reported on in six month monitoring	The group raised concerns that outcomes of professional abuse Strategy meetings being effectively communicated	The Board required further information and assurance that outcomes were routinely shared in a timely manner.	CP leads did not always receive information on outcomes following the completion of HR or criminal investigations.
9	Use of restraint	In line with requirements of working together LA's with secure establishments in their area need to	Caroline Dyer	YJB letter requested information by December 2016. However this request was missed	Hillside visited in December 2016 and Parc visited in January 2017.	There is a YJB HMP YPI Parc and SCB project Board now looking in detail	

		review the use of restraint		as key member of staff of sick. Yjb contacted and deadline extended to January 2017 due HMPYOI Parc's inspection.	Findings differed as There are 22 beds in Hillside (12 YJB and 10 Welfare) There are 1600 beds in Parc (64 of which are in the YOI) The review in Parc was undertaken during a time of a number of emerging issues. The final report is due for completion by January 26th.	at the safeguarding mechanisms within Parc.	
10	Review of Performance Impact Framework	Group QA'd the PMF to ensure realistic information is being gathered	Lisa Hedley	March 2016	Areas were updated and addressed in line with SS&WB act.	Taken to Board for sign off in March. Further amendments made and signed of in May 2016	Signed off in May 2016 but work continues to realise areas to be included -Annual reports are currently obtained from secure estate these need to be more robust and include information specific to use of restraint. Referral and response. Care and support needs.

No		Method	Lead	Timescales	Findings	Actions	Comments
PRIORITY: Domestic Abuse							
	Still to be confirmed						
No		**Method**	**Lead**	**Timescales**	**Findings**	**Actions**	**Comments**
Additional Areas: Protocols & Procedures							
11	Minor Injuries in non-mobile babies protocol	Andrea Warlow and Matthew Obaid are to audit cases where minor injuries have been referred to the PAU following the ratification of the protocol, to see if the process has been followed.	Janet Morgan	January 2016	Further analysis was needed of files to check on actions pre and post the referral. No concerns were raised - information passed to PPPMG to inform ongoing ratification of the protocol		**COMPLETED** There has been a delay in the completion of the minor injuries audit as this involves requesting the records initially from both hospital sites and we haven't had them yet , then a physical trawl through to review processes as recorded in the notes.
12	Final report on Audit of CP paediatric services in Wales – rec 5	Update required in six months on progress made against the recommendation	Lisa Hedley	February 2017			

No	Area of Audit	Method	Lead	Timescales	Findings	Actions	Comments
Additional Areas:							