# CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD

## LEARNING AND IMPROVEMENT FRAMEWORK 2016

## Introduction

The purpose of the Learning and Improvement Framework is to foster a learning culture across agencies in Cambridgeshire that supports the continuous improvement of services that safeguard and promote the welfare of children and young people.

To achieve this end, the Board will create a culture of openness and facilitate effective and regular challenge to all partner agencies.

Statutory Guidance lays down that Cambridgeshire LSCB is required to:

- "coordinate 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
- ensure the effectiveness of what is done by each such person or body for those purposes." Working Together 2015

Working Together 2015 also includes:

"Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

Local Safeguarding Children Boards (LSCBs) should maintain a local 'Learning and Improvement Framework' which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

The local framework should cover the full range of **reviews** and **audits** which are aimed at driving improvements to safeguard and promote the welfare of children. "

And in addition,

"In order to fulfil its statutory functions under regulation 5 an LSCB should use data and, as a minimum, should

"assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

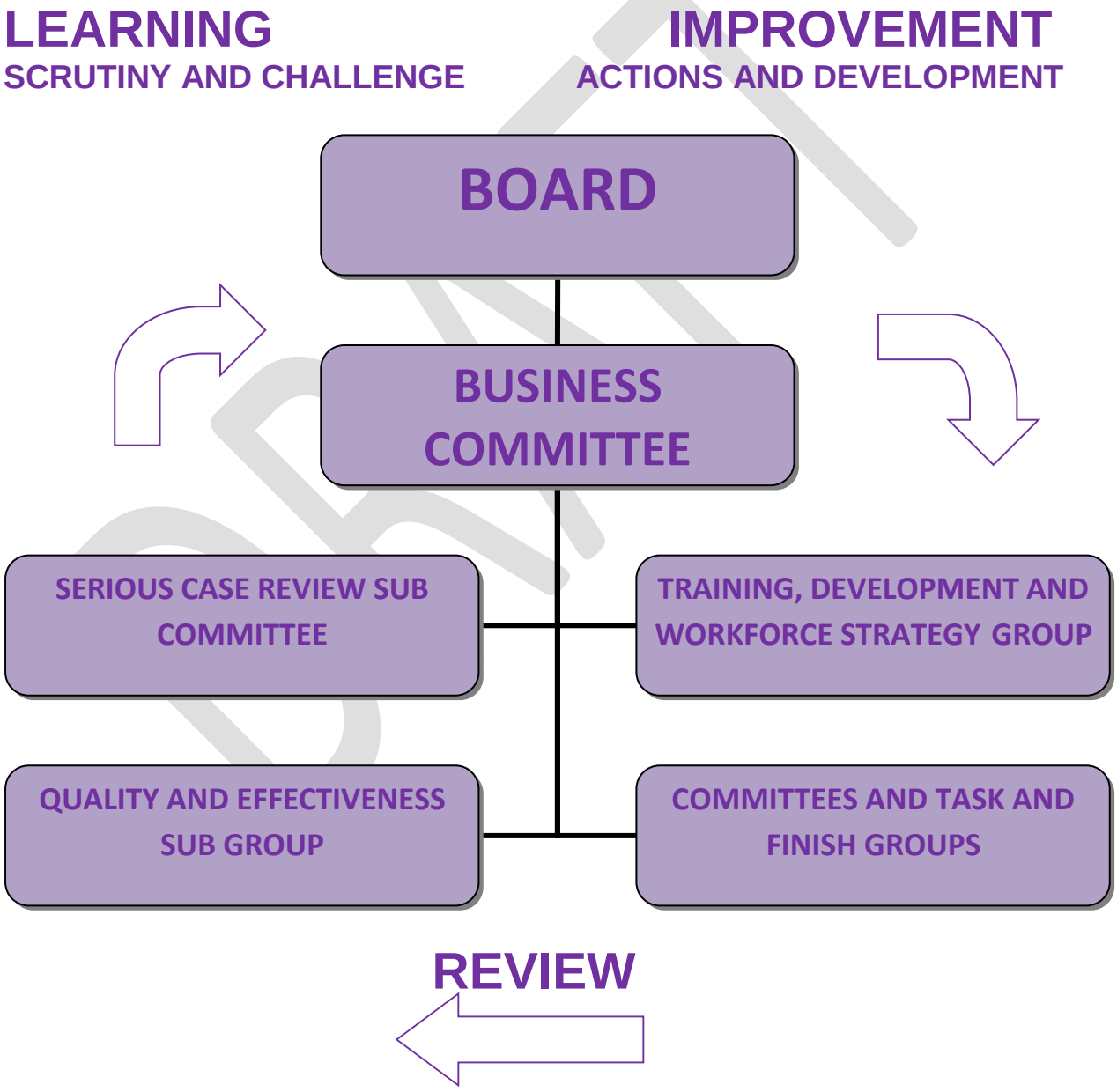
Local authorities and Board partners should provide the LSCB with data to enable it to fulfil its statutory functions effectively."

## Governance

The structure of the LSCB supports a cycle of learning and improvement.

Learning (Scrutiny and Challenge): Evidence about practice in Cambridgeshire and relevant information and insight from wider sources is obtained and reviewed by the LSCB, in particular through the Serious Case Review Sub Committee (SCR Sub Committee) and Quality and Effectiveness Sub Group (QEG).

Improvement: Together with the Business Committee, the SCR Sub Committee and QEG identify key points of learning and agree action points as required. The Training, Development and Workforce Strategy Group (TDWSG) has responsibility for disseminating the learning.



## Recording and Coordinating

To support the Learning and Improvement Framework the LSCB will maintain:

1. An Evidence of Performance Log
2. An Action Tracker to monitor the implementation of recommendations
3. When required, a rolling SCR Learning and Improvement Action Plan
4. A Staff Development Strategy informed by the learning

## The relationship of the LSCB with other bodies

Learning and improvement is not exclusive to the LSCB and it must be open to importing learning from, and exporting learning to, other bodies, including the Health and Wellbeing Board, the Adult Safeguarding Board, and Community Safety Partnerships. The annual report of the Board will be an important means of communicating Board learning.

## Principles for learning and improvement

The following principles should be applied by LSCBs and their partner organisations to all reviews:

a. "there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
b. the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
c. reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
d. professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
e. families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
f. final reports of SCRs **must be published,** including the LSCB's response to the review findings, in order to achieve **transparency.** The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
g. improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children."

SCRs and other reviews should be conducted in a way which:

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

## Effective Auditing Practice

Audits should be conducted in line with the RiP Leaders Briefing on Multi-Agency Auditing for LSCBs Checklist for Good Practice (Appendix 2):

## Learning, Scrutiny and Challenge

The process of scrutiny and challenge is informed through the collation and coordination of different types of evidence from different sources.

- Serious Case Reviews
- Other Multi-Agency Reviews
- Single Agency Reviews
- Audits commissioned outside LSCB process but relevant to Safeguarding
- Ofsted, and other multi-agency Inspections
- Single agency Inspections
- Annual Reports to LSCB (including LADO, Private Fostering, Safer Recruitment, MASH, CDOP, Complaints, Missing, Other Local Authority (LAC), LAC, Independent Reviewing Officer, Safeguarding Adults Board, Health and Wellbeing Board).
- Dashboard
- Core dataset covering information on the child protection (including CP quarterly returns)
- Health and other sector or agency quarterly returns
- Dataset defined by current priorities
- Multi-agency Audits
- Single Agency Audits
- Consultation with Service Users
- Consultation with professionals
- Section 11 returns

Responsibility for facilitating learning through these sources is attached as Appendix 3

By combining learning from Reviews, audits, research and statistical data the LSCB is able to develop a more holistic and complete understanding of the quality of safeguarding in Cambridgeshire.

The Terms of Reference of the Serious Case review Sub Committee are attached to outline in more detail the review process (Appendix 1).

## The Voice of Children, Young People and their families

The Cambridgeshire LSCB has a commitment to hear and learn from the views and experience of children and young people. It will:

- Build on and support the work of consultative processes within single agencies
- Evaluate and learn from the outcome of consultations undertaken in Cambridgeshire
- Commission specific consultation exercises to support priority work
- Deliver programmes designed to raise awareness of issues amongst children
- Liaise and support voluntary sector and other groups who work with or advocate for

children and young people.
- Challenge partners to demonstrate how the voice of the child influences their work.
- Incorporate the perspective of children into its training programme

## Involving Front Line Staff and Managers

Cambridgeshire LSCB's approach includes:

Involvement for front line staff and managers in Cambridgeshire LSCB Serious Case and Learning reviews
Delivering a multi-agency training programme
Involvement of front line staff and managers in multi-agency audits
Review feedback from training sessions, workshops and conferences

## Consultation with the Public and Other Stakeholders

This involves communicating what the LSCB does and seeking the views of the wider public through:

Developing the LSCB website as a means of communicating messages and receiving feedback
Maintain a Twitter account as a means of communicating messages and receiving feedback
Involving Lay Members in the Board and other activities

## Review

The LSCB will keep the Learning & Improvement Framework under review and when needed will adapt the Framework to increase its effectiveness improving safeguarding practice

## APPENDIX 1

# Cambridgeshire LSCB Serious Case Review Sub-group

# Terms of reference: Referral and Decision Making Process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### 1.1. Criteria for Serious Case Review – the legislation

1.2. **"Serious Case Reviews** Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

- 5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
- (2) For the purposes of paragraph (1) (e) a serious case is one where:
- abuse or neglect of a child is known or suspected; and
- 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.

1.3. "Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;
- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

1.4. This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

1.5. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

1.6. Cases which meet one of the criteria described above **must always** trigger an SCR. This includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii) when a child has been seriously harmed, unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB **must** commission an SCR.

1.7. In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home.

1.8. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

1.9. The final decision on whether to conduct an SCR rests with the LSCB Chair. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not required because the criteria in

regulation 5(2) are not met, the LSCB **may** still decide to commission an SCR or they may choose to commission an alternative form of case review.

**1.10.** The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report." Working Together 2015 Ch 4.

## 2. Purpose of the Serious Case Review sub-group

2.1. The purpose of the Serious Case sub-group is to:-

- Enable agencies to share information and consult on cases where they identify indications that a referral could be required but lack sufficient evidence to make a decision.
- Identify and consider referrals for those cases which meet the criteria for a Serious Case Review
- Identify those cases where lessons can be learned but which do not meet the criteria for a Serious Case Review
- Identify any themes or trends within the referral cohort to support local learning
- Consider any themes or issues from national Serious Case Reviews that may further improve the quality and impact of safeguarding in Cambridgeshire
- Ensure that the learning from all case reviewing activity is embedded in practice
- This guidance should be used in conjunction with chapter 4 of Working Together[1] 2015 and is supported by the principles of the Cambridgeshire LSCB Learning and Improvement Framework.
- The SCR subgroup will be chaired by an Independent Chair

### 2.2. Scope of the Serious Case Review sub-group

2.3. The SCR sub-group will:-

- Share information held by agencies where an agency has sufficient cause to be considering whether a serious incident or serious case review referral is required.
- Review all serious incidents referred to consider if the Serious Case Review Criteria have been met

2.4. For those cases **that reach** the Serious Case Review threshold, the SCR sub-group will:-

- Support the chair of the sub-group in outlining the rationale for the chair's decision to initiate a Serious Case Review
- Support the development of the draft terms of reference for the Serious Case Review and consider the methodology for carrying out the review
- Identify a potential independent reviewer with the relevant skills and knowledge to conduct the review and produce a final multi-agency report
- Identify the multi-agency review team
- Outline the membership for the Serious Case Review Panel
- Monitor the implementation and impact of any multi-agency lessons to be learned
- Ensure the outcome has been shared with National Serious Case Review Panel, DfE and Ofsted

2.5. For those cases that **fall below** the Serious Case Review threshold the SCR sub-group will:-

- Support the chair in developing the rationale to not initiate an SCR if one has been requested.
- Determine if there is relevant possible learning from the case and recommend the process and methodology for understanding the learning
- Ensure, where relevant the outcome has been shared with National Serious Case Review Panel, DfE and Ofsted
- Identify who needs to contribute to the review
- Outline the terms of reference for the review and the methodology for carrying out the review
- Identify a timescale for the review and submission of any reports
- Translate learning and challenges into action; outlining how the impact and effectiveness of any response will be evaluated
- In addition the SCR sub-group will:
- Identify relevant SCRs in other LSCB areas to further develop and enhance local safeguarding practice
- Agree a model to evaluate how learning from any statutory or non-statutory reviews commissioned has been implemented including impact on practice

## 3. How to make a referral to the SCR subgroup?

3.1. For an initial information sharing exercise members of the group will be required to submit the child and relevant family/carer details and supporting documents to the Chair via the LSCB or Business Manager at least 10 working days prior to the meeting

3.2. For advice regarding whether or not a case should be referred to the Serious Case Review sub-group, please contact the named or designated safeguarding lead/ SCR sub-group representative in your organisation in the first instance. They will then discuss with the Independent Chair of the SCR sub-group or Business Manager and make them aware of your intention to refer the case for consideration.

3.3. All cases for consideration should be referred using the SCR referral and decision form at Appendix One and sent to

gcsxseriouscasereview@cambridgeshire.gcsx.gov.uk . Please ensure that this is sent securely.

3.4. This form is to be used to describe the reason for the referral. Once the referral has been processed, this form will be used to outline the rationale for the decision of the Independent Chair of the sub-group as to the course of action to be taken

## 4. Making the Decision to initiate a Serious Case Review

4.1. When the referral form regarding a request for any case review is received by the LSCB, it will be considered by the Chair of the SCR sub group. If the chair sees the referral as appropriate, it will be placed on the agenda of the next monthly Serious Case Review sub-group. At this point, the referring agency may be asked to provide further information

4.2. Agencies will be asked to submit a brief précis of their involvement with the child, its siblings or any family members identified in the referral. This will be shared with the SCR subgroup members in order to inform the discussion and recommendations about the referral.

4.3. Information about the involvement of agencies with the child and the family will be shared by the relevant member and a discussion regarding whether the case fits the criteria for an SCR is met. Each agency's representative will be asked to offer their recommendation to the chair as to whether to initiate

4.4. Should the information suffice, the Panel will make a recommendation as to the need for a SCR. The LSCB Independent Chair will make the final decision.

4.5. The LSCB Independent Chair's decision will normally be deferred for a week after the SCR sub-group. During this time there will be the opportunity for the LSCB Independent Chair to reflect on the available information, request more information if required, and have further discussion with agencies as regards the decision to initiate a Serious Case Review.

4.6. Once the Chair has made this decision it will be recorded and will be shared via email with all of the agencies that attended the SCR sub-group that discussed the referral, and with the referring agency's LSCB Board member, and the Director of Children's Services and the Chief Executive of the Local Authority. The decision will be recorded on the SCR Referral and Decision form.

*4.7. NB there is a useful grid at Appendix 2 to this document which can support the decision-making - process*

## 5. Where there is no Serious Case review requested or initiated from the referral

5.1. Where the threshold for a Serious Case Review is not met, the SCR sub-group will consider alternative ways of learning about the safeguarding practice/ system. This could include:-

- Single agency management reviews
- Multi-agency reviews
- Single or multi-agency theme based case audit
- Literature or research reviews
- Local Practice groups
- Peer Review/ mentoring between local agencies

5.2. If a Serious Case Review is to be held then the following should be informed by the Business Manager using the required templates:

- Ofsted
- Department of Education
- National SCR Panel

## 6. Serious Case Review sub-group membership

6.1. **Chaired by an Independent Chair**, the Serious Case Review sub-group should include as standing members:-

- Children's Social Care: Head of Safeguarding (deputy: Head of Service)
- Designated Doctor Safeguarding Children;
- Designated nurse Safeguarding children
- Police: Head of Public Protection ( deputy: DCI in PPD)
- Learning: Head of Service
- Enhanced Preventative Services: Head of Service (deputy: Youth Offending Service Manager)
- Probation: Team Manager.

6.2. Where the Serious Case Review sub-group are to consider a referral, a representative from all agencies known to be involved in the case will be invited to be part of the discussion and in formulating a recommendation about how to proceed with the case. This could include named nurses from provider health trusts, CAFCASS safeguarding lead, drug and alcohol treatment services, key voluntary organisations. There is flexibility within the sub group membership to co-opt additional members with expertise or knowledge relevant to any of the cases being reviewed or screened.

6.3. However, the chair of the sub-group will seek the recommendation of the members of sub-group only as to what they advise the decision of the chair should be.

6.4. Also, in attendance

- Legal representative - required to provide legal advice regarding decision making about a referral; Terms of Reference for SCRs; and would also join any panel for an SCR where there where legal issues arising
- Business Manager
- Minute taker

**6.5. Appointing a panel to oversee a Serious Case Review**

6.6. When a Serious Case Review is initiated and the lead reviewer has been appointed and the terms of reference approved by the SCR sub-group, the case will then be overseen by a panel. Membership will consist of representatives from all agencies providing an agency report. The representative will have oversight of the work of the agency author and will quality assure the work. The panel will be chaired by an independent chair, most likely the chair of the SCR sub-group. The panel will meet at critical points in the review to ensure that the Terms of Reference are appropriate and are being met by the work of the agency authors and the lead reviewer. The LSCB Business Manager and a minute taker will attend and where required, legal and expert advice will be sought if the panel deem this necessary.

## 7. Organisational and performance arrangements

7.1. The SCR sub-group meets monthly, on Tuesday mornings. The meetings will be set for a year ahead.

7.2. Members of the group will be required to submit any agenda items and supporting documents to the Chair via the LSCB or Business Manager at least 10 working days prior to the meeting.

7.3. Agendas and documentation will be sent by secure email at least 5 working days before the meeting.

7.4. Progress of Serious Case Review Action Plans and other action plans will be monitored through a 'RAG Rating' System and reviewed on a quarterly basis.

7.5. The SCR sub-group will contribute to the Learning and Improvement framework report which is reported on an annual basis to the LSCB as part of the LSCB annual report

7.6. The following measures will be used to evaluate the SCR sub-group effectiveness

- 100% of planned and required meetings take place – however where appropriate, meetings may be cancelled where it anticipated that there is no business. This is the decision of the chair

- Agencies will ensure 100% attendance, offering a regular deputy should the lead not be able to attend.
- The SCR sub-group ensures that all reviewing activity decided upon as the appropriate response to a referral is begun within 3 months of the decision and completed within 12 months
- The sub-group highlights any agencies or actions that are at risk of not being completed within the timescale to the LSCB's independent chair
- Minutes are circulated within 14 working days of a meeting
- An annual Learning and Improvement summary is completed

## 8. Informing the Department of Education

8.1. In all cases the decision made as to whether an SCR will be initiated will be shared with the Department of Education - Mailbox.CPOD@education.gsi.gov.uk and details of the author when appointed send to the National SCR Panel - Mailbox.SCRPANEL@education.gsi.gov.uk

## APPENDIX 2

### RiP Leaders Briefing on Multi-Agency Auditing for LSCBs Checklist for Good Practice

1. A body, such as an Auditing/QA subgroup, comprising people able to drive the process within their own agencies, should lead on the planning, including the appointment of a coordinator with a multi-agency overview to lead the audit team.

2. Establish an audit team with a good understanding of what 'good' practice looks like and an understanding of the complex circumstances in which professionals work together to safeguard children. Include frontline practitioners/managers who are new to auditing in order to add fresh thinking and challenge.

3. Agree priorities, scope and outcomes focused terms of reference based on a range of information and intelligence sources

4. Selection of sample cases will depend on the nature of the audit (i.e. whether it is general or more specifically focused), but should be representative of the relevant user group in relation to demographic factors. The selection of cases is best carried out by a neutral person, with no vested interest in selecting cases that are known to have gone well or badly. Use a relatively small number of cases (GOL, 2009, suggest that, from their experience, ten cases, for example, can be as fruitful in identifying key issues as a greater number). Further audits can always be undertaken, if necessary, to test a finding out.

5. Limit the timeframe of casework being looked at, for example within the last 12 or 18 months.

6. The coordinator and auditors should meet to plan the process, including timescales, and ensure everybody understands the audit tool (see further resources section for examples of tools) and how to apply it to their organisation's 'cases'. This also involves planning for communicating the purpose, process and focus of the audit to teams whose cases are being audited to help alleviate anxieties about the process and a potential fear of being named or blamed for any problems identified.

7. Ensure auditors (and the tool used) identify good practice (and get at the details of this), in a spirit of Appreciative Inquiry, as well as identifying gaps/anomalies.

8. Factors that impact positively or negatively on local practice, such as size of caseloads and organisational 'churn' should also be noted so that the LSCB response to findings is informed by a recognition of the context of practice.

9. Auditors should seek to 'understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight'. This includes understanding 'who did what and the underlying reasons that led individuals and organisations to act as they did' (HM Government, 2015).

10. Following audits, auditors should give initial feedback within their own agencies (including informing relevant managers immediately if any urgent/safeguarding

issues need addressing). This will keep the audit 'live' by enabling immediate adjustments to practice for the benefit of the child/family concerned and will aid practice learning.

11. In line with Ofsted inspection methods, highly valuable insights can be added into the learning by an appropriate person consulting in a sensitively planned way with the CYP/parents/carers involved in the cases audited.

12. Audits should test how evident CYP voices and views are within the records.

13. The coordinator should review initial findings - identifying questions, gaps, inconsistencies and emerging themes - then reconvene the auditing group to exchange learning, clarify and debate emerging themes. This enables group and individual agency ownership of the findings. Note: further learning may occur about the quality of working together at this stage resulting in individuals reviewing their initial findings. Use this meeting to learn about the audit process itself in order to make future adjustments.

14. The coordinator's report should highlight (in quantifiable ways with qualitative illustrations) what was found to be working well, emerging concerns, overall judgements and recommendations about the most significant areas in which change is needed.

15. Devise a SMART (S-Specific, M-Measureable, A-Achievable, R-Relevant, T-Timely) action plan to address recommendations and embed learning. This may include a decision to undertake further investigation such as widening the audit sample or drilling down in a more focused audit to gain greater understanding.

16. Disseminate the findings effectively to all staff to aid learning and create ownership. Further discussions with key people who particularly need to understand and influence practice will also need to take place.

17. Feed findings into other learning cycle activities and training plans and agree a process (for example through future audits) to assess implementation (and impact) of the recommendations.

APPENDIX 3

## Sources of Evidence

| Source of information | Description | Who | Lead Committee (under the overall authority of the Board |
|---|---|---|---|
| Serious case review | Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.[2] | Partner agencies<br>Relevant organisations.<br>Independent Reviewer.<br>LSCB Business Unit. | SCR Sub Committee |
| Multi-agency partnership reviews | Review of a safeguarding incident which falls below the threshold for an SCR. | Partner agencies<br>Relevant organisations.<br>Possible Independent Reviewer or author.<br>LSCB Business Unit. | SCR Sub Committee |
| Single Agency Review | Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child | Partner Agency | SCR Sub Committee |
| Child Death Review | A review of all child deaths. | Child Death Overview Panel (CDOP) | CDOP |
| Multi-agency thematic case audits (also known as 'deep dive' audits) | Audit of practice relating to a specific safeguarding issue (case sample) as highlighted in multi or single agency. | Partner agencies<br>LSCB Business Unit. | QEG |
| Multi-agency case audits | Audit of practice relating to a child's journey through the system (case sample). Highlighting where things go well as well as opportunities to improve. | Partner agencies<br>LSCB Business Unit. | QEG |

[2] Criteria for an SCR are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

| | | | |
|---|---|---|---|
| Single agency audits and reports | Audit of practice as reported to QEG. | Partner agencies as detailed in the schedule or reports | QEG |
| Section 11 reviews | Self-assessment of an organisation's safeguarding arrangements and practice against Section 11 of the Children Act 2004. | Partner agencies | QEG |
| Section 175/157 audits | Self-assessment by schools of their safeguarding arrangements and practice (s.175/157 of the Education Act 2002) | Schools | Board |
| National research, SCRs, etc. | Key messages from research, other LSCB's SCRs, Children's Commissioner, government reviews, Ofsted Inspections etc. | LSCB Business Unit and Committees | LSCB and Committees |
| Annual and other regular Reports to LSCB | Information on areas of Early Help and Safeguarding activity | Partner Agencies | Board |
| Dashboard and Dataset | Data on key aspects of service delivery and performance across Early Help and Safeguarding | Partner Agencies and LSCB Unit | QEG |