Lancashire Safeguarding Boards

Annual Report 2016/17

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Latest version: 24/08/17

Contents

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1. Foreword by the Independent Chair

This report relates to my third year as Independent Chair of the Children Safeguarding Board and my first as Independent Chair of the Adult Safeguarding Board. It continues to be a privilege and a pleasure to chair the Boards and to see the impact of the dedicated and skilled workforce to whom I send my thanks.

It has generally been a year of continued pressures as agencies strive to deliver services against increasing demand and decreasing budget levels. We have seen the impact of this on the capacity of professionals, particularly senior and middle managers, who have sometimes struggled to fully engage with the Boards' business. An important role for the Board is one of challenge and it is to their credit that our experience is of agencies picking up the challenges with good grace and working towards improvement.

During the last twelve months the two Boards, the Lancashire Safeguarding Children Board (LSCB) and the Lancashire Safeguarding Adult Board (LSAB), have been, wherever possible, working together supported by a single business unit. As a result, some of our work now focusses across the age range and while we are currently required by regulation to maintain two separate Boards we are reporting on both via this one annual report. The report largely follows the format of the previous children's report and uses the nationally recommended framework.
In last year's LSAB report, the previous Chair reported difficulty in obtaining performance data and significant concerns about delay in dealing with referrals. During 2016-17 we have been able to establish a series of Board Sub-groups, including one focussed on data analysis, performance review and audit. This work continues to develop but has enabled the Board to better understand the level and quality of services and to put in challenge where safeguarding practice needs improvement.

In last year's LSCB report, we reflected on the Ofsted Inspection findings in respect of the Lancashire County Council and the Lancashire Safeguarding Children Board. The year covered by this report has seen considerable activity focussed on improvement and while there is evidence of change there are still areas to address. While timeliness in some areas of work continues to be a challenge, new assessment procedures have been adopted within Social Care and across partner agencies. These together with significant more recent improvements in the Multi-agency Safeguarding Hub (MASH) give grounds for optimism for the coming year.

Additional Board capacity has been developed during the year and new methodologies adopted for audit and case reviews. This has enabled the Boards to drill down into the quality of services at a case level and has produced valuable learning for all agencies.

For the first time, the Boards have been proactive in raising safeguarding awareness via the media, with campaigns being reported on in the local press and nationally. Concerns re suicide levels, particularly in Preston area resulted in coverage over three days on suicide and suicide prevention. Concerns arising following an adult's death as a result of fire involving the use of emollient creams

DRAFT

was covered in the local press and picked by the media nationally both in newspapers and on radio. Articles were also run on issues such as toy safety in the run up to Christmas and on-line safeguarding issues for children.

This report covers the safeguarding practice of Lancashire agencies and the work of the Boards themselves. While it identifies much to commend, challenges remain. Ensuring vulnerable people get the right services at the right time is work in progress and more needs to be done. Revised guidance has been issued and a new early help service launched - these things should impact during 2017-18. Suicide figures are still high for adults and, in some areas, children and adolescents are still not able to access a timely and comprehensive mental health and well-being services. Too many children and adolescents attend hospital due to self-harm. Numbers of children looked after by the local authority and those needing the support of a child protection plan are high. Around 1,000 children looked after by other local authorities are placed in Lancashire resulting in high numbers of children with complex needs requiring access to local services. The majority of safeguarding alerts in respect of adults occur in care/nursing settings, sometimes where the placement struggles to meet the challenging needs of the adult. Domestic abuse, particularly of vulnerable elderly, is a growing concern. The Boards continue to challenge agencies to address these areas.

During 2017-18 it is expected that the government will issue guidance on new arrangements for safeguarding children. There will specific changes for the current Children's Board which may in turn impact on the Adult's Board. We plan to begin preliminary work on new models in the Autumn. Change may be quite radical but it is clear that safeguarding will remain a priority.

Direct engagement of the Boards with service users is important and the Children's Board has continued to benefit from the work of young inspectors. The Adult's Board has not yet developed direct arrangements but has engaged with existing service user groups. As in previous years a young person's version of this report will be produced, as will a more accessible version for adults.

I look forward to the coming year. Lancashire is a complex and diverse area but, despite all the challenges and concerns, good outcomes as a result of the work of dedicated staff also continue to be in evidence. My thanks go to all concerned.

Jane Booth, Independent Chair

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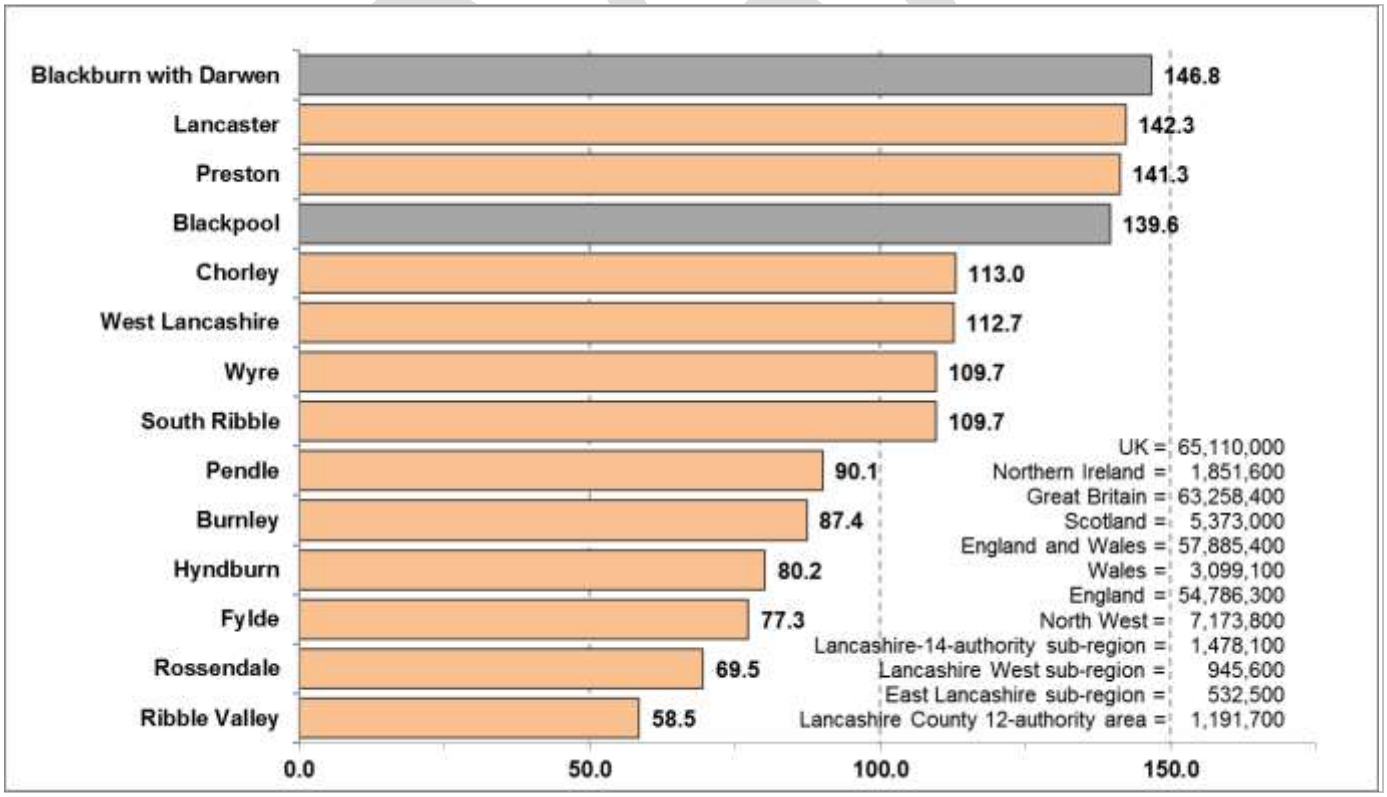
2. Local Context and Background

Lancashire is a large and diverse Shire County, with one County Council and 12 District Councils. Mid-year 2015 population estimates indicate that Lancashire local authority area is the fourth largest in the United Kingdom (of a total of 418 local authority areas), with a population of 1,191,691; the three larger local authority areas being Kent, Essex and Hampshire respectively.

Within the former county footprint there are two unitary authorities, Blackpool and Blackburn with Darwen. They have separate administrations including individual Safeguarding Boards. With the unitary authority populations (Blackburn with Darwen –146,846 and Blackpool – 139,578), Lancashire County Council area (the Lancashire – 12 area) has a total population of approximately 1.5 million (1,478,115 Lancashire-14, 2015 mid-year estimate).

2015 mid-year estimates indicate that the Lancashire-12 area (1,191,691) saw a 0.6% yearly increase in population numbers. This was on a par with the North West percentage population increase. As the graph below shows, the populations for each district within Lancashire varies considerably. Lancaster district had the largest population in the Lancashire-12 area (142,283) closest followed by Preston (141,302). Ribble Valley (58,480) and Rossendale (69.487) were the two authorities with the lowest population totals.

2015 mid-year population estimates (thousands) for local authorities with the Lancashire-12 authority area and unitary authorities



Source: Office for National Statistics (ONS) annual mid-year population estimates.

The Lancashire-12 area continues to register more births than deaths each year, however there are district variations. Fylde, Lancaster, Ribble Valley, West Lancashire and Wyre all registered more deaths than births in 2015. It is assumed that this is due to those districts being home to large elderly populations.

Within Lancashire, there are pockets of severe social and economic deprivation. Deprivation is measured by the indices of deprivation (IMD), which provides detailed results for very small areas. This information indicates severe deprivation in urban centres within Lancashire. The county has a large number of small areas that fall within the 10% of the most deprived localities in England but also a number of affluent localities in the county. Of 152 upper tier local authorities, Lancashire-12 area is ranked 87, which puts the county in the middle nationally, (57%) however within this data there are significantly district variances. Burnley (ranked 17th), Hyndburn (ranked 28th) and Pendle (ranked 42nd) are in the top 20% most deprived areas in the country. In contrast, Ribble Valley is ranked 290th and falls within the top 20% least deprived area.

The map below illustrates the 'indices of multiple deprivation' across the county, red areas show the most deprived and green the least deprived districts. It is also useful to note that even within the district areas, there is considerable variances within local neighbourhood deprivation.

District	DistrictMapPerc
Ribble Valley	88.96
South Ribble	71.78
Fylde	66.87
Chorley	57.06
Wyre	51.23
West Lancashire	50.31
Lancaster	38.34
Rossendale	30.06
Preston	22.09
Pendle	12.88
Hyndburn	8.59
Blackburn with Darwen	7.36
Burnley	5.21
Blackpool	1.23

***Lancashire JSNA** information,*
Last updated July 2017

Mid-year population information estimates there to be 275,890 individuals aged 0-19, this accounts for 23.2% of the total population in Lancashire-12 area. 19.9% of the total population (237,437) were aged 65+, with 29,805 aged 85+ (2.5%).

The gender split in the Lancashire-12 area, is equal throughout all age groups, until age 65. From age 65 onwards the percentage of females exceeds males for each age group, by the 85+ age group; 65.9% of the population is female. This pattern is representative of the National picture and is assumed to be due to females having a comparatively longer life expectancy.

2.1 What do we know about Adults in Lancashire?

The following information is based on Adult Health and Social Care profiles, which are available via the NHS Public Health profiles and information taken from the LSAB's multi-agency dataset.

2.1.1 Public Health Profiles

The key indicators illustrated in the Health Profiles table includes a key list of health and social indicators and comparisons can be made locally, nationally and over a period of time. Data is RAG rated against the benchmark set by Public Health with a direction of travel compared to the previous time period. The information in the health and social care profiles below is based on the Lancashire-12 area, this will mask local variations across each of the distinct districts.

Red = worse, Amber = similar, Green = better
Benchmark RAG – Lancashire compared with the Public Health England benchmark
Direction of Travel – most recent Lancashire data compared with previous
Most recently available data as of June 2017.

Health Profiles Life expectancy and causes of death		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
1	Life expectancy at birth (males)	79.5	78.1	78.5	78.4	Stable	
2	Life expectancy at birth (females)	83.1	81.8	82.1	82.1	Stable	
3	Suicide Rate - per 100,000 population	10.1	11.3	11.6	11.9	Stable	
4	Smoking related deaths	283.5	342.9	322.3	312.8	Worse	
5	Under 75 mortality rate: cardiovascular – per 100,000 population	74.6	88.5	85.0	85.5	Stable	
6	Under 75 mortality rate: cancer – per 100,000 population	138.8	138.8	143.4	149.7	Better	
7	Excess Winter Deaths - ratio	19.6	20.1	18.8	15.2	Worse	

Data relating to life expectancy at birth in Lancashire shows that figures are stable compared with the previous year, although they have a benchmarked RAG rating of red compared to regional comparator areas. The suicide rate is also relatively stable having dropped marginally (0.3 per 100,000 population) compared to the previous year, again however this indicator is RAG rated red compared to the benchmarked data available via the Public Health profiles.

It is important to remember that such indicators will have district variations, many of which will have correlations with other measures of public health; for example deprivation. The suicide rate is one such example of a Public Health indicator which has district variation, as the table below shows Preston has a much higher rate than the Lancashire average, whilst other districts have a comparably lower rate which evens out the overall Lancashire rate.

DRAFT

Suicide rate 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,429	10.1	10.0	10.3
Lancashire	–	357	11.6	10.4	12.8
Burnley	–	26	11.5	7.5	16.9
Chorley	–	26	8.7	5.7	12.8
Fylde	–	26	11.7	7.6	17.3
Hyndburn	–	28	13.7	9.1	19.8
Lancaster	–	44	12.2	8.8	16.5
Pendle	–	29	12.4	8.3	17.9
Preston	–	58	16.8	12.7	21.8
Ribble Valley	–	17	*	-	-
Rossendale	–	21	*	-	-
South Ribble	–	32	11.3	7.7	15.9
West Lancashire	–	25	8.7	5.5	12.8
Wyre	–	25	9.2	5.9	13.7

Source: Public Health England (based on ONS source data)

Disease and Poor Health		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
8	Hospital stays for self-harm - per 100,000 population	196.5	250.4	235.0	236.1	Stable	
9	Admission episodes for alcohol related conditions - per 100,000 population	647	737	669	681	Stable	
10	Hip fractures in people aged 65 + - per 100,000 population	589	618	564	626	Better	

Public health information relating to disease and poor health shows that hospital stays for self-harm and alcohol related conditions is stable compared to Lancashire's data for the previous year, although is RAG rated red compared to regional neighbours. The number of hip fractures in people aged 65+ has improved with a rate of 564 per 100,000 in 2016/17, compared with 626 in the previous year, this is considered similar to neighbouring benchmarked local authorities.

Adult Social Care People with care and support needs		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
11	Prevalence of dementia, all ages – proportion %	0.76	0.81	0.87	0.86	Stable	
12	Prevalence of learning disabilities – proportion %	0.44	0.46	0.45	No data		

Prevalence of dementia within Lancashire is stable compared to the previous year, with the percentage having increased marginally (by 0.1%).

Compared with the Public Health benchmark, Lancashire is RAG rated red.

Enhancing quality of life for people		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
13	Percentage of people who use services who feel they have control over their daily life	76.6	76.6	77.4	No data		
14	Percentage of people who use services, who reported that they had as much social contact as they would like	45.4	46.1	47.1	No data		

The above indicators provide some insight to the voice of the adult with regards to the proportion of service users who feel they have control over their daily life and the proportion who feel they have sufficient social contact. Unfortunately previous data is not available for these measures. However, Lancashire is benchmarked as similar to neighbouring Local Authorities for these measures and reports marginally higher percentages in both measure than the North West and National averages.

Delaying and reducing the need for care and support		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
15	Total delayed transfers of care per 100,000	12.1	9.4	13.3	12.1	Worse	
16	Delayed transfers of care attributable to adult social care	4.7	2.5	2.0	2.0	Stable	

The total delayed transfers of care per 100,000 in Lancashire has worsened in 2015/16 compared to the previous year. Most recent data (2015/16) reports a rate of 13.3 which is 1.2 higher than the previous time period. 13.3 also means that Lancashire is now higher than the National average and considerably higher than the North West figure. The delayed transfers of care attributable to adult social care are stable at 2.0, this is below the National and regional benchmarks and stable compared to Lancashire's rate in the previous period.

Safeguarding Vulnerable Adults		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
17	Percentage of people who use services who say they feel safe	69.2	70.0	74.5	72.9	Better	
18	Percentage of people who use services who say that those services have made them feel safe and secure	85.4	84.6	88.4	88.9	Stable	
19	Emergency hospital admissions due to falls in people aged 65 or over	2169	2452	1969	2094	Better	
20	Hip fractures in people aged 65 and over	589	618	564	626	Better	
21	Excess winter deaths index (single year, all ages)	27.7	27.3	26.3	13.0	Worse	

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Lancashire's Adult Social Care Outcomes Framework (ASCOF) survey results are consistently above the National and North West figures. The percentage of people who use services and feel safe has risen in 2015/16 compared with the previous year, in 2015/16 74.5% of those asked in Lancashire reporting that they feel safe (compared with 72.9% in 2014/15). 88.4% of Lancashire residents questioned, report that the services that they use have made them feel safe. This percentage is marginally lower (0.5) that the previous year but remains above the National and North West figures. Lancashire's emergency hospital admissions due to falls in people aged 65+ have improved from 2094 to 1969 and are consistently better than the National and North West figures. The number of people aged 65+ with hip fractures has also improved. In contrast, the excess winter deaths index has worsened, from 13.0 to 26.3 in the current period. This figures is marginally better than the National and North West figures but is considerably higher than the previous period for Lancashire.
Source – Public Health England. Child Health Profiles 2017 *Red = worse, Amber = similar, Green = better – as specified by Public Health England* *Benchmark RAG – Lancashire compared with the Public Health England benchmark*

2.1.2 LSAB Multi-agency dataset

The following tables of information are extracted from the LSAB's multi-agency dataset. Significant work has been done on the dataset throughout 2016/17 with a view to making the dataset more representative of numbers of and services for vulnerable adults across Lancashire. The dataset considered by the quality assurance, audit and performance sub-group to the board contains information from various partners and is categorised according to areas of the Care Act. Within the main dataset, further detailed information is collected and considered by the LSAB's quality assurance, audit and performance sub-group however the information below illustrates the general picture across Lancashire for 2016/17.

Empowerment and Proportionality

Deprivation of Liberties (DoLS)	2015/16	2016/17	Comments
DoLS applications received	4649	4256 Reduce	The number of DoLS applications received has reduced by 9.2% from 4649 in 2015/16 to 4256 in 2016/17.
Number of DoLS applications authorised	397	433 Increase	The number of DoLS applications authorised has increased by 9.1% from 397 in 2015/16 to 433 in 2016/17.

In the Q2 performance report to board, information was obtained from the DoLS team in an effort to explain the high backlog of DoLS applications. Information from the DoLS team states that the DoLS regulations specify that if an application for a standard DoLS authorisation is received but the person is discharged, moves or dies prior to the assessment process being completed, the local authority should complete DoLS form 6, officially not granting the Standard authorisation. The DoLS team report that with an estimated 5000+ backlog of applications, there was a very large number of cases where this process should occur. The DoLS team took the decision that it was not a good use of

resources to continue to complete and send out all this paperwork when there is so many high priority cases to deal with.
The DoLS team allocate in line with the Association of Directors of Adults Services (ADASS) prioritisation tool and continue to only be in a position to respond to high priority cases where there is objection to the care arrangements or significant risk to Lancashire County Council (LCC) for alternative reasons.

Partnership and Accountability

The LSAB Quality and Performance sub-group have begun to receive Care Quality Commission (CQC) information on a regular basis. The information received shows CQC rating for all establishments in Lancashire, with North West and National figures included for comparative measures.

CQC Position as of 01/04/2017	**CQC Ratings - All establishments**					
April 2017 Grade	Lancs.	Lancs. %	North West	NW %	England	Eng. %
Outstanding	17	2.3%	96	2.6%	657	2.3%
Good	543	74.2%	2718	74.8%	22332	78.5%
Requires Improvement	160	21.9%	735	20.2%	4975	17.5%
Inadequate	12	1.6%	87	2.4%	484	1.7%
Total	732	100.0%	3636	100.0%	28448	100.0%

As of April 2017 there were a total of 732 establishments in Lancashire that had a CQC rating. At this point in time, 17 (2.3%) were outstanding, 543 (74.2%) were good, 160 (21.9%) required improvement and 12 (1.6%) were inadequate. These figures were generally on a par with North West and National figures, although Lancashire compared with England has a marginally higher proportion of establishments graded as requiring improvement and slightly lower percentage classed as good.

Prevention

Fire	**2015/16**	**2016/17**	**Comments**
Number of accidental dwelling fires	679	615 Better	615 accidental dwelling fires occurred in Lancashire in 2016/17, which is 9.4% lower than 2015/16 when there were 679 accidental dwelling fires.
Number of dwelling fires where no smoke alarm fitted	178	163 Better	In 2016/17 there were 163 dwelling fires in Lancashire where no smoke alarm was fitted. This is 8.4% lower than the previous year.
Fire deaths in accidental dwelling fires	4	2 Better	In 2016/17 there were 2 fire deaths in accidental dwelling fires in Lancashire, both occurring in quarter 4
Number of completed home fire safety checks	11520	8533 Reduce	The number of completed home fire safety checks undertaken by Lancashire Fire & Rescue has reduced by 25.9% from 11520 in 2015/16 to 8533 in 2016/17.
Agency commentary from Lancashire Fire & Rescue – Lancashire Fire & Rescue still conduct home fire safety visits for vulnerable people within the community. This service is accessed via the website or phone line, both methods ask targeted questions which seek to measure			

the vulnerability of the caller, including issues such as do they have an existing fire alarm, do they smoke, and do they live alone. Requests for home fire safety visits are prioritised according to vulnerability and involve a free smoke alarm being fitted and educating the individual on fire safety within the home. Previously fire home safety visits were available for anyone but due to limited resources, requests now need to be prioritised according to vulnerability.

Safeguarding Adult Reviews (SARs) – (These are conducted in response to death or significant harm where abuse and neglect are suspected and multi-agency working has been a concern.	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Number of safeguarding adult reviews referred in		4	4	3	In 2016/17 the LSAB have received 11 referrals for safeguarding adult reviews.
Number of safeguarding adult reviews commissioned		1	2	1	In 2016/17 the LSAB commissioned 4 safeguarding adult reviews. These will report in 2017-18

Protection

Police Potentially Vulnerable Person (PVP) referrals	**15/16**	**16/17**	**diff**	**Comments**
Total PVP referrals – vulnerable adults (VA)	6813	8908	30.7%	The number of PVP referrals for vulnerable adults has risen by 30.7% from 6813 in 2015/16 to 8908 in 2016/17.
High risk PVP referrals – VA	1429	1688	18.1%	The number of high risk PVP referrals for vulnerable adults has risen by 18.1% to 1688 high risk referrals in 2016/17. High risk referrals account for 18.9% of PVP referrals in 2016/17.
Medium risk PVP referrals – VA	2977	4092	37.5%	The number of medium risk PVP referrals for vulnerable adults has risen by 37.5% to 4092 medium risk referrals in 2016/17. Medium risk referrals account for 45.9% of PVP referrals in 2016/17.
Standard risk PVP referrals – VA	2407	3124	29.8%	The number of standard risk PVP referrals for vulnerable adults has risen by 29.8% to 3124 standard risk referrals in 2016/17. Standard risk referrals account for 35.1% of PVP referrals in 2016/17.
PVP referrals flagged for Domestic Abuse	250	276	10.4%	The number of PVP referrals flagged for domestic abuse has risen from 250 to 276 in 2016/17. This is a 10.4% increase.
PVP referrals flagged for Financial Abuse	283	348	18.7%	The number of PVP referrals flagged for financial abuse has risen from 283 to 348 in 2016/17. This is an 18.4% increase.
PVP referrals flagged for Missing from Home	372	513	37.9%	The number of PVP referrals flagged for missing from home has risen from 372 to 513 in 2016/17. This is a 37.9% increase.
PVP referrals flagged for Neglect	582	659	13.2%	The number of PVP referrals flagged for neglect has risen from 582 to 659 in 2016/17. This is a 13.2% increase.

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PVP referrals flagged for Physical Abuse	925	1028	11.1%	The number of PVP referrals flagged for physical abuse has risen from 925 to 1028 in 2016/17. This is an 11.1% increase.
PVP referrals flagged for Sexual Abuse	542	564	40.6%	In 2016/17 there were 564 PVP referrals for vulnerable adults flagged for sexual abuse. This is a percentage increase of 40.6% compared to the previous year.

PVP referrals flagged for 'Vulnerable Adults', are categorized according to risk level (high, medium or standard). PVP referrals are also flagged according to any specific safeguarding concerns, data relating to the number of cases flagged for specific safeguarding concerns is useful to the sub-group since it helps us to identify whether there are specific emerging trends that the board may need to be cited on. PVP information is considered by the sub-group over a time series to help ensure that any seasonal fluctuations or unique increases/decreased in referrals are considered in context.

Multi-agency Risk Assessment Conferences (MARAC) – these take place in respect of high risk domestic abuse cases	**15/16**	**16/17**	**diff**	**Comments**
Total volume of MARAC cases discussed	2179	1563	-28.2%	In 2016/17 there were 1563 MARAC cases discussed. This has reduced by 28.2% compared to the preceding year.
Number of MARAC cases heard that are repeats	635	410	-35.4%	Of the 1563 MARAC cases heard, 410 were repeat cases.
% MARAC cases heard which are repeats	29.1%	26.2%	2.9%	The percentage of MARAC cases heard which are repeats has dropped by 2.9% from 29.1% in 2015/16 to 26.2% in 2016/17.

Annual data (as above) shows a 28.2% reduction in MARAC cases discussed and a 35.4% reduction in repeat MARAC cases heard. The decrease in repeat MARAC cases heard would be expected considering the overall volume of MARAC cases discussed has fallen. This is in the context of an overall increase of 10% in PVPs related to domestic abuse.

Multi-agency Safeguarding Hub referrals (MASH)	**15/16**	**16/17**	**diff**	**Comments**
Total MASH referrals received	8811	10767	1956	In 2016/17, 10767 Adult cases were received by the MASH, this is 22.2% higher than the previous year.

MASH referrals received by source	**15/16**	**16/17 number**	**16/17 %**	**Comments**
Care Quality Commission	No data	271	2.5%	Of the 10767 referrals received by MASH in 2016/17:- - 50.6% were from social care staff - 21.8% were from health staff - 13.0% were classed as 'other'
Education/training/workplace		13	0.1%	
Family member		657	6.1%	
Friend/neighbour		110	1.0%	
Health staff		2345	21.8%	
Housing		123	1.1%	
Other		1402	13.0%	

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Other Service User		5	0.0%	
Police		309	2.9%	
Self-referral		81	0.8%	
Social Care Staff		5451	50.6%	

MASH referrals received by abuse type	**15/16**	**16/17 number**	**16/17 %**	**Comments**
Discriminatory	No data	69	0.5%	The number of abuse types recorded in 2016/17 was 13128, this is because some of the referrals made to MASH will have referenced more than one abuse type. Of the 13128 abuse types recorded by MASH in 2016/17:- - 37.7% were neglects and acts of omission - 29.9% were physical abuse - 13.7% were emotional/psychological abuse - 10.4% were financial and material abuse
Domestic Abuse		150	1.1%	
Emotional/psychological		1796	13.7%	
Financial and material		1363	10.4%	
Modern slavery		8	0.1%	
Neglects and acts of omission		4951	37.7%	
Organisational		327	2.5%	
Physical		3921	29.9%	
Self-neglect		107	0.8%	
Sexual (incl. sexual exploitation)		436	3.3%	

The way in which MASH information is provided to the sub-group changed part way through 2016/17. Information above shows MASH referrals by source and by abuse type, this data was provided to the sub-group for the 2016/17 year only, which limits the ability to compare the data over time as there is no data available for 2015/16.

The LSAB Quality and Performance Sub group have now receive monthly information from Business Intelligence which indicates the number of cases in the MASH backlog on a monthly basis. This data is based on the number of cases in the MASH work trays at the beginning of each new month and also provides the group with an indication of the priority and level of complexity of the cases waiting to be actioned. It is important to note that the cases in the 'MASH backlog' will have already been through initial prioritisation in order to ensure that any urgent cases are dealt with in a timely manner, Adult Social Care have also sought additional resources to assist in clearing the back log of cases from the MASH service. Because this information has only recently been brought to the sub-group and is based on data at a 'snapshot in time', data for 2016/17 is not available, however the group are now reviewing this information on a quarterly basis and will ensure that the MASH backlog statistics are shared with board.

Referrals to the LCC Adult Care Safeguarding Enquiry Team	**15/16**	**16/17**	**diff**	**Comments**
Number of referrals opened in the reporting period	9842	11533	1691	In 2016/17, 11533 referrals were opened to the safeguarding enquiry team, this is an increase of 17.2% compared to the previous year.
Number of repeat referrals opened in the reporting period	No data	4184	N/A	Of the 11533 referrals opened in 2016/17, 4184 were repeat referrals in the reporting period, which equates to 36% of referrals in the year being repeats.
Percentage of all safeguarding enquiries which are repeat referrals	No data	36%	N/A	
Individuals for whom a referral was opened in the reporting period	8709	10361	1652	10361 individuals had referrals opened for them in 2016/17, this is an 18.9% increase on the previous year. The increase in the number of individuals is on a par with the overall increase in referrals opened.

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Number of referrals proceeding to an assessment	4027	4579	552	In 2016/17 4579 referrals proceeded to an assessment, this is 13.7% higher than the previous year. However, this increase is purely due to the overall increase in assessments, as illustrated by the fact that the percentage of referrals proceeding to assessment has marginally fallen by 2.0%.
Percentage of referrals proceeding to an assessment	46.2%	44.2%	2.0%	
The LSAB also receive referral information from the Safeguarding Enquiry Team which breaks down referral information by age, gender, district, referral source and outcome. This information is presented to the LSAB quality assurance, audit and performance sub-group and shared with LSAB board as appropriate.				

2.1.3 Summary

The information within this data supplement provides Lancashire's local background and context and specific data relating to the Health and Social Care needs of vulnerable adults within Lancashire. The contextual information evidences the fact that Lancashire is a large and diverse county with an increasingly ageing population, these factors will undoubtedly put pressure on those organisations who provide a service to those individuals within Lancashire who have care and support needs.

The Public Health data presented illustrates that Lancashire does have significant challenges compared to the local authorities that we are benchmarked against, with many indicators showing Lancashire to be RAG rated red. However, when Lancashire's current data is considered against the previous timeframe, the direction of travel is often stable and for some indicators improving. Public Health information suggests that Lancashire does have hurdles to overcome specifically in relation to smoking related deaths, suicide rate and hospital admissions for self-harm and alcohol. It is however pleasing to note that the proportion of adults who uses services and feel safe continues to increase and remains above the North West and National averages.

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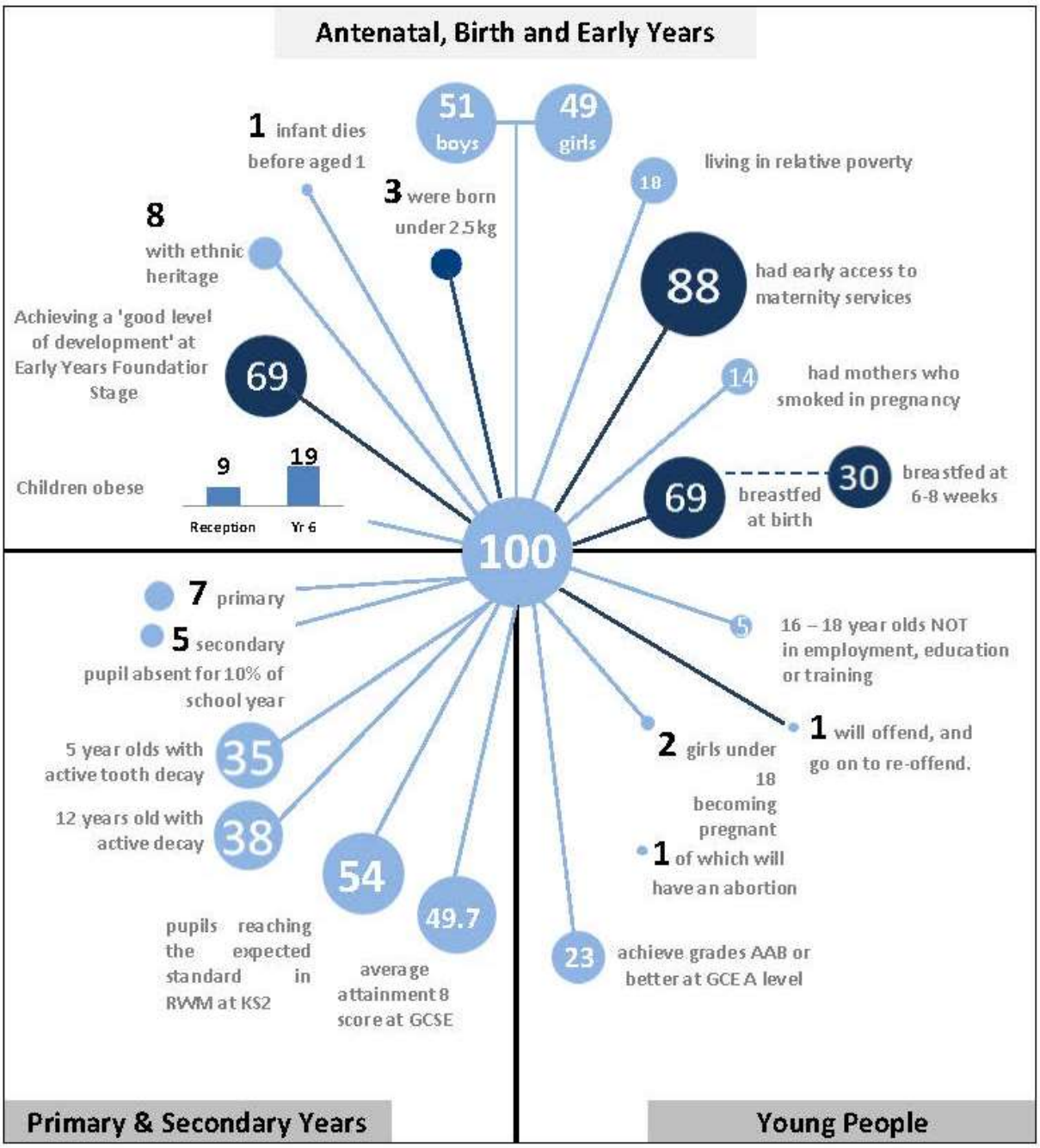
2.2 What do we know about Children in Lancashire?

Lancashire has a child population of approximately a quarter of a million (245,516 – 2015 mid-year estimate), this has increased by 0.3% compared to the mid-year estimate for the previous year (244,755 – 2014 mid-year estimate for population aged 0-18). According to the 2015 mid-year estimates 20.6% of the population were children.

The following diagram, provided by LCC Business Intelligence, illustrates the diverse range of needs and demographics factors for children within Lancashire.

If Lancashire were a village of 100 children…



What do we know about the health and well-being of Children in Lancashire?

The following information is based primarily on the Child Health Profiles (Public Health England) these provide a snapshot of child health and wellbeing for each local authority in England. By using a list of key health indicators, comparisons can be made locally, nationally and over time. Below figures are provided for the Lanacshire-12 area, with North West and National comparator data provided as a point of reference. The data is RAG rated according to the benchmarked information provided by Public Health England, with direction of travel stated based on the change in the data compared to the previous time period. It is important when considering the information presented in the table below that Lancashire is a large area with 12 distinct and diverse districts. Different areas of the county have a different demographic composition and unique local issues to contend with, such aspects should be born in mind when considering the child health profiles for the Lancashire-12 area.

Red = worse, Amber = similar, Green = better
Benchmark RAG – Lancashire compared with the Public Health England benchmark
Direction of Travel – most recent Lancashire data compared with previous
Most recently available data as of June 2017.

Child Health Profiles		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
Premature mortality							
1	Infant mortality (Rate per 1,000 live births)	3.9	4.2	4.6	4.8	Stable	
2	Child mortality rate (per 100,000 1-17 year olds)	11.9	14.0	16.8	15.9	Worse	
Wider determinants of ill health							
3	Percentage of children achieving a good level of development at the end of reception	69.3%	66.7	69.2%	67.5%	Better	
4	Percentage of 16-18 year olds not in education, training or employment	4.2%	4.8%	4.8%	5.0%	Better	
5	First Time Entrants to the youth justice system (rate per 100,000 of 10-17 population)	368.6	336.1	306.0	368.8	Better	
6	% of children in low income families (under 16 years)	20.1	22.8	19.1	16.9	Worse	
7	Family homelessness (per 1000 households)	1.9	0.7	0.3	0.3	Stable	
8	Children in care (rate per 10,000 of under 18's)	60	82	68	66	Worse	

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Health Improvement							
9	Percentage of 4-5 year olds classed as obese	9.3	9.8	9.3	9.4	Stable	
10	Percentage of 10-11 year olds classed as obese	19.8	20.6	18.9	18.4	Worse	
11	Percentage of children (aged 5) with decayed, missing or filled teeth	24.8	33.4	32.0	34.9	Stable	
12	Hospital Admissions due to alcohol specific conditions (rate per 100,000 under 18 year olds)	36.6	53.5	56.0	62.7	Better	
13	Hospital Admissions due to substance misuse (rate per 100,000 15-24 year olds	95.4	139.6	137.6	132.6	Worse	
Prevalence of ill health							
14	Accident and Emergency attendances for children aged 0-4 (rate per 1000)	587.9	699.1	564.0	526.7	Worse	
15	Hospital admissions caused by injuries in children aged 0-14 years (rate per 10,000)	104.2	139.2	148.6	151.1	Stable	
16	Hospital admissions for asthma (under 19 years, rate per 100,000)	202.4	317.2	342.2	379.8	Stable	
17	Hospital admissions for mental health conditions (rate per 100,000)	85.9	111.6	120.6	114.8	Worse	
18	Hospital admissions as a result of self-harm (10-24 years, rate per 100,000)	430.5	520.5	549.8	504.3	Worse	

Source – Public Health England. Child Health Profiles 2017

Lancashire performance is worse than the benchmark in respect of premature mortality and hospitals admissions for a variety of reasons including asthma, alcohol, drugs, mental health and self-harm. In contrast Lancashire is performing better than the benchmarked average for A&E attendance for 0-4 year olds, first time entrants to the youth justice system, homelessness, low income families and obesity in 10-11 year olds.

In terms of Lancashire's current performance compared to the previous time period, improvements have been made with regards to child development at the end of reception, percentage of 16-18 year olds not in education, training or employment and hospital admissions due to alcohol. This improvement on the previous period is important to note since compared purely to the benchmarked RAG rating Lancashire's position for these areas remains stable or has worsened.

In summary the information contained within the table above suggests that challenges still exist for Lancashire in relation to:

1. Premature Mortality (infant and child)
2. Self-Harm and Mental Health
3. Hospital admissions due to substance misuse

It is of concern that that these areas of challenge are consistent with those highlighted in last year's Annual Report without insufficient evidence of progress.

2.2.1 Safeguarding and supporting children in specific conditions

The information contained within the following table provides annual data for some of our main performance indicators relating to supporting children with specific needs.

Indicator	2014/15	2015/16	2016/17	Comments
Number of Police Vulnerable Child (PVC)referrals with a Child Sexual Exploitation (CSE) marker	975	1220	1190	The number of vulnerable children referred to the Police with a CSE marker has reduced marginally (2.5%) compared to the previous year. In 2016/17 there were 1190 compared with 1220 in 2015/16.
Number of Domestic Violence notifications from Police where a child is recorded to live at the address	9354	8644	10258	In 2016/17 there were 10258 Domestic Violence notifications from the Police where a children was recorded to be living at the address, this is 18.7% higher than the previous year and reverses the reducing trend that had been seen over the past 2 years.
The rate of violent and sexual offences against children aged 0-17 per 10,000 of U18 population	130.9	160.6	169.7	There is a continued increase in the rate of violent/sexual offences against children. The rate in 2016/17 is 169.7 (per 10,000 of the under 18 population, this is an increase of 9.1 compared to the previous year). The rate has increased by 51.6 since 2013/14 (2013/14 rate – 118.1)
Of those cases discussed at MARAC, the number of children in the household	2456	2519	2566	The number of children in the household for MARAC cases discussed has risen by 1.9% from 2519 in 2015/16 to 2566 in 2016/17.
Privately fostered children	28	26	26	The number of Lancashire children identified as privately fostered has remained stable. Quarterly figures available throughout the year show slight changes in numbers but no definite increasing/decreasing pattern.
CLA placed in Lancashire from other LA (at year end)	981	986	970	A slight decrease in this figure, although numbers remain relatively stable with monthly fluctuations evident throughout the year. A high proportion of those looked after from out of area originate from neighbouring local authorities
Local Authority Designated Officer Allegations/ Investigations against professionals	491	496	547	The number of referrals referred to the Local Authority Designated Officer (LADO) have increased by 10.3%. There were 547 referrals to the LADO in 2016/17 compared to 496 in the previous year.
Independent Reviewing Officer Caseloads	109	92	75	The recommended National caseload for IRO's is 50-70 (IRO Handbook). 2016/17 saw a notable decrease in IRO Caseloads

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Indicator	2014/15	2015/16	2016/17	Comments
				within Lancashire with an average at year end of 75 compared to 92 at the same point in the previous year. This is a percentage reduction of 18.5%.

Children Missing from Home/Care/Education

	2015/16				2016/17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Missing from home	503	514	522	527	411	425	365	362
% of children reported missing who were looked after by the local authority	17.6%	23.1%	24.3%	16.8%	21.8%	20.6%	20.8%	20.9%
Number of children confirmed as missing from education (not on school roll or receiving alternative provision)	41	44	62	75	62	64	59	88

The number of missing from home episodes has fallen 24.3%, from 2066 in 2015/16 to 1563 in 2016/17. Throughout 2016/17, 20-21% of those children reported missing were looked after children. LCC Business Intelligence report that system and procedure change has occurred along with who is now responsible for recording the missing episode on Liquidlogic Children's System (LCS). This is now the responsibility of admin. Missing episodes are now being accurately captured on the system and duplicate missing episodes have ceased to be recorded on LCS. In the past there would often be multiple missing episodes recorded on the same child for the same day. Indeed some of these would be multiple episodes but often would merely be a duplication of entry.

Information from the children missing from education team confirms that there were 273 children missing from education in 2016/17, this is 22.4% higher than the previous year. This increase is partly due to improved reporting and recording.

Referrals to Children's Social Care

Referrals to Children's Social Care refers to the number of referrals which are accepted by Children's Social Care. In 2016/17, the number of referrals accepted by Children's Social Care has fallen by 18.5% in 2016/17 compared to the previous year, this translates to a rate of 412.5 for 10,000 child population in Lancashire.

It is important to note that the calculation in respect of the number of referrals changed from April 2014. Only referrals that progress to an assessment are now counted, which brings Lancashire's statistics in line with other local authorities in the North West region.

	2013/14	2014/15	2015/16	2016/17
Lancashire (number)	19460	12394	12156	9907
Lancashire (rate per 10,000 child population)	799.2	506.4	495.1	412.5

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Data for the last 2 years shows the referrals to Children's Social Care are on a downward trajectory, but with monthly fluctuations and considerably difference in numbers and rate across the different districts in Lancashire.

Repeat Referrals

The table below shows the percentage of referrals that were repeat referrals to Children's Social Care. A repeat referral is one which is received within 12 months of initial referral. The repeat referrals rate in 2016/17 is 19.1% which is 3.4% higher than the previous year.

	2013/14	2014/15	2015/16	2016/17
% Re-referrals	15.1%	15.7%	15.7%	19.1%

Monthly data for this indicator shows the percentage of repeat referrals on an upwards trajectory through2016/17, however with considerable monthly peaks and troughs in the data. The fact that there are fewer referrals accepted by Children's Social Care overall and a greater percentage of those received are re-referrals implies that the number of new children and young people that Children's Social Care are working with is falling.

Percentage of assessments completed to timescale

	2013/14	2014/15	2015/16	2016/17
Lancashire	96.1%	79.8%	73.2%	75.0%
North West	85.1%	82.2%	83.3%	tbc
England	82.2%	81.5%	83.4%	tbc

75.0% of Lancashire's single assessments were completed within timescales (45 working day target). This has increased by 1.8% compared to the previous year. Although North West and England averages for 2016/17 are not yet available, comparison with the previous year benchmarks indicate that Lancashire's assessment completion percentages remain below the regional and national figures. It is promising to see that the percentage has increased on the previous year and important to consider this information alongside the referral rates and high social worker workloads.

Children in Need (per 10,000 of the child population)

Children in Need	2013/14	2014/15	2015/16	2016/17
Lancashire (number)	9,034	8,534	9,316	8,377
Lancashire (rate per 10K)	371.5	348.7	380.1	342.3
England	346.4	337.3	337.7	tbc

The number of children in need has fallen by 10.1% compared to the previous year, with 8377 children in Lancashire classed as Children in Need. This reducing number in turn lowers the rate per 10,000 of the child population from 380.1 in 2015/16 to 342.4 in 2016.17. The National rate is not yet available, however based on the previous year's rate, Lancashire are just above the National

Average. The rate is now much closer in line with the 2014/15 data, which may suggest that the increase in the previous year occurred in part at least in response to the concerns raised by an inadequate Ofsted inspection.

Children subject to a Child Protection Plan (per 10,000 of the child population)

Children subject to a Child Protection Plan							
Area	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Lancashire rate	27	23	36	44.4	38.9	59.0	57.0
England Rate	39	38	38	40	42.1	42.9	Tbc

Last year, a significant increase in the number of children subject to a Child Protection Plan was reported (from 38.9 in 2014/15 to 59.0 in 2015/16). In 2016/17 the rate dropped marginally from 59.0 to 57.0. Although there has been a reduction in 2016/17 the annual rate is likely to still be well above the national average (based on the most recently available national rate). Monthly data as monitored by the performance sub-group to the board indicates that although the overall trajectory continues upwards, since October 2016 the rate of children subject to a child protection plan has begun to fall consistently. If this trend continues in to 2017/18, it is likely that the child protection plan rate will continue to fall.

The significant increase reported last year was considered to have occurred due to the Local Authorities response to the concerns raise in the Ofsted Inspection, with a significant number of cases being escalated to Child Protection Plans. It is important that assessments and interventions result in the right children receiving the correct level of service based on their needs, however the board recognises that high numbers of children on child protection plans has contributed to high social worker caseloads and puts pressure on other agencies who are involved in meeting the needs of the children on child protection plans.

The reason for a child being subject to a Child Protection Plan is categorized by need and recorded under the following headings: Neglect; Physical Abuse, Sexual Abuse, Emotional Abuse or Multiple Categories (data as below).

Child Protection Plans by Abuse Type

Lancashire Percentage	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple Categories
2014	40%	11.9%	4.1%	34.6%	9.3%
2015	34%	6.1%	2.5%	48.8%	8.8%
2016	33.8%	6.9%	4.9%	50.3%	4.1%
2017	32.4%	4.2%	6.0%	48.6%	8.8%

Most recently available data (March 2017) shows an increase in the percentage of child protection plans whereby the need related to 'sexual abuse' or 'multiple categories'. Multiple categories is hard to analyze since we cannot know what types of abuse this category are experiencing. It would also

be interesting to know whether there is a pattern to the types of abuse categories which most commonly occur together. It is interesting that the percentage of child protection plans for sexual abuse has increased, this may be as a result of improved recording or greater propensity of children and young people to report sexual abuse; perhaps indicating an increase in public awareness of sexual abuse.

In last year's Annual Report attention was drawn to the fact that the number of children supported due to sexual abuse was 'concerningly low' (2015 – 2.5%). Work was undertaken to try to ascertain whether this low number was indicative of the fact that nationally intra-familial sexual abuse often goes unrecognized. Unfortunately there isn't sufficient data to be able to know the proportion of children on child protection plans specifically due to intra-familial sexual abuse; the sexual abuse data isn't broken down to that level of detail. The rate in respect of sexual abuse remains, however, well below what would be expected given national prevalence statistics based on self-reporting by adults.

Child Protection Plans Lasting Two Years or More

This measure provides an indication of whether children or young people and their families are receiving the services necessary to bring about the required changes on a timely basis. This is based on the fact that a long period on a Child Protection Plan may indicate a lack of targeted support and potential drift in the case. In 2015/16 the figure had risen to 3.7%, in 2016/17 this has fallen to 2.9%. This is now lower than the most recently available national rate of 3.7%.

Area	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Lancashire rate	4.8%	4.4%	2.4%	1.2%	3.0%	3.7%	2.9%
England Rate	6.0%	6.0%	5.2%	3.5%	2.6%	3.7%	tbc

Children Looked After (CLA)

At 2016/17 year end Lancashire had responsibility for 1864 1691 Lancashire looked after children, this equates to a rate of 76.2 per 10,000. This a 10.2% increase in the number of looked after children at the end of the previous year (2015/16 – 1691 Lancashire looked after children). Assuming that the regional and national averages don't alter drastically from previous years (current benchmarks not yet available), Lancashire's CLA rate remains above the national average but below the North West average, despite the 10.2% increase. It will be interesting to see whether the rate of increase demonstrated within Lancashire over the last 5 years continues and whether the regional and national benchmarks experience a similar percentage increase when their rates are updated.

Rate of CLA	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Lancashire rate	53	54	60.9	66.3	67.2	69.1	76.2
North West Rate	77	76	79	78	81	82	tbc
England Rate	59	59	60	60	60	60	tbc

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In addition approximately a thousand children who are looked after by other local authorities placed in Lancashire, residing in Private/Independent Children's Homes or with foster carers. As stated in data above, the number of looked after children from out of area fluctuates on a monthly basis. Confidence in the accuracy of these figures has improved throughout 2016/17, however there is some concern that there is still scope for improvement with regards to timeliness of notifications being received. This is an area that the quality and performance sub-group intend to consider via focus group activity.

Social Worker Caseloads

The following table shows the average social worker caseloads within Children's Social Care by month and level of social worker experience. The colour coding is provided for the Ofsted Improvement Board. The information within the table and as graphed below illustrates that social worker caseloads have fallen for all experience levels over the last year.

Experience	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
NQSW	22.3	20.8	19.1	18.6	16.1	17.8	18.6	16.9	16.2	17.7	15.8	17.3
1-2 years	25.7	26.5	23.3	22.3	21.7	22.1	21.1	20	19.5	19.3	18	19.7
2-3 years	25.5	27.6	24.9	24.5	19.5	21.8	19.8	17.9	19.5	18.8	19.6	20.1
3-5 years	28.6	27.7	24.2	25.5	22.5	21.9	21	20.1	19.2	18.6	17.6	19.9
5 years +	27	28.1	27.4	26.8	22.8	25.4	20.4	23.4	22.1	19.6	21.3	24.3
Grand Total	**25**	**24.7**	**22.5**	**22.1**	**19.4**	**20.5**	**19.6**	**18.8**	**18.2**	**18.4**	**17.4**	**19.1**

Early Help

The Common Assessment Framework (CAF) is an assessment and early help framework for children and families in need of help.

During 2016/17 a total of 5,115 CAF assessments were completed, this is an increase of 22.2% on the previous year when 4,185 completed in 2015/16. The number of CAFs open at the end of each quarter (including SEN) in 2016/17 ranged from 8,000 to 9,300. In 2015/16, the highest number of CAFs open occurred in the final quarter of year when 8,293 CAFs were open. By quarter 4 of 2016/17, the number of CAFs open at the period end had risen to 9,285; this is 11.9% higher than the same point in the previous year.

2016-17 data indicates that the percentage of CAFs closed each quarter for 'needs met' fluctuates between 57%-64%, with 11%-18% of CAFs closing because the case requires escalation to statutory assessment. There has been significant work undertaken this year to encourage agencies to complete a CAF. The importance of the CAF assessment will increase since a greater proportion of services delivered by the wellbeing, prevention and early help service are targeted support, which by its nature requires an assessment of need prior to the service being able to complete any work with a child or young person.

Early Help	2015/16				2016/17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of CAFs initiated in the period	1131	986	1038	1030	1071	970	1470	1604
Number of CAFs open (including SEN) at period end	7781	8059	8272	8293	8510	8041	9253	9285

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% of CAFs closed in period due to 'needs met'	65%	69%	65%	65%	57%	64%	60%	64%
% of CAFs closed in period due to escalation to statutory assessment	13%	17%	16%	17%	18%	16%	11%	12%

Police Data – Protecting Vulnerable Persons - Child (PVP - VC) referrals

	15/16	16/17	diff	Comments
Total PVP referrals – vulnerable children (VC)	8067	8738	8.3%	The number of PVP referrals for vulnerable children has risen by 8.3% from 8067 in 2015/16 to 8738 in 2016/17.
High risk PVP referrals – VC	3391	3535	4.2%	The number of high risk PVP referrals for vulnerable children has risen by 4.2% to 3535 high risk referrals in 2016/17. High risk referrals account for 40.5% of PVP referrals for vulnerable children in 2016/17.
Medium risk PVP referrals – VC	3804	4139	8.8%	The number of medium risk PVP referrals for vulnerable children has risen by 8.8% to 4139 medium risk referrals in 2016/17. Medium risk referrals account for 47.4% of PVP referrals for vulnerable children in 2016/17.
Standard risk PVP referrals – VC	872	1064	22.0%	The number of standard risk PVP referrals for vulnerable children has risen by 22.0% to 1064 standard risk referrals in 2016/17. Standard risk referrals account for 12.6% of PVP referrals for vulnerable children in 2016/17.
PVP referrals flagged for Child Sexual Exploitation	1220	1190	-2.5%	The number of PVP referrals flagged for Child Sexual Exploitation have fallen by 2.5% from 1220 to 1190.
PVP referrals flagged for Domestic Abuse	409	462	13.0%	The number of PVP referrals flagged for domestic abuse have risen by 13.0% from 409 to 462.
PVP referrals flagged for so called Honour Based Abuse	18	28	55.6%	The number of PVP referrals flagged for so called honour based abuse rose by 55.6% from 18 to 28. The percentage increase should be considered with caution, comparatively low numbers compared to other referral flags mentioned above mean that the percentage swing is greater.
PVP referrals flagged for Missing from Home	945	1059	12.1%	In 2016/17 there were 1059 PVP referrals for vulnerable children flagged due to 'missing from home'. This is a 12.1% increase compared to the previous year.

ePVP referrals are flagged according to any specific safeguarding concerns, data relating to the number of cases flagged for specific safeguarding concerns is useful to the sub-group since it helps us to identify whether there are specific emerging trends that the board may need to be cited on. PVP information is considered by the sub-group over a time series to help ensure that any seasonal fluctuations or unique increases/decreased in referrals are considered in context.

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The cases flagged for specific vulnerabilities pose an interesting question when considered by the sub-group. It is always difficult for agencies to be able to ascertain whether an increase in cases reported for safeguarding concerns such as domestic abuse and CSE represent an actual increase in the number of cases, or whether greater public awareness has had an effect on public confidence and willingness to report such issues to the Police.

2.2.2 Summary

While these figures demonstrate the totals for Lancashire, it is crucially important to bear in mind the notable district and local area variations that exists across Lancashire. It is an ongoing challenge for all agencies within Lancashire to ensure that the services which are provided for children and young people are equitable but also meet the needs of specific areas of the county. It is for this reason that the LSCB quality and performance sub-group have invested time in sourcing and reporting on data not just at Lancashire level, but also at district level; to ensure that the board are aware of local variations and thus the impact that these may have on services.

The LSCB's performance scorecard is continually reviewed to ensure that the information presented to the board is relevant and representative of the Lancashire demographic and of the agencies that serve our Children and Young People. There are an ongoing challenges in receiving regular, accurate and timely performance data from all partner agencies on a countywide basis and ensuring that the information that is presented to board is of use and relates back to the safeguarding agenda.

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3. What do we know about services in Lancashire and their effectiveness?

3.1 Member agencies

The Boards request submission of information about the quality of safeguarding in its member agencies either via external inspection activity or through direct annual feedback. The feedback reports embedded below have been presented to the Board to reflect the work undertaken by the agencies during 2016-17.

Lancashire County Council provides support for vulnerable adults, children and their families through direct services from: Adults Social Care; Adults Disability Service; Domiciliary Care; Older People Services (residential and day care); Public Health services; Children's Social Care; Wellbeing, Prevention and Early Help Services; Schools and specific support for children involved in the criminal justice system via the Youth Offending Team (YOT).

The Local Authority has strong representation on LSAB and LSCB and its sub groups, with regular attendance. Two of the LSAB sub groups are chaired by LCC Board members: Practice with Providers; and Safeguarding Adults Leadership Group.

	Adults Safeguarding	Children's Services	Wellbeing, Prevention and Early Help
2016/17 Feedback Reports:	LCC Adults.pdf	LCC - Children's Services.pdf	WPEH.pdf

Lancashire Constabulary covers the former county area which now includes Lancashire County Council, Blackburn with Darwen and Blackpool. It delivers its services through three divisions (East, West and South). It provides direct policing across the county and is fully engaged in partnership safeguarding services as part of the Child Sexual Exploitation teams, Multi-agency Safeguarding Hub, Multi-Agency Risk Assessment Conferences and Multi-agency Public Protection Arrangements. Increasingly the force has been moving its focus towards early action and preventative policing.

Lancashire Constabulary is represented on the LSAB and LSCB and its sub groups, with a representative chairing the Lancashire CSE Operational Group during 2016/17.

2016/17 Feedback Report:	Lancs Constabulary.pdf

Six **Clinical Commissioning Groups** (CCGs) operate across Lancashire and are responsible for commissioning most hospital and community healthcare services. From April 2015 co-commissioning arrangements were brought in which involves CCGs in the commissioning of primary care services. The 6 CCGs in Lancashire are:

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- Fylde and Wyre CCG
- Lancashire North CCG (Morecambe Bay CCG as of 1 April 2017)
- East Lancashire GGG
- Chorley and South Ribble CCG
- Greater Preston CCG
- West Lancashire CCG

All CCGs are well represented on both Boards, attending regularly. A number of our sub groups are Chaired by CCG representatives: LSAB/LSCB Learning and Development Groups; Safeguarding Adult Review (SAR)/ Serious Case Review (SCR) Groups; Mental Capacity Act (MCA) Implementation Sub Group; Safeguarding Adults Leadership Group; and Practice with Provider Sub Group.

2016/17 Feedback Report:	Collective CCG Response.pdf

Seven **NHS Hospital Trusts** provide a range of community and acute services for children and vulnerable adults. The NHS hospital trusts that serve the Lancashire area as follows:

- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospital Trust
- Lancashire Care NHS Foundation Trust
- Lancashire Teaching Hospitals Foundation Trust
- Mersey Care NHS Foundation Trust (Whalley)
- Southport and Ormskirk Hospital Trust
- University Hospital Morecambe Bay NHS Foundation Trust

With the exception of Mersey Care, all Trusts are represented on the LSCB and attend on a regular basis. The representative for East Lancashire Hospital Trust is the Chair of the LSCB QAPI Sub Group. Lancashire Care Foundation Trust; Lancashire Teaching Hospitals; and Mersey Care are all represented on the LSAB.

2016/17 Feedback Reports:		
Blackpool Teaching Hospital BTH.pdf	East Lancs Teaching Hospital ELHT.pdf	Lancs Care Foundation Trust LCFT.pdf
Lancs Teaching Hospital Lancashire THT.pdf	Mersey Care Foundation Trust Merseycare.pdf	Southport and Omrskirk Hospital SOHT.pdf

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Lancashire Probation Trust (now: HM Prison and Probation Service) – The specific duties of the National Probation Service (NPS) are: to provide advice to Courts and deliver pre-sentence assessments; management of all high risk of serious harm offenders; management of all offenders sentenced to 12 months or more for a serious sexual or violent offence; and the management of all offenders who are subject to statutory supervision and are registered sex offenders.

Public protection, including safeguarding children and vulnerable adults is a key priority and thorough and robust safeguarding arrangements are in place. The service work closely with other agencies and make necessary checks and referrals at pre-sentence stage and throughout our period of contact. In Lancashire the service currently supervises around 3,440 cases, predominantly violent and sexual offenders with a high number of domestic violent offenders.

The Probation service is represented on both the LSAB and LSCB, attending regularly and engaging in work of the sub groups and task and finish approaches.

2016/17 Feedback Report:	NPS.pdf

Cumbria and Lancashire Community Rehabilitation Company (CLCRC) delivers offender management and rehabilitation services to offenders assessed as presenting a low and medium risk of serious harm. These could be serving community sentences or be sentenced to custody in which case CLCRC will be involved in their rehabilitation both inside prison and in supervising the post release licence. CLCRC delivers a range of programmes to help rehabilitate offenders by providing access to learning new skills, changing and challenging offenders thought processes and managing risky behaviour. In particular, and central to safeguarding, CLCRC delivers 2 specific domestic abuse programmes in addition to modules to address emotional resilience, conflict resolution and stress resilience.

CLCRC is represented on both the LSAB and LSCB with regular attendance and engagement with various workstreams.

2016/17 Feedback Report:	CRC Cumbria & Lancashire.pdf

Children and Family Court Advisory and Support Service (Cafcass) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and families.

Cafcass is represented on the LSCB, attending on a regular basis.

2016/17 Feedback Report:	- CAFCASS.pdf

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The Children's Society is a charity organisation which provides support and services for 10 to 18 year olds who are especially vulnerable and often experiencing severe and multiple disadvantage.

The charity is represented on the LSCB, providing a voice and perspective for the Voluntary Sector. Representatives are heavily involved with the work of our sub groups, particularly Child Sexual Exploitation (CSE).

2016/17 Feedback Report:	The Children's Society.pdf

Lancashire Fire and Rescue Service (LFRS) delivers Prevention, Protection and Response functions across the county of Lancashire, employing staff in a variety of roles operating from 39 operational bases. The service works extensively with partner organisations to allow for a more efficient and effective delivery in order to keep the residents of Lancashire safe.

LFRS joined the membership of both Boards during the reporting year, attending regularly and engaging with various pieces of work.

2016/17 Feedback Report:	Lancashire Fire & Rescue.pdf

There are 12 **District Councils** providing services across the county. All 12 have a nominated safeguarding lead and ensure staff are appropriately trained in respect of safeguarding issues.

Engagement with the Districts has improved over the reporting year, with successful challenge panels taking place with regard to the annual safeguarding audits, and regular attendance of the Business Manager at Districts Leads Safeguarding Groups.

The District Councils have historically been represented by one Chief Executive on the LSCB, and has more recently been added to the membership of the LSAB. The current representative is the Chief Executive for Wyre Council, who provides feedback to the other Districts via the Chief Executives Group.

Two District Councils have shared their achievements and challenges from the reporting year.

	Wyre Council	Burnley Council	Burnley Council (Prevent)
2016/17 Feedback Report:	Wyre BC.pdf	Burnley Council.pdf	Burnley Council (Prevent).pdf

Schools – There are over 600 mainstream schools (including 29 special schools and 9 short stay schools) of which currently 8 have been judged to be inadequate. There are also a significant

number of schools and organisations providing education outside the public sector. The LSCB is notified if a school is judge to be inadequate in respect of safeguarding when inspected by Ofsted and liaises with the local authority to ensure appropriate steps are taken. Provisional data provided by Ofsted suggests 94.5% of Primary Schools and 77.1% of Secondary Schools were rated as Good or Outstanding as at April 2017.

Education providers are represented on the LSCB via a Primary School Head teacher; Secondary School Head teacher; Lancashire Association of School Governors; and a representative from Further Education. The Secondary representative stepped down at the end of March 2017 and the LSCB are currently seeking a replacement.

Our Further Education representative is from Burnley College and has provided a feedback report for 2016/17:

Burnley College (FE).pdf

Healthwatch Lancashire is the public voice for health and social care in Lancashire and exists to make services work for the people who use them.

The Chief Executive represents the organisation on the LSAB and Chairs the LSAB QAPI Sub Group.

2016/17 Feedback Report:	Healthwatch.pdf

Lancashire Care Association (LCA) is a not-for-profit company representing independent care sector providers (private and third sector; larger groups and small independents; adults and older people care homes and domiciliary care.) LCA supports providers in ensuring the provision of safe services; quality, performance and inspection monitoring; and partnership working through the Health and Social Care Partnership.

The LCA is represented on the LSAB and a number of its sub groups and task and finish groups to offer a 'provider' voice in safeguarding arrangements.

2016/17 Feedback Report:	LCA & HSCP.pdf

North West Ambulance Service (NWAS) provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in Cumbria and Lancashire; Cheshire and Merseyside; and Greater Manchester. Employing over 4,900 staff across the North West region, the service provides emergency response; transport for patients attending

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hospital appointments; and deals with major incidents. NWAS also delivers the NHS 111 service in the North West.

NWAS are currently compiling an annual report for thee geographical footprint which will be shared with the 46 LSABs and LSCBs in the area on completion.

Private/Independent Sector Providers – There is a wide range of community support services available cross Lancashire, including drug and alcohol services, sexual health services and domestic abuse services.

Housing providers – the area is supported by a wide range of private providers, Registered Social Landlords (RSLs), hospices and hostels, sheltered housing provision and local authority housing provide accommodation across the County. Progress Housing represent the sector on the LSAB.

There are over **100 children's homes** in the County with a high percentage of private providers. Many of the children placed are out of area placements. The LSCB receives notification of any provider that is judged to be inadequate by Ofsted with regard to safeguarding.

681 **child minders** provide day care across the County along with, 327 day nurseries and 129 pre-school play groups. As at the end of June 2017, there were no Inadequate Child Minders or Children's Homes.

The Board itself exercises challenge and scrutiny of agencies using a number of mechanisms for assessing the quality of local services and agencies commitment to safeguarding. These include:

3.2 Section 11 Audit Process:

Section 11 of the Children Act 2004 sets out agencies responsibilities in respect of safeguarding children and the LSCB conducts an annual audit of all member agencies safeguarding arrangements. The section 11 audit tool has been updated in recent years to encourage agencies to consider their safeguarding arrangements specifically in relation to training for counter terrorism and child sexual exploitation, and to demonstrate how they respond to learning raised through Serious Case Reviews.

Once completed, the audit tool provides the board with assurance that all agencies have the necessary arrangements in place to safeguard children effectively. Compliance levels are generally high across the standards set out in the audit, the 2016/17 response rate is 84.8% (as at 3 July).

The area which is most frequently scored amber is training, where not all staff have been trained to the correct level or have access to specialist safeguarding reflective supervision. To complement the generic section 11 tool, an additional 'training s11' was devised by the Learning & Development sub-group and distributed for completion at the same time as the main s11. As of 3 July only 7 of the 'training s11's' had been returned to the LSCB Training Coordinator. Of the total responses received, 89.1% were graded green and 10.9% graded amber.

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The 2016 Section 11 returns are currently being quality assured by members of the Quality Assurance and Performance Information (QAPI) sub-group to ensure that they have met the minimum requirements for each section of the audit tool. Based on this exercise, the sub-group will then select agencies to visit for a challenge event. The purpose of the challenge event is to test that the statements made in the section 11 are evidenced in practice and that staff are familiar with safeguarding policies and procedures.

The Adult's QAPI sub-group are in the process of considering ways in which they can mirror the section 11 process in order to gain assurances that vulnerable adults are appropriately safeguarded. Where possible the LSAB will seek to mirror processes which are already working well for the LSCB.

3.3 Thematic Audits

3.3.1Suicides

Last year, the LSAB reported concerns regarding the suicide rate in Lancashire being one of the highest in the country, and later raised the concerns with the Health and Wellbeing Board. During the reporting year the LSAB has taken various actions in an attempt to address the issue:

- Explored the option of a Task and Finish Group to further understand the issues surrounding suicides. Initial scoping around the task group highlighted a national imperative around the issues and following conversations with Public Health colleagues it was agreed a wider group would be established on a Sustainability and Transformation Partnerships (STP) footprint with Lancashire and South Cumbria. It was therefore agreed that the link to attend this group and regular updates back to the LSAB would be provided by the LSAB NHS England representative and the Director of Public Health who would provide assurances that the issues were being addressed.
- The LSAB Chair engaged with the Lancashire Evening Post as part of a three-day special investigating the high rates of suicide in Preston, and other areas of Lancashire, with a view to heighten the awareness of the issue and campaign for further work to address it.
- Public Health colleagues initiated an audit of suicides during the reporting year, recently reporting the overall findings to both the LSAB and LSCB. The final report is currently being signed off and will be shared via Public Health. Both Boards are interested in the next steps to be taken following the audit and are fully supportive of any action to be taken, and will offer engagement as necessary.

3.3.2 S47 Audit

In July 2016 the LSCB completed an audit which looked at the areas of deficit identified by Ofsted in respect of the process for strategy meetings when S 47 investigations were being carried out.

The audit identified some issues about the timeliness of strategy meetings; recording of strategy meetings; multiagency engagement; and post-qualification experience of allocated social workers. Recommendations were made, and an action plan developed by the QAPI sub group which is now completed and signed off.

A re-audit of s 47 proceedings is due to take place Autumn 2017.

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3.3.3 MASH Diagnostic

As reported in 2015/16 the LSCB commissioned a diagnostic review in order to assess existing Multi Agency Safeguarding Hub (MASH) arrangements and explore models in other areas with a view to redeveloping Lancashire's approach.

The findings from the diagnostic were reported to the LSAB and LSCB in September 2016, and the full report can be found at appendix 1. The overall findings of the review demonstrated that the primary aim of improving decision making through multi-agency information sharing was being achieved, however it was clear that the existing service design was not viable and needed urgent review, requiring input and commitment from all key agencies in order for a successful re-shaping of the service.

The review found that as much as two thirds of the work being processed via the MASH could be better dealt with – cases requiring an early help response could have been referred direct. While cases which clearly required an urgent and statutory response could go direct to the police investigator, the children's and adult social care MASH process was seen as adding significant value in producing a multi-agency chronology to inform decision making on a very timely basis (3 hours target). This should be further explored as part of the service redesign.

The reality picture showed that MASH was only responding to police referrals; 3 MASH's pan-Lancashire working differently creates a postcode lottery around vulnerability; with many 'front-doors' creating waste, failure and duplication. The MASH held excessive demand and therefore risk built into the system and does not include other agency referrals. Inconsistencies and gaps in service provision were identified.

The findings report made a number of recommendations as detailed below, along with a progress update:

Recommendation	**2016/17 Progress**
1. Identify high level accountability and establish effective strategic group to drive forward to phase 2	MASH Strategic Board established November 2016 (formally Steering Group), chaired by the LSAB/LSCB Independent Chair. The group oversees the development of the MASH and is responsible for improving safeguarding arrangements.
2. Re-visit vision, objectives and customer cohort for MASH	In-depth review of business processes has been completed using the Police "futures" team (see 3 below) and has resulted in a service redesign. There is now clarity about customer cohort and service pathways.
3. Scope likely workload and identify resource requirements	External consultant commissioned September 2016 to initiate the process of the service redesign. Scoping of Diagnostic

	recommendations took place between Sept – Dec 2016 to inform how the re-design may be progressed. This included case tracking of contacts/referrals through CART, MASH and Customer Access; consultation with frontline practitioners and managers in Bury, Blackburn with Darwen and Lancashire; consultation with senior managers with LCC and Lancashire Constabulary; literature search to better understand national and regional MASH models; and interrogation of data in respect of demand and activity.
4. Commission service redesign	Redesign initiated and continues to progress in 2017/18. The following operational achievements were made in the reporting year: • Practice Managers screen all new contacts at the beginning of the process and provide direction to social workers in respect of action/timescales; • Practice Manager, Senior Social Worker and Business Support Officer are now in post to support CSE cases specifically; • Two Early Help practitioners are now within MASH to assist in developing timely step down processes; • CSC referral form amended to ensure more robust Information Sharing, and to align with Risk Sensible practice; • Improvement in partner engagement have been made, particularly with Probation; Fire and Rescue; and substance misuse services; • Development of Information Sharing Agreement; Memorandum of Understanding; and Privacy Impact Assessment, all of which are due to be formally signed off.
5. Agree areas for joint commissioning - including non-service specific staff e.g. referral assistants	While the possibility of joint commissioning in the future has not been ruled out, the current arrangements are based on partnership working.

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6. Agree multi-agency partners and single agency contribution/resource commitment	A memorandum of understanding has been developed which outlines the role and contribution of each agency.
7. Explore integrated agency approach with single line management chain	As a partnership rather than a jointly commissioned single service, each agency retains line management responsibility for their staff. Discussions continue, however the need for a "lead manager".
8. Explore options re single/central versus locality based arrangements	Co-located partners in MASH on a locality footprint (North, Central, East) Pilot established in the North, triaging and information sharing within one locality. Pilot includes the co-location of adult duty social worker.
9. Identify and align under-pinning areas:	
a. Redesign e.g. Customer Services and Police Contact management	A single point of contact ('Front Door') for all contacts and referrals on cases not open to CSC has been created and the distinction between MASH and CART (CART ceases to exist) removed. Changes to the role of Customer Access Services have been completed – social workers answer telephone calls and make recommendations based on the Continuum of Need (CON) for those not open.
b. Establishment of refreshed thresholds	Multi-agency LSCB Task and Finish Group reviewed the CON levels and supporting thresholds guidance and launched July 2016. LSAB created Guidance for Safeguarding Concerns (re adults) to support professionals in making appropriate decisions to report concerns. Guidance includes appendices to provide guidance around Falls and medication errors.
c. Development of common language and common risk assessment measures.	Risk Sensible Practice model introduced into Children's Social Care. LSCB tasked with creating a supporting framework for multi-agency partners to ensure consistent approach

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	and language are used across agencies. Multi-agency framework launched July 2017.

3.4 Service Area Annual Reports

The Board also receives a number of annual reports in relation to key multi-agency services. Reports are received regarding the following:

1. Local Authority Designated Officer (LADO)
2. Common Assessment Framework (CAF)
3. Wellbeing, Prevention and Early Help (WPEH)
4. Counter Terrorism
5. Domestic Abuse
6. Independent Reviewing Officer (IRO)
7. Multi-agency Public Protection Arrangements (MAPPA)
8. Secure Estate (Young offenders institutes)
9. Private Fostering

All service area annual reports for 2016/17 are available at Appendix 2.

3.5 Multi-Agency Audit Framework

In 2016, the Boards introduced a new scheme of multi-agency audit activity which aims to identify good practice and to highlight areas for concern and development both on a single agency and multi-agency basis.

The QAPI sub groups are responsible for co-ordinating the audits and sets a specific topic for each (based on recommendations from the Boards; Ofsted Improvement Board; and findings from recent SCRs and SARs). There has been positive engagement from agencies, which means the audit process is proving successful so far. Agencies to have been involved include: Local Authority (CSC; WPEH; SEND); Health providers; Clinical Commissioning Groups; Education; Police; Probation; and organisations from the voluntary, community and faith sector.

The LSAB QAPI sub group initiated the first audit in January 2017, focussed around Domestic Abuse. The audit has recently concluded and is due to be reported to the LSAB in September. The findings will be shared with partners and referenced in the 2017/18 annual report. The audit schedule for the year ahead includes plans to audit around Timeliness and information sharing; and Making Safeguarding Personal (MSP).

The LSCB QAPI sub group initiated and completed two multi-agency audits during the 2016/17 period: Children in Need of Prevention and Early Help; and Transitions from child to adult services.

A third audit into Child Sexual Exploitation was also initiated in the reporting period, concluding in May 2017. Summary reports can be accessed here:

http://www.lancashiresafeguarding.org.uk/quality-assurance-and-audit.aspx

The next audit to be undertaken under this framework is scheduled to begin September 2017, focussed around Non-accidental injuries.

3.6 Themes from Child Death Reviews

The Child Death Overview Panel (CDOP) reviews every child death in the county and analyses any factors that may have contributed to the death in order to identify themes and trends for preventative measures. 86% of deaths reviewed during 2015/16 were completed within 12 months.

A summary of the key findings for 2016/17 are as follows:

- 14% of deaths were of children from an Asian Pakistani heritage, compared with the child population of 6% in the 2011 census (this is an increase of 7% from deaths reviewed in 2015/16)
- 60% of children were aged under 1 year (31% 0-27 days and 29% 28 – 264 days)
- 32% of deaths were due to chromosomal, genetic and congenital anomalies and 29% were due to perinatal/ neonatal events.
- 38% of deaths were identified to have modifiable factors*
- Of the 38% of deaths identified to have modifiable factors the most common category of death was perinatal neonatal events (38%), this was also the case for Pan-Lancashire. The second largest category to have modifiable factors was sudden, unexpected, unexplained deaths (30%).
- The most common modifiable factors were smoking by parent/carer and safer sleep

*Factors which could be modified to reduce the risk of future child deaths

3.7 Safeguarding Adult Reviews (SAR)/Serious Case Reviews (SCR)

During 2016/17, the SAR and SCR Groups have successfully implemented a new methodology for undertaking reviews, using the Welsh Model. The model allows for a more timely and practiced based review, providing focussed and SMART recommendations.

A resource pack was developed to support the implementation of the model, which includes roles and responsibilities of panel members; independent review; independent chair; and business co-ordinator; a learning event briefing; certificates for learning events; and a 7 minute briefing on how the model works. Prospective Chairs are also able to observe a full SAR/SCR prior to undertaking the chairing role, allowing come form of training prior to undertaking a full review.

2016/17	**SARs**	**SCRs**
Number of referrals:	11	20
Number converted to reviews:	4	3
Number converted to Multi-agency learning reviews	0	1
Number pending decisions	2	1

The first Safeguarding Adult Review, published to the LSAB website in June 2017, concluded outside of the reporting year and will be referenced in the 2017/18 annual report. Three cases continue through the review process and will be published, if appropriate, in due course.

One Serious Case Review, Child LA, was published during the reporting year which can be found in full on the LSCB website. Since the end of the reporting year, an additional 4 cases have been published and will be referenced in the annual report for 2017/18.

The review into Child LA, published December 2016, highlighted a number of learning points, including those detailed below:

Child LA Key Learning Points:

- **Age of the child:** professionals treated LA, in terms of her age, as if she were an adult – a significant issue which impacted on interventions considered and offered. Children are children until aged 18 in law; the Children Act 1989 defines a child as any person under the age of 18 (section 105(1)).

- **Thresholds for Neglect:** LA and the family lived with a number of concerns including mental health issues, suspected substance misuse, self-harm, sexual exploitation, emotional abuse and neglect. The conditions where LA lived during the timeframe were poor. Professionals did visit and record their concerns and at times challenged what they saw; however, there was a sense of acceptance on the behalf of professionals. The independent reviewer discusses the definition of neglect and that the circumstances /environment do not have to get progressively worse for the threshold to be met, it can also be met by the neglect concerns not getting any better, despite professional intervention.

- **Responses to Child Sexual Exploitation:** The report highlights it was positive that LA was identified as being at risk of child sexual exploitation (CSE). Creative disruption techniques in response to concerns were used as child abduction.

- **Responses to children who go missing from home:** LA was formally reported missing seven times during the review period and was found on occasions to be in circumstances where CSE was known or suspected. The return interviews were not robust and were not consistently documented.

- **Engaging parents and carers/disguised compliance:** It was evident that Mother was not consistently difficult to engage, however there were concerns about parenting capacity and ability to support and protect her children. Disengagement, resistance and disguised compliance should be included as a key area of concern when assessing risk to a child, and therefore be included in supervision discussions about decisions and risk analysis.

The full overview report and practitioner learning brief for Child LA can be accessed on the LSCB website.

The LSCB also published practitioner learning briefs for two SCRs in January 2017, however overview reports were delayed in publication due to ongoing parallel proceedings. The reviews into Child LB and LD highlighted key learning around:

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Child LB Key Learning Points:

- **Voice of the child:** was not heard by agencies. Children should be given opportunities to have their voices heard in a safe environment as soon as possible.

- **Inter-Agency Working through Early Help:** Professionals should always provide parents/carers opportunities to consider a CAF and attempt to gain parental consent to instigate a CAF. Prior to discharging/closing a referral, the referrer should be notified to enable appropriate multi-agency discussion and challenge.

- **Engagement with resistant or uncooperative families:** Resistance and non-engagement should be included as a key area of concern when assessing risk to a child and therefore be included in supervision discussions;

- **Professional curiosity relating to minor injuries:** Being professionally inquisitive is crucial to ascertain whether explanations of injuries (however minor) are plausible. It is also important for professionals to view minor injuries collectively with other information about a child which together could give cause for greater concern.

- **Decision making in referrals and escalation processes:** All assessments should include multi-agency clarification of concerns, the voice of the child and consideration of a strategy discussion with clear decisions documented within records. All professionals should be familiar with the LSCBs escalation policy: Resolving Professional Disagreements Guidance and have the confidence to use it.

Good practice was highlighted as part of this review:

- Providing Child LB with the same consistent counsellor enabled them to build trust and a rapport which eventually led to the disclosure;
- School Nurse was tenacious in pursuing opportunities and strategies, including with other professionals, to try to enable the child to be seen in a safe environment;
- Both schools involved worked hard in their recording of concerns and incidents involving LB, and tried continuously to engage the carers, encouraging some communication under challenging circumstances.

Child LD Key Learning points:

- **Hostile, Aggressive and Resistant Parents:** was frequently witnessed and the family evaded professional support and interventions. This made it difficult to form a clear picture of the child's needs due to the child being inaccessible. Professionals should be supported in respectfully challenging non-cooperative families.

- **Historic Sexual Abuse and Inappropriate Sexualised Behaviour:** Relevant information sharing to inform risk assessments is essential to support the protection of children at risk or experiencing sexual abuse including familial risk indicators.

- **Safeguarding Children and Duty of Care to Adults**; Professional's duty of care to adults should not obscure their responsibility to safeguard children.

- **Neglect:** the review found the daily lived experience of Child LD was highly likely to have been neglectful and abusive.

Practitioner learning briefs for LB and LD can be viewed in full on the LSCB website.

Multi-agency Learning Review (MALR)

One MALR was completed during the reporting year, exploring issues raised within children's homes. Learning from the MALR is shared via a learning brief on the LSCB website, and is generating debate with the DfE with regard to Children's Homes regulations. Further detail and progress will be reported in 2017/18.

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4. Statutory and Legislative Context

4.1 Lancashire Safeguarding Adults Board

Section 43 of the Care Act 2015 sets out the statutory objectives and functions of an LSAB as follows:

1) Each local authority must establish a Safeguarding Adults Board (an "SAB") for its area.
2) The objective of an SAB is to help and protect adults in its area in cases of the kind described in section 42(1).
3) The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.
4) An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.
5) Schedule 2 (which includes provision about the membership, funding and other resources, strategy and annual report of an SAB) has effect.
6) Where two or more local authorities exercise their respective duties under subsection (1) by establishing an SAB for their combined area
    a) a reference in this section, section 44 or Schedule 2 to the authority establishing the SAB is to be read as a reference to the authorities establishing it, and
    b) a reference in this section, that section or that Schedule to the SAB's area is to be read as a reference to the combined area.

The LSAB must promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal' and ensure all work is underpinned by the six key safeguarding principles:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed.
- Protection – delivering support to victims to allow them to take action.
- Prevention – responding quickly to suspected cases.
- Proportionality – ensuring outcomes are appropriate for the individual.
- Partnership – information is shared appropriately and the individual is involved.
- Accountability – all agencies have a clear role.

4.2 Lancashire Safeguarding Children Board

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 sets out the statutory objectives and functions for an LSCB as follows:

a) 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

b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1a. developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

i. the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
ii. training of persons who work with children or in services affecting the safety and welfare of children;
iii. recruitment and supervision of persons who work with children;
iv. investigation of allegations concerning persons who work with children;
v. safety and welfare of children who are privately fostered;
vi. cooperation with neighbouring children's services authorities and their Board partners;

1b. communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

1c. monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

1d. participating in the planning of services for children in the area of the authority; and

1e. Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

2. In order to fulfil its statutory function 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 set out in chapter 2 of this guidance;
   - 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

4.3 Wood Review

In December 2015, the Department for Education (DfE) asked Alan Wood to lead a review of the role and functions of Local Safeguarding Children Boards (LSCBs) in England within the context of local strategic multi-agency working. As part of the review he also looked at Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOP) and Serious Case Reviews of the government has accepted several of the recommendations and will introduce changes over the next two years. The Children and Social Work Act 2017 has received royal assent and introduces a number of significant changes for LSCBs. These include:

- The LSCBs to be replaced by a local safeguarding partnership whose remit will be agreed between police, LA and Health (CCGs)
- Serious Case Reviews to be commissioned nationally with local learning reviews for less serious cases

The functions of the Child death Overview Panel to be transferred into health (or may be Public Health)

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5. Governance and accountability arrangements

5.1 Relationship between the LSAB/LSCB

In 2015/16 we reported that developments were being made to align the work and support arrangements of the two Boards, following the introduction of statutory obligations for LSABs.

An increase in financial contributions from partner agencies was agreed, and a joint Business Unit established to work across both Boards. The Business Unit is now operating at full capacity and making good progress. Where possible, the Business Unit and Board members aspire to implement joint initiatives and methods across both Boards to ensure consistency and improved joint working around the Safeguarding agenda.

A Development Day took place in March 2017, bringing members of the LSAB and LSCB together for the first time. The day was well received by members, looking at the history of the two Boards and how they have developed; sharing the key functions and roles of all sub groups; and identifying some key priorities for the future. The following key decisions were made:

- Adoption of a general principal of only doing things once!
- Disestablishment of the LSCB Executive Group – it was agreed the LSCB Executive was potentially inefficient and presents risks of undermining the accountability of the full Board, however was a useful forum for management of financial issues and decisions. It was therefore suggested that the group be disestablished and replaced with quarterly budget meetings to address financial issues, and quarterly sub-group chairs meetings to manage the business plans. This was agreed and the LSCB Executive met for the final time in May 2017;
- Communication and Engagement – it was agreed that communication and engagement is a key function requiring further development. The establishment of a Joint Communication and Engagement Sub Group was agreed which should be made up of professionals in Safeguarding and supported by skilled media/communications officers. The group has been established since the end of the reporting period, first meeting in June 2017;
- Pan-Lancs collaboration should be maximised where possible – many agencies work across borders, therefore aligned policies and procedures should be considered;
- Common approaches to Case Reviews, Audits and training should be adopted wherever possible.

Some joint initiatives in place:

- Independent Chair is the same for both Boards;
- Safeguarding Adults Reviews and Serious Case Reviews use the same methodology based on the Welsh model;
- Multi-agency Audit tool has been implemented using the same processes for both Children's and Adults audits;
- Joint meetings of the LSAB and LSCB pan-Lancs Chairs and Business Managers (Lancashire, Blackpool, Blackburn with Darwen; and Cumbria);
- Joint Communication and Engagement Sub Group (est. June 2017)

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- Joint meeting of the LSAB/LSCB scheduled for September 2017 to address issues common to both Boards.
- Joint Annual report 2016/17.

5.2 Board Structure

The Board structure can be found on the next page, illustrating the governance between the Boards, its sub groups, and links with other partnerships.

The Boards have recently established three additional sub groups which will be developed over the coming year and included in the 2017/18 annual report:

- Joint Communications and Engagement Sub Group
- LSCB Policies and Procedures Sub Group
- LSAB Policies and Procedures Sub Group

Partnerships in Lancashire such as the LSAB/LSCB, Children and Young People's Trust, Health and Well Being Board and Community Safety Partnership all produce detailed strategic plans setting out the key outcomes to be achieved within a 3 year timescale. These plans are based on a detailed analysis of the needs, the aspirations of the Lancashire residents and the resources available to organisations to meet these needs and aspirations. Arrangements in place to share this annual report with these key strategic groups and join up the business planning processes so priorities can be shared and reflected accordingly.

In 2014/15 the Local Safeguarding Groups were merged with the District Children's Trusts which resulted in 5 Children's Partnership Boards (CPBs) which bring partners together locally under the wider children's agenda. The CPBs are not formal sub groups of the Board but working links are in place to allow the LSCB to hold the groups to account for coordination of effective safeguarding, ensuring it is embedded in priorities and plans. The four Business Co-ordinators attend CPB meetings on a regular basis, providing the safeguarding link.

The CPBs continued to progress in 2016/17, with another year of funding agreed for 2017/18. A review of Children and Young People's Trust arrangements is to take place in the coming year, which the CPBs will be consulted on.

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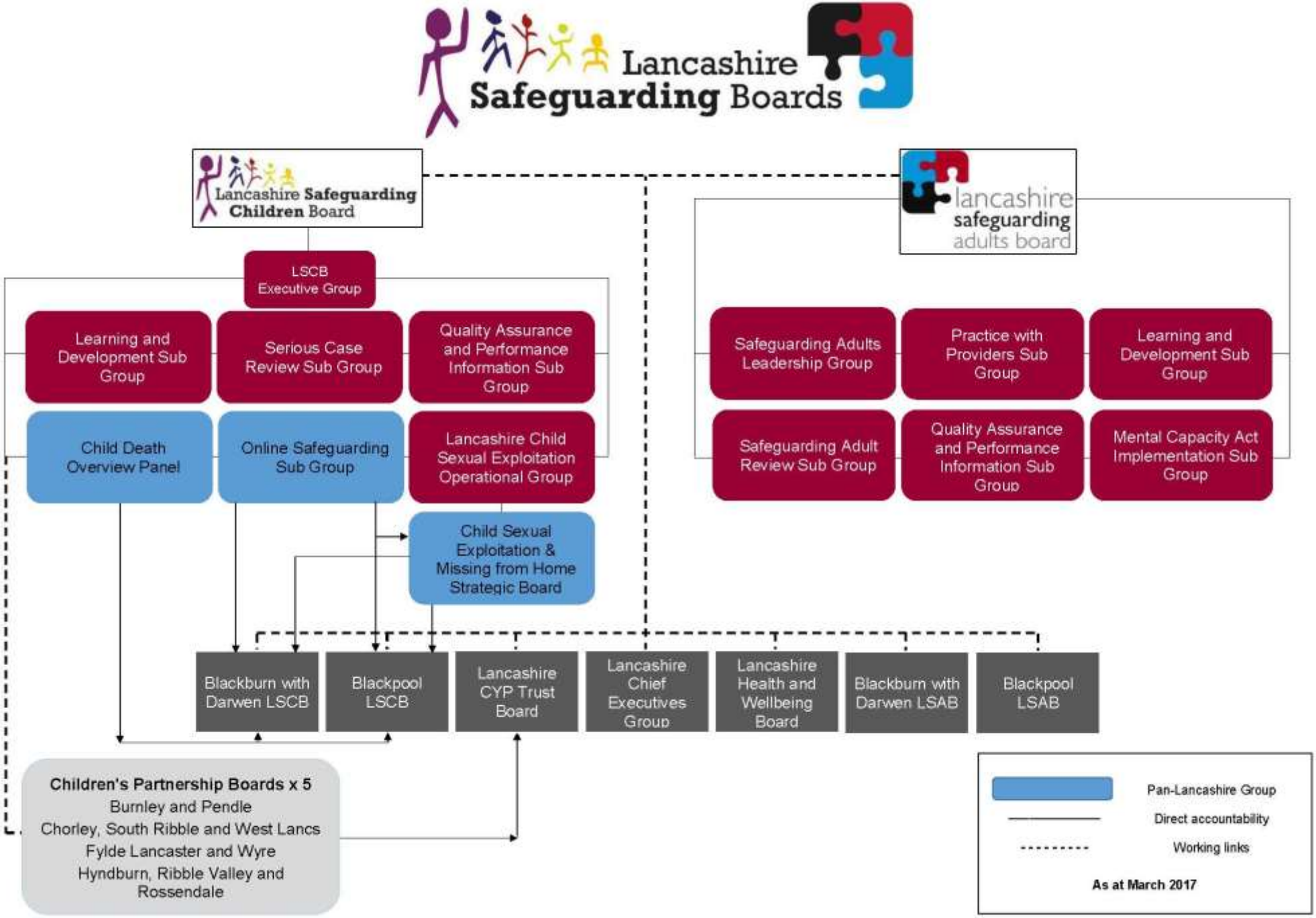
Lancashire Safeguarding Boards
Lancashire Safeguarding Children Board
LSCB Executive Group
Learning and Development Sub Group
Serious Case Review Sub Group
Quality Assurance and Performance Information Sub Group
Child Death Overview Panel
Online Safeguarding Sub Group
Lancashire Child Sexual Exploitation Operational Group
Child Sexual Exploitation & Missing from Home Strategic Board
lancashire safeguarding adults board
Safeguarding Adults Leadership Group
Practice with Providers Sub Group
Learning and Development Sub Group
Safeguarding Adult Review Sub Group
Quality Assurance and Performance Information Sub Group
Mental Capacity Act Implementation Sub Group
Blackburn with Darwen LSCB
Blackpool LSCB
Lancashire CYP Trust Board
Lancashire Chief Executives Group
Lancashire Health and Wellbeing Board
Blackburn with Darwen LSAB
Blackpool LSAB
Children's Partnership Boards x 5
Burnley and Pendle
Chorley, South Ribble and West Lancs
Fylde Lancaster and Wyre
Hyndburn, Ribble Valley and Rossendale
Pan-Lancashire Group
Direct accountability
Working links
As at March 2017

5.3 Accountability and inspection

Despite having statutory functions, the LSAB does not undergo the same scrutiny processes as the LSCB. However it should be noted that agencies represented on the LSAB are often inspected in terms of quality and compliance around issues of safeguarding.

The LSCB is reviewed as part of the local authority inspection of services for children in need of help and protection, children looked after and care leavers, carried out by Ofsted. The last inspection took place in 2015 and the LSCB was judged to be 'good' following a separate assessment and judgement of its effectiveness.

The independent chair is the same for both Boards and is held to account by the Chief Executive of the Local Authority through regular meetings and Board member participation in a process of standardised appraisal.

5.4 Business Planning and Strategic Priorities

5.4.1 LSAB Business Plan

The LSAB developed its first Business Plan based on priorities agreed at the LSAB Development Day in September 2016. The plan incorporates the actions required to ensure the Board itself is efficient and effective in fulfilling its statutory responsibilities. Key priorities for 2016-18 were set based on the 15 Care Act Responsibilities under 6 Key Safeguarding Principles: Empowerment; Prevention; Proportionality; Protection; Partnership; and Accountability.

The information below details the priorities given initial precedence with completion deadlines during the April 2016 – March 2017 period:

Empowerment

- *Care Act No. 9 – Develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.*

  Progress update: Links have been established with the LeDeR Programme (Learning Disabilities Mortality Review) with regard to vulnerable adults. Representatives from the programme attended and presented to the LSAB in November 2016 and the Practice with Provider Sub Group February 2017.

  The MCA and DoLS Sub Group has worked extremely hard to develop and implement robust policies and procedures are in place to protect those who lack mental capacity. The detail of this work is shared at the end of this section and via the Sub Group update (section 6.4).

  The newly established Communication and Engagement will consider issues of diversity throughout all activity undertaken to deliver work plans and strategies.

Prevention

- *Care Act No. 2 - Establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time*

  Progress update: The QAPI Sub Group is well established with appropriately skilled members. The group has developed and implemented a data and performance framework and reporting mechanisms, scrutinising all data and findings before presenting highlight reports to Board on a bi-monthly basis.

  The group has also agreed and implemented an effective multi-agency audit programme with a team of multi-agency auditors in place who initiated the first multi-agency audit in early 2017.

- *Care Act No. 5 - Establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives*

  Progress Update: Following discussions at the LSAB/LSCB Development Day in March 2017, it was agreed to establish a Policies and Procedures Group for the purpose of developing and reviewing policies and procedures on behalf of the LSAB. This group is currently in development, along with a new approach to developing Pan-Lancashire procedures.

  It is the expectation of the Policies and Procedures; and the Communication and Engagement Sub Groups, to make effective links in order to successfully engage relevant stakeholders and service users throughout development and dissemination of information and guidance.

- *Care Act No. 6 - Develop preventative strategies that aim to reduce instances of abuse and neglect in its area*

  Progress Update: The Communication and Engagement Sub Group is working to put in place an effective strategy for communication/engagement which includes an objective to raise awareness of abuse and neglect throughout agencies, service users and members of the public, in order to assist the recognition of the signs and in turn help prevent abuse from happening.

  Learning from SARs are highlighted to practitioners via concise Learning Briefs, and further supported via the development and wide distribution of 7 Minute Briefings.

- *Care Act No. 7 - Identify types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority as an enquiry*

  Progress update: A comprehensive guidance tool was developed during 2016/17 to assist practitioners in making appropriate referrals in response to safeguarding concerns.

  The guidance is for Providers and Practitioners alike as key partners in safeguarding adults with care and support needs. It is intended to assist in the management of risk and making appropriate decisions around the level of support and response required to suspected or recognised abuse.

  The Guidance was agreed and launched in March 2017 and continues to be successfully embedded across agencies and services. The guidance is supported by three appendices:

- Appendix 1: Safeguarding Concerns Checklist for recording and evidencing information;
- Appendix 2: Information and guidance on when to consider making a safeguarding alert following a fall; and
- Appendix 3: Information and guidance on when to consider making a safeguarding alert for medication errors.

A fourth appendices is about to be launched to provide advice and guidance in relation to service user to service user incidents. The full 'Guidance for Safeguarding Concerns' package can be accessed on the LSAB website.

- *Care Act No. 12 - Carry out safeguarding adult reviews*

  Progress update: The SAR Sub Group has worked hard over the past year to develop and implement processes for timely reviews. Due to the successful implementation of the Welsh model for SCRs, it was agreed the processes and templates would be adapted and developed to suit SARs. Training events were held for potential reviewers; authors; and Chairs in September 2016. The first SAR was initiated in June 2016 and published June 2017. Five cases continue to progress through the review process.

Proportionality

- *Care Act No. 10 - Balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'*

  Progress Update: Members of the LSAB are engaged in the MASH review process and are represented on Strategic Board, fully sighted on roles and responsibilities, and the development of information sharing agreements. Detail of the MASH progress is detailed at section 3.3.3.

  All sub groups are working to embed the principles of Making Safeguarding Personal (MSP), and the QAPI Sub Group has scheduled a multi-agency audit around MSP later this year.

Protection

- *Care Act No. 15 - Promote multi-agency training and consider any specialist training that may be required. Consider any scope jointly to commission some training with other partnerships, such as the Community Safety Partnership*

  Progress Update: The training provision for the LSAB has made developments during 2016/17, with further work still to be done. During the reporting year number of single and multi-agency training sessions and conferences have been delivered, including topics such as: managing modern safeguarding challenges; MCA/DoLS; safeguarding and care homes; Self-Neglect; and modern slavery.

  The LSCB 7 Minute Briefing processes has been replicated by the LSAB Learning and Development Sub Group, with briefings developed and distributed on topics such as: Advocacy; Emollients and Smoking; Honour Based Violence; information Sharing; MCA DoLS; Oral Health; Prevent; and the Safe Use of Agency Staff. Eight topics have been proposed and agreed for development during 2017/18.

The LSAB website has a dedicated area for Learning and Development, which will be further developed over the next year in line with progress made by the sub group.

An options paper was presented to the LSAB in April 2017 to propose three options for the future direction of Learning and Development. This is currently under review but initial discussions revealed the preferred option is to adopt and develop a multi-agency training pool. This is being further explored and will be reported on in 2017/18.

Partnership

- *Care Act No. 14 - Evidence how SAB members have challenged one another and held other boards to account*

  Progress Update: a number of mechanisms have been successfully implemented in terms of quality and performance, audits and SARs during the reporting year, creating effective routes for constructive challenge amongst agencies.

  The LSAB QAPI sub-group are in the process of considering ways in which they can mirror the section 11 process in order to gain assurances that vulnerable adults are appropriately safeguarded.

Accountability

- *Care Act No. 1 - Identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults*

  Progress update: Membership and structure of the LSAB and its sub groups are regularly reviewed and amended as necessary. All sub groups are well developed with work plans and clear Terms of Reference agreed. Governance arrangements were reviewed and published to the LSAB website in April 2017, setting out the aims, priorities and Terms of Reference of the LSAB; membership and responsibilities of members; and structure and role of sub groups.

In addition to all progress detailed above, it would be remiss not to highlight the progress and success made by the sub group dedicated to the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS). The group advises the LSAB on processes, procedures and outcomes in relation to the implementation of MCA and DoLS, providing progress updates and assurance that the Act is being embedded in practice of multi-agency partners. A number of objectives have been delivered during the reporting year and are detailed within the 'Sub Group updates' later in this report. Examples of objectives met are as follows:

- **Pan-Lancashire MCA Media Resource and E-Book**: developed in 2015/16, the resource was launched via a conference in April 2016 and shared with the national NHS England MCA Sub Group. The work was shortlisted for a national 'Patient Safety' award and featured as an example of best practice in Baroness Finlay's MCA Forum Chairs annual report.
- **Regional and National collaboration and sharing of best practice:** sharing resource tools across services – including the NHS Deciding Right app which supports care providers in making care decisions in advance for people who may lose capacity or those who have already lost it.

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- **Learning and Development:** significant investment in strengthening learning and development opportunities to support agencies in applying the principles of the Act into practice. Examples include:
    - Funding received from NHS England allowed the group to coordinate a number of multiagency training events, commissioning Afta-Thought; a drama based training company who specialise in training delivery using scenarios that are realistic, recognisable and measurable. Sessions were well attended and received positive feedback.
    - Expert speaker 'Neil Allen' Barrister from 39 Essex Chambers and Senior Lecturer at Manchester University was commissioned to provide targeted training on MCA and case law updates for GP's and hospital medics across the pan Lancashire footprint.
    - Roll out of 7 minute briefings around MCA in practice, and Advocacy Focus, the support services available to adults in Lancashire.
    - Practice based learning sessions led by the MCA Coordinator
- **Awareness Raising:** easy read leaflets purchased from Research in Practice for Adults (RIPFA) to raise awareness of MCA with the public.
- **Research project:** pan-Lancashire research commissioned to understand of health and social care provider's experiences of working with the Act. The research is the first of its kind from a local and national perspective and will inform practice with evidence based recommendations.

The work undertaken during 2016/17 has implemented successful mechanisms for achieving the LSAB's requirements of the Care Act. Members of the LSAB and its sub groups will make further developments over the year ahead in order to meet the objectives of our business plan.

5.4.2 LSCB Business Plan

The Business Plan has been develop by the LSCB and has the support of all the Board's partner agencies. It takes account of and is informed by statutory requirement and the implementation of LSCB processes: QA Framework - Section 11 Audit, Multi-Agency case file audits, Performance Indicators. Themes from SCR are inbuilt into our priorities. The plan incorporates the actions required to ensure the Board itself is efficient and effective in fulfilling its statutory responsibilities.

The key priorities for 2016-18 were agreed at the Board's Development Day on 7th June 2016, as follows:

- *Priority Area 1:* Improve the effectiveness of agencies and the community in preventing Child Sexual Exploitation and addressing other complex safeguarding issues (including female genital mutilation, forced marriage and honour based violence).

- *Priority Area 2:* Improve the effectiveness of agencies in meeting the needs of Children Missing for Home, Care and Education

- *Priority Area 3:* Improve the effectiveness of safeguarding activity for children in specific circumstances:
    - Children placed in Lancashire from other areas, and in other areas from Lancashire
    - Children whose parents are in prison

- Children in need of support for emotional and mental health issues
- Children in need of support with regard to online safety

- *Priority Area 4:* Cross cutting themes

- *Priority Area 5:* Ofsted improvement plan

Priority updates:

- **<u>Child sexual exploitation/complex safeguarding</u>**

A review of the multi-agency Pan-Lancashire CSE Action Plan (2015-18) was undertaken in October 2016. The review found that significant work has progressed in this area in recent years, and good progress has been made particularly in relation awareness raising across professionals in all sectors. The Leadership and reporting structures are well developed and issues are well understood across the 3 LSCB areas. Partnership working is key and continues to contribute to the success.

The LSCB appointed a Business Co-ordinator in January 2017 with a responsibility to support the CSE and Complex Safeguarding agenda.

As reported last year the LSCB, in partnership the Police and Crime Commissioner, had started working closely with District Councils in order to improve safeguarding policies and practice in relation to private hire cars and taxi drivers. All districts have been engaged in this process, training hundreds of Taxi Drivers and licensing committee members in CSE Awareness, and making completion of training a mandatory condition of licensing applications. Furthermore, and more recently, a 'Taxi Driver Workbook' has been created to further embed key messages around CSE and help educate drivers about their responsibilities in safeguarding children and vulnerable adults and has been made available to the District Councils.

A project was commissioned in the East of the County (Burnley and Pendle) to improve engagement with BME Communities, and explore perceptions of such communities around issues of CSE. The project was carried out in two Phases, with Phase 1 conducting an initial needs assessment which demonstrated the need for focussed engagement work to increase empathy towards victims and eradicate misconceptions surrounding CSE. Two voluntary sector organisations led on Phase 2 of the project holding a number of workshops within the communities in order to educate participants on CSE. Participants were required to complete a questionnaire before and after the workshops in order to measure any changes in views/understanding. Although the project successfully engaged with communities, the overall findings uncovered some negative changes in the perceptions towards victims of CSE, following participation in the workshops. These findings are of concern to the LSCB and the pan-Lancashire CSE Strategic Board, and will be considered as part of delivery against priorities for the year ahead.

The Lancashire CSE Operational Group was established in April 2016, reporting directly to the LSCB and pan-Lancashire CSE Strategic Board. Detail of progress made during 2016/17 can be found later in this report as part of the sub-group updates.

In March 2017, the Boards contributed to and supported a Modern Slavery and Human Trafficking Conference, along with Blackpool Safeguarding Boards and Blackpool Teaching Hospitals. The conference was extremely popular, providing training to over 300 practitioners around: understanding and awareness of Modern Slavery and Human Trafficking; recognising the signs and knowing how to respond; roles and responsibilities; and support services available.

Presentations were given around prevalence and complexities (nationally and internationally); key legislation; responsibilities and processes; Child Trafficking, including the experiences of victim's; an overview of East Lancashire's Modern Slavery Unit; and information and outcomes of Operations to have taken place across the country.

Since the conference, there has been an increase in referrals, intelligence and arrests for modern slavery. There is increased awareness and consideration of key issues amongst practitioners and improved multi-agency working, however there is still much work to be done. Developments will now be made around modern slavery to make improvements in training; multi-agency processes; intelligence; and victim support services.

- **Children missing for home, care and education**

The pan-Lancashire CSE/MFH Strategic Board reviewed the Strategy and Action Plan for children missing from home, and agreed the refreshed document in August 2016, pending any changes made as a result of the recommendations of the All Party Parliamentary Group on this subject.

The National College of Policing released guidance in anticipation of likely revision of government guidance in January 2017, advising the removal of the 'absent' category. Lancashire Constabulary are developing systems to remove the category and replace it with 'missing – with no apparent risk'. Whilst the constabulary can move forward in preparation, the DfE are yet to release guidance for local authorities – the LSCB has made contact with the DfE to seek advice regarding the timescale of this but no update has been provided to date. Once DfE guidance is released, the Pan-Lancs Strategy for children missing from home will undergo further review to take changes into account.

Data collection for those missing from home, care and education has been improved in the 2016/17 period, with stronger links made with the children missing from education team within the local authority.

- **Children placed in Lancashire from other areas, and in other areas from Lancashire**

In last year's annual report it was noted that a themed audit had been undertaken around children looked after who are placed outside the local authority. The draft findings report was received by the LSCB QAPI sub group, however due to a low response rate, and various restructures/changes in staffing it was difficult to unpick the details initially reported. It was therefore agreed that the audit would be revisited via a focus group approach to test the current processes in place.

Links between the LSCB and the Corporate Parenting Board remain strong, with annual reports of each Board being presented to one another. In November 2016, a member of LINX (Children in

Care Council) attended a meeting of the LSCB to present key updates on behalf of the Corporate Parenting Board. This is detailed a little later in this report, as part of 'Views of Service Users'

- **Children whose parents are in prison**

As reported in last year's annual report, the LSCB recognises that children with a parent in prison are at risk of experiencing poor outcomes comparable with those of looked after children. This cohort of children was made a priority of the Board following a number of awareness raising events held in 2015/16 in partnership with the CYP Trust Board and charity iHop.

Work has been undertaken during 2016/17 to address this priority and has resulted in the establishment of a multi-agency task group to consider how we identify such children and to develop a pathway to ensure an appropriate offer of support is made, regardless of the route of identification. Whilst there is still some work to be done, headway has been made with a draft pathway almost complete; existing support mechanisms identified with potential to tap in to; and multi-agency engagement from Probation; Children's Social Care; Community Rehabilitation Company; Schools; Further Education; Prison Service; Lancashire Constabulary; and the Prison Advice and Care Trust (PACT). The work of the task group continues into 2017/18 with an aspiration to launch the pathway during Children's Grief awareness week in November 2017.

- **Children in need of support for emotional and mental health issues**

Last year, the LSCB expressed concerns around the pace of progress surrounding the re-design of CAMHS services and the quality and equity of access to timely support. A report was presented to the Health and Well-being Committee who agreed priority action was required.

During 2016/17 the Board has received regular updates from the Transformation Board with regard to the service redesign and specific workstreams within the project. This has provided insightful updates in terms of progression and identified mechanisms for feedback to and from the LSCB. The LSCB is now represented on the Care of the Most Vulnerable Working Group.

However concerns have continued to be raised and it is clear that children in Lancashire are still not able to access a service which meets the recommended standard. The Board has received reports showing unacceptable timescale for access to services and examples of very unwell children being held in a general hospital setting because no specialist CAMHS placement could be found. The Board has received Serious Case Review referrals following child suicides and data shows Lancashire has high levels of hospital admission as a result of self-harm.

While a transformation programme is in place, and some significant improvements can be evidenced, the Board remains concerned that what is being delivered is too little and too late.

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Additional areas of focus:

- *Ofsted improvement – LSCB contribution*

Following the 2015 Ofsted inspection of services for children in need of help and protection, children looked after and care leavers; and a review of the effectiveness of the LSCB, a multi-agency Improvement Board was established by the local authority, which the LSCB Independent Chair attends. The LSCB were tasked with progressing a number of recommendations as part of the improvement journey, which were built into the LSCB Business Plan. All actions are marked as complete and are found below with progress updates:

Recommendation	**Actions taken**
1. Ensure that the learning from audit activity is shared and acted upon across partner organisations through the LSCB. Robust feedback mechanisms/processes are in place.	Audit programme agreed and a virtual audit team identified and completing training in July 2016. Formal audit programme commenced in September 2016. Section 47 Audit completed in June 2016. Feedback and learning will be embedded in L&D programmes and 7 minute briefings as appropriate. Audit summary reports can be accessed via the LSCB website. LSCB newsletter will be launched during 2017/18 and will act as an additional mechanism for sharing learning.
2. Ensure that audit activity undertaken by partner organisations is shared and understood	QAPI sub-group now requests all agencies to provide summary of any audit or inspection activity which identifies safeguarding concerns and considers implications and proposed actions; system is agreed for learning to be passed to L&D sub-group for inclusion in L&D activity.
3. LSCB to ensure Working Together compliance of multi-agency strategy discussions	Section 47 audit completed and initial findings reported to the Improvement Board. Further work is to be completed and final recommendations from LSCB to Police and CSC from QAPI Group to be monitored. Some follow up underway.
4. Review and update or re-affirm policy, procedures and practice standards around honour based violence, forced marriage and female genital mutilation and other complex safeguarding risks such as CSE, human trafficking, modern slavery and radicalisation	Review completed May 2016 and outcome reported to Improvement Board.
5. Update Threshold Document and the Continuum of Need	Refresh completed and reported in June 2016. Roll out briefings were delivered across county on 11-13 July 2016 and 7 minute briefing published October 2016.
6. Re-affirm and re-brief to all staff to ensure that in cases involving CSE and complex safeguarding issues children and young people are considered as victims of abuse when the threshold is met	Continuum of need updated to reflect appropriate response to children where there are concerns about CSE and other complex safeguarding issues.
7. Use 7 minute briefing system to raise practitioner awareness and provide specialist information regarding a range of complex	7 Minute Briefings are circulated widely by the LSCB on a monthly basis. All briefings are available on the LSCB website.

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Recommendation	Actions taken
safeguarding concerns in annual training needs analysis	
8. Include the scoping of training requirements regarding range of complex safeguarding concerns in annual training needs analysis	Built into routine review
9. Ensure appropriate single training is provided to relevant staff	10 briefing sessions were held across the county to brief staff on changes to the CON and Thresholds. Findings from audits are fed back to L&D Sub Group to inform training packages.
10. Provide up to date information for individual agency activity and referral data in relation to female genital mutilation on a quarterly basis	Information now to be provided via NHS England. Further work to ensure data quality to be completed via the FGM task & finish group, associated with the CSE/MFH sub-group. FGM Group to be mad aware and to request that a flag is added to the CSC system to enable accurate reporting

In addition to the above, the LSCB also developed a Risk Sensible Framework for multi-agency partners in order to support the roll out of Risk Sensible practice within Children's Social Care. The Framework was developed during 2016/17 and formally launched July 2017.As the Improvement plan is updated the LSCB continues to commit as lead on relevant aspects.

- *Children in Custody:*

The LSCB receives a statutory annual report from Lancashire Youth Offending Team each year. The 2016/17 report can be found at appendix 2.

Following the release of NSPCC and the Association of Independent LSCB Chairs guidance into Child Protection and Safeguarding in Young Offender Institutions, Secure Training Centres and Secure Children's Homes, Lancashire Youth Offending Team were tasked with completing a self-assessment audit tool to review current practices within the local area. The findings of the audit were reported to the LSCB in July 2016. The overall findings were positive, and some recommendations made to the LSCB:

- *LSCB ensure their child protection procedure require that all incidents of strip-searching in custodial establishments are investigated by the local authority under Section 47 if the Children Act 1989, and they monitor compliance with such policy.*

  Members of the LSCB held discussions around this issue and agreed that YOT would ensure the issue of strip searching is added to the YOT Practice Guidance for YOI Review meetings to ensure that the YOT are asking young people whether there have been any incidents of strip searching whilst conducting vulnerability checks.

- *LSCBs champion the rights of children in custody locally and nationally*

  The LSCB routinely requests reports around children in custody and picks up issues as appropriate. The Independent Chair wrote to the Leeds Safeguarding Board to raise concerns around the Young Offenders Institute in Wetherby.

- *Schools Safeguarding*

Engaging effectively with schools across the county is a challenge for the LSCB. Schools are represented on the Board, as are school governors. The Chair and Business Manager meet regularly with the local authority Schools' Safeguarding Officer to share information and updates, and make links with the Headteacher forums: Primary Heads in Lancashire, and the Lancashire Association of Secondary School Headteachers.

The Board's Online Safeguarding Officer, however, has very strong links with schools and continues to provide training and support, via face-to-face sessions and online resources.

The Secondary School representative stepped down from the Board in March 2017 – a suitable replacement is currently being sought.

- *REACh (Routine enquiry into childhood adversity)*

The LSCB allocated provisional funding in 2015/16 to support a project looking at improving support and engagement with young people who go missing from home or care using this approach. . However, this project was brought to a close in early 2017 when professional capacity to manage the project could not be found.. The LSCB remains committed to exploring new ways of working which embed our understanding of the impact of adverse childhood experiences (ACE), for example, through the Pan Lancashire Child Death Overview Panel (CDOP) with a thematic audit, recommendations from Serious Case Reviews and learning emerging from national research which can be shared with LSCB partners.

- *Intra-familial sexual abuse*

In 2016 The Children's Commissioner published an analysis re the prevalence of intra-familial sexual abuse, raising concerns about likely significant under-identification and therefore lack of support for child victims. A task and finish group is currently in progress to look at Lancashire data against both the Children's Commissioners figures and estimate the likely cohort of such children in Lancashire. The aims of the group are to review Lancashire's recording of sexual abuse and intra-familial sexual abuse and compare this data against the national picture. Following this review the group will report to the Board on findings and make recommendations for practice.

5.5 Views of service users

Over the past few years, the LSCB had developed some effective arrangements for involving children and young people in various aspects of its work and seeking their views as appropriate. The following activity has taken place within 2016/17:

a) 'Takeover' – national 'Takeover Day' takes place in November, and each year Lancashire aspires to increase engagement by extending the initiative to take place over the entire month. The LSCB has engaged in the process for a number of years, and in November 2016, the following took place:
    - A young person co-chaired the LSCB meeting which proved a rewarding and useful experience and challenged LSCB members to ensure dialogue is meaningful and accessible to young people

- A young person 'took over' part of the CSE Operational Group meeting in November, acting as the Chair for the second half of the meeting and delivering a number of agenda items to share the views of children and young people in relation to CSE. This activity prompted positive discussions and gave the opportunity to gain a young person's perspective in the approach to tackling CSE.

b) Corporate Parenting Board – a representative from LINX (Children in Care Council) attended the LSCB meeting in January 2017 to deliver an update on behalf of the Corporate Parenting Board. As part of the discussions, the young person advised of the proposal made to district councils to exempt all care leavers from paying Council Tax prior to 25 years of age – a proposal which had been accepted by the county council who are in negotiation with the District Councils

c) Young Inspectors – a group of young people 'Lancashire CSI' assist agencies in making improvements in service by carrying out their own inspections and making recommendations. The group feedback to the LSCB via the QAPI Sub Group.

During the reporting year, the young inspectors have carried out inspections of the following:

- Youthzone Facebook April 2016;
- CANW re-visit in May 2016;
- LSCB CSE survey and work November 2017;
- Police CSE Inspection January 2017.

Last year, the Young Inspectors created a summary of the LSCB Annual Report and will be asked to do the same again this year.

d) CSE Awareness Week – Engagement of young people in a CSE conference which informed a parallel event for adults and influenced the CSE Strategy.

e) Young Person's Safety Toolkit – last year we reported that a group of young people were helping with the design of a toolkit to assist professionals in having conversations with young people about issues of risk and safety, whilst also giving messages to young people about what constitutes risky activities and situations as well as what might be safer. The development of the toolkit continued in 2016/17 and was launched in February 2017: http://www.lancashiresafeguarding.org.uk/media/31316/Young-Peoples-Safety-Toolkit.pdf

f) Annual report – following the publication of the 2015/16 annual report, a group of young people developed a one sided summary of the issues they felt were most relevant to them. The summary can be found here: http://www.lancashiresafeguarding.org.uk/media/26115/Annual-report-Young-Peoples-summary.pdf . We will again be asking young people to look at creating a version of this year's annual report which is more engaging for children and young people.

Collecting the views of Adults as service users is a new challenge for the LSAB. During 2016/17 we have engaged with a group of service users to develop an Easy Read Guide: 'What is safeguarding and how to report your concerns', which aims to help vulnerable adults understand what 'safeguarding' is; what 'abuse' is; the different types of abuse, and what to do if they are worried

or concerned. This was developed in partnership with the Learning and Disability Partnership Board, and is currently awaiting final sign off.

In 2016/17 the LSCB recruited two new Lay Members. A similar approach is currently being explored for the LSAB.

As part of the SAR/SCR process the LSAB/LSCB routinely consults and seeks the views of family members in relation to the review and ensures their views are appropriately reflected.

The newly established Communication and Engagement Sub Group will address service user engagement as part of their strategy and work plan over the next year, looking to develop more effective methods.

5.6 Board Performance

The Boards also have performance indicators which relate to its own effectiveness, with the year-end returns as follows:

Indicator	**2014/15**	**2015/16**	**2016/17**	**Target**	**Direction of Travel (at Q4)**
Attendance at LSAB Meetings*	Not available	Not available	76%	80%	
Attendance at LSCB Meetings*	69%	67%	68%	80%	Better
SCRs referrals considered within timescale	100%	100%	100%	100%	Same
Number of cases reviewed by CDOP	84	86	68**	N/A	N/A

*A full breakdown of attendance by agency can be viewed at appendix 3. Where agency representation is poor, this addressed by the Chair.

** The number of cases reviewed by CDOP is lower than normal due to the implementation of the database. The number of cases reviewed still remains higher than the national average. Further details can be found in the CDOP annual report.

A risk register is in place for each Board to ensure the appropriate controls are in place to mitigate against key risks to the delivery of Board business and the effectiveness of the partnership.

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6. Key Achievements from the Sub Groups

The work of the Boards is delivered through a range of themed sub-groups as illustrated in the structures above. Each sub-group has its own work plan which are drawn from the Business Plans and in turn based around the Boards' strategic priorities. The work plans have been reviewed for the year and key achievements are as follows:

6.1 Safeguarding Adult Review and Serious Case Review Groups

Role – To consider referrals for SARs and SCRs against the criteria, commission reviews and monitor implementation of single and multi-agency learning from case reviews.

SAR/SCR Activity 2016/17

2016/17	**SARs**	**SCRs**
Number of referrals:	11	20
Number converted to reviews:	4	3
Number converted to Multi-agency learning reviews	0	1
Number pending decisions	2	1

Key Achievements 2016/17

The SAR and SCR Groups have successfully implemented the Welsh methodology for undertaking SAR/SCRs and they continue to embed this into practice, raise awareness with practitioners and learn from reviews undertaken on behalf of the Board.

The first SAR has been completed and was presented to the LSAB in April 2017. Three SCRs were commissioned in the reporting year, undertaking an additional 7 throughout the year which were commissioned during 2015/16.

A resource pack has also been developed which includes roles and responsibilities of panel members/ Independent Reviewer/ Independent Chair and Business Coordinator, learning event briefing, certificate for learning event, and a 7 minute briefing on the Welsh methodology. A system has also been set up to enable prospective chairs to observe a full SAR/SCR prior to undertaking the chairing role, this provides an opportunity for new chairs to receive some form of training prior to undertaking a full review.

Furthermore, a tendering process and contract has been developed and utilised for the 2 most recently commissioned SCRs, and 3 SARs. This process will be used for any future reviews commissioned.

Priorities for 2016/17

SAR Group:

- Contribute to the Welsh Model Evaluation being undertaken by an independent reviewer,
- As the SAR Group gains experience and learns from reviews undertaken they will look to tailor the Welsh Model (where appropriate) so it is specific to the adults agenda,

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- Develop a robust method for implementing and monitoring multi-agency actions plans as a result of SAR recommendations, being mindful of evidencing impact and outcome,
- Develop effective methods of disseminating learning to partner agencies and frontline practitioners,
- Develop communication with other sub-groups of the Board to improve dissemination of lessons and reduce duplication,
- Review the Terms of Reference (TOR) and ensure the membership is made up of appropriate agency representatives (including seniority),
- Continue to promote the SAR panel, its role and referral pathways with LSAB partners

SCR Group:

- Undertake an independent evaluation of the Welsh Methodology;
- Improve dissemination of learning to the multi-agency workforce;
- Improve evidence impact and outcomes from action plans;
- Develop a retention policy and formulate a member agreement;
- When the first 6 SCRs are completed using the Welsh method, Review Group should consider the need for a thematic audit and if agreed plan this as a separate piece of work.

6.2 Learning & Development Sub Groups (LSAB and LSCB)

Role – The principal purpose of LSAB and LSCB learning & development sub-group is to promote learning and development.

LSAB

The Adults Learning and Development Sub Group has met regularly and has had good attendance from multi-agency partners.

The Sub Group has undergone a number of changes with regard to its Chair, however, Lorraine Elliott, has taken on this role. The group members are committed to strengthening multiagency learning opportunities despite the challenges within existing financial constraints.

The main priorities for the group has been to review the terms of reference for the group, review the membership and begin to identify the work plan and future priorities for the group.

Key Achievements for 2016/17

- Web site presence for the LSAB and a page dedicated to Learning and Development.
- Delivery of single and multi-agency training sessions via the Care Act task and finish group, topics include: managing modern safeguarding challenges, MCA / DoLS and safeguarding and care homes. The task and finish group members have capitalised on existing networks and resources to realise statutory requirements on a cost neutral basis.
- Development of a process to agree and publish Seven Minute Briefing topics
- A conference on self-neglect has been held and evaluated well. The conference was oversubscribed indicating the need for further sessions.
- Agreement on future direction and focus on multiagency learning topics incorporating complex safeguarding matters.

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Priorities for 2017/18

- An Options Paper has been presented at the LSAB which outlines three options for the future direction of Learning and Development. This is currently under review .The preferred option is the development of a multi-agency training pool. A training pool model brings multiple benefits by trainers providing agency specific skills. The trainers bring knowledge and experience, along with different kinds of specialist knowledge combined with local knowledge re structures and systems.
- 7MB topics proposed and agreed:
    - Confidentiality and information sharing
    - Financial Abuse
    - Learning from SARs
    - MCA & DoLS
    - Best Interest decisions
    - Self-Neglect (incl. hoarding)
    - How to make a safeguarding referral
    - Safeguarding and interface with legislation
- Safeguarding Adult Review (SAR) learning will be a regular agenda item, agreement to incorporate key themes following SARs into the 2017 work plan. To date agreement on multiagency learning topics:
    - Consideration of domestic abuse in the context of adults with care and support needs
    - Strengthening MCA implementation across agencies, due to inconsistent awareness of how to apply the principles into practice
    - Risk assessment and safeguarding and effective use of family views
- Development of a robust process to cascade multiagency learning following the outcome of SARs. Where there is crossover with the LSCB learning and development subgroup, the group will join up to reduce duplication of efforts and provide a more consistent approach to safeguarding learning and development.
- Review the terms of reference (TOR) and ensure the membership is made up appropriate representatives including seniority.
- Arrangement of a learning and development day to plan and develop objectives for 2017/18

LSCB

Key Achievements for 2016/17

- 61 events planned;
- 920 people attended, with 112 non-attenders (11%);
- E-learning was popular again and 12.782 completed e-learning courses;
- 5 courses quality assured externally;
- 6 level 1 courses quality assured by L&D sub group;
- 14 seven minute briefings were published;
- One MALR facilitated and written;
- Training s11 collated and published;
- Published evaluation report.

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Priorities for 2017/18

- Ensure that an appropriate level of CSE training is available to all professionals who require it; specialist training should be targeted on those working with children and young people at risk of or suffering from CSE;
- Evaluate the impact of training with a focus on how it makes a positive difference to keeping children and young people safer;
- Use 7 minute briefing system to raise practitioner awareness and provide specialist information regarding a range of complex safeguarding concerns in annual training needs analysis;
- Include the scoping of training requirements regarding range of complex safeguarding concerns in annual training needs analysis;
- Ensure appropriate single training is provided to relevant staff;
- Provision of a focussed, directed training plan, aligned to the Board needs:
    - provision and maintenance of skilled training pool;
    - Maintain 4 e-learning courses. (CDOP, Level 1, Level 2, CSE);
    - Refresh of course materials for each course annually;
    - Publish 7 minute briefings 14 times per year;
    - Provide 80 courses per year, at levels 3 - 6;
    - Collate statistical information on attendance.
- Evaluate training provision by single agencies and the LSCB:
    - QA 4 LSCB course annually;
    - QA 6 single-agency courses annually;
    - Ask each participant for feedback and to set an action plan which is checked 3 months later;
    - Use the s.11 process to quality assure each member agency's level 1 and level 2 safeguarding training.
- Be reactive to needs of local, national and Board requirements/requests in respect of Learning and Development;
- Involvement with Board Chair's meeting ensure connectivity with SCR group and SCR a standing agenda item upon Learning and Development. Ensure national initiatives are upon agenda as required.

6.3 Quality Assurance and Performance Information Sub Groups (LSAB and LSCB)

LSAB

Role – to ensure that the LSAB is assured that there is an effective and wide spread approach in ensuring the safety of adult citizens of Lancashire.

Key achievements for 2016/17

- Formed a forum where safeguarding issues or potential issues can be discussed, resolved and shared
- Established a process to develop, implement and deliver a programme of multi-agency thematic audits, including having the knowledge, skills, abilities within the membership to undertake the audits
- Shaped an effective membership to identify and respond to changes in local and national safeguarding policy and priorities

- Committed to receiving, discussing and utilising data from multiple sources, with recognition that there is a vast amount of complex data
- Created a Terms of Reference for the sub group that ensures effective and relevant membership and a mechanism to focus the group's activities
- Initiated first multi-agency audit around the topic of Domestic Abuse in Vulnerable Adults

Priorities for 2017/18

- Maintaining the commitment from member organisations in supporting the function and remit of the group.
- Identifying key topics for audit for 2017/18 – the first of these being 'Time scales and information sharing'.
- Ensuring the sub group maintains its focus on its key priorities.
- To further refine the performance data presented to the group and the board.
- To explore how the group will align to the Safeguarding Adult Review (SAR) and the Learning and Development (L&D) sub groups.

LSCB

Role – to develop QA capacity and test the quality of multi-agency responses to vulnerable children and their families in order to inform service development and training needs.

Key achievements for 2016/17

- Appointment of new chair and Business Support Officer for QAPI
- Joint working with Rochdale to adapt their multi-agency audit process for use across Lancashire recognising the challenges of scale. Multi-agency training on the audit methodology.
- 3 multi-agency audits undertaken across Lancashire on:
    - Early intervention and Children in Need
    - 16/18 year old transitions as a result of recent SCR finding and findings of the Ofsted/CQC inspection of health providers in Lancashire.
    - Child Sexual Exploitation
- All audits to include generic questions on the Voice of the Child, Information sharing and assessment and planning. Discussions are to be had with the young inspectors re their involvement in this process.
- S47 audit completed as requested by the Improvement Board involving 36 cases chosen by CSC, which identified a number of issues relating mainly to record keeping. Good discussions have been held with CSC as a result, action plan developed and completed.
- S11 audit completed and challenge sessions held with 2 local councils, a health provider and probation.
- Performance dashboard developed for reporting to LSCB with agreed exception reporting.

Priorities for 2017/18

- Complete risk register amalgamating risk that currently sit at a sub group level and ensure regular updates to board.
- Robust analysis of S11 audits utilising new format and all members of the QAPI group to agree partners to be challenged.
- Undertake agreed multi-agency audits and focus group reviews.

- Monitor completion of action plans against completed audits

6.4 Mental Capacity Act Implementation (MCA) Sub Group (LSAB)

Role – to advise the LSAB on processes, procedures and outcomes in relation to the implementation of the MCA and Deprivation of Liberty Safeguards (DoLS).

It's estimated that as many as two million adults in England and Wales lack the mental capacity to make decisions on a daily basis. Consequently, the Mental Capacity Act 2005 (MCA) lies at the core of many decisions and should be a key theme of all services providing care for individuals with care and support needs. The MCA empowers people to make decisions for themselves wherever possible and protects people who lack capacity, by providing a framework that places individuals at the very heart of the decision-making process.

The MCA/ DoLS implementation subgroup was a newly formed subgroup of the board as of February 2016. The group was implemented following the House of Lords Select Committee recommendations and to support the work of the pan Lancashire MCA practice group. The purpose of the group is to advise the LSAB on processes, procedures and outcomes in relation to the implementation of the MCA and the Deprivation of Liberty Safeguards 2009. This includes progress updates and assurance of how the Act is embedded in practice across multiagency partnerships.

Key achievements for 2016/17

The group has made a positive contribution to the work of the LSAB, by identifying potential barriers to implementing best practice and highlighting areas of risk regarding MCA/DoLS implementation. Strategies have been implemented to mitigate potential risks and progress has being made to standardise practice across the system where appropriate. Over the reporting period the group have delivered on a number of objectives including:

- Following the successful development of the pan Lancashire MCA media resource and E book reported in the annual report of 2015/16; the resource was launched at a local conference in April 16 and shared with the national MCA sub group of NHS England. The work was shortlisted for a national 'Patient Safety' award and also featured in the national MCA forum chairs annual report of Baroness Finlay as an example of best practice. The links to the resource can be found below.
    - https://youtu.be/6mQlN6Yw03E%20
    - http://pub.lucidpress.com/MCABLBNetwork/
- The group have collaborated with regional and national groups sharing best practice resource tools across services, including the NHS Deciding Right App; a guide to support care providers through the process of making care decisions in advance for people who will or may lose capacity in the future, or those who have already lost capacity for those decisions.
- Over the reporting period there has been a significant investment in strengthening learning and development opportunities to support agencies in applying the principles of the Act into practice. Using funding received from NHS England the group have coordinated a number of multiagency training events, commissioning Afta- Thought; a drama based training company who specialise in training delivery using scenarios that are realistic, recognisable and measurable. The sessions were targeted across statutory services, including health, social care and the police along with independent care providers and third sector agencies. The sessions were well attended and evaluated positively.

- Expert speaker 'Neil Allen' Barrister from 39 Essex Chambers and Senior Lecturer at Manchester University was commissioned to provide targeted training on MCA and case law updates for GP's and hospital medics across the pan Lancashire footprint.
- Development of two 7 minute learning briefings in the Mental Capacity Act and how this applies in practice, along with a briefing to outline the role of Advocacy Focus - a statutory support service available to adults in Lancashire who are experiencing or living with health or social care needs.
- Purchase of easy read leaflets from RIPFA which have been used to raise awareness if the Act with the public.
- Commissioning of a pan Lancashire research project to understand the experience of health and social care provider's experiences of working with the Act. The research is the first of its kind from a local and national perspective and will inform practice with evidence based recommendations.
- Introduction of practice based learning sessions led by the MCA coordinator with opportunities to discuss case law updates and reflect on complex cases across statutory health and social care providers.

Priorities for 2017/18

- Further embed the MCA into practice across all agencies and effectively challenge providers to demonstrate compliance with the Act.
- Strengthening MCA arrangements for 16 & 17 year olds.
- Incorporation of the service user voice and engagement with the public to help in understanding their rights.
- Multi-agency audit against the ADASS MCA Improvement Tool.
- Consideration of the recommendations from the pan Lancashire MCA research project.

6.5 Practice with Providers Sub Group (LSAB)

Role – a multi-agency forum to discuss the wide safeguarding agenda following amendments to the Care Act, with a view to raising awareness and sharing learning across agencies and providers.

Key achievements for 2016/17

In consultation with partners:

- Developed the "LSAB Guidance for Safeguarding Concerns" including associated appendices. This guidance is for Providers and Practitioners as key partners in safeguarding adults with care and support needs. Its aims are to support delivery of professional safeguarding duties and responsibilities. It received approval of the LSAB on 21 April 2017 and subsequently has been shared widely by multi-agency partners in a range of forums, including the appendices:
    - Safeguarding Concerns Checklist
    - safeguarding guidance in relation to Medication Errors
    - safeguarding guidance in relation to Falls and unexplained injuries
    - safeguarding guidance in relation to incidents between service users
- Developed 7 minute briefings on the following:
    - Safe Use of Agency Staff
    - Oral Health for adults with Care and Support Needs
    - Risks regarding emollients and smoking

- Contributed to a review and a refresh of the Best Practice guidance for Pressure Ulceration
- Promoted the use of the Hydration Toolkit for care homes
- Facilitated discussion in response to concerns from Providers regarding the proposed health commissioning arrangements being introduced for Medicines Optimisation and Safety of Medicines in Care Homes including the Principles of managing the use of homely remedies
- Provided a briefing and awareness raising for Providers on the NHS England Prevent national update
- Made available to Providers a Care/Nursing home sample Safeguarding Adult Policy which is Care Act 2014 and Mental Capacity Act 2005 Compliant

Priorities for 2017/18

- Raise awareness and engagement with Providers through a variety of methods including the Champions network and the communications and engagement group of 'Making Safeguarding Personal' agenda and engage with Providers as to how they can contribute to achieving positive and person centred safeguarding outcomes. This is of particular importance where a registered provider is asked to undertake a safeguarding enquiry on behalf of the commissioner /local authority for an adult in their care
- Develop guidance information and a report template to assist partners and/or providers by detailing the key areas to consider when a request has been made by the local authority safeguarding service for an internal provider led safeguarding enquiry to be completed
- Explore if and how this sub group could take forward initiatives from best practice evidence in relation to acknowledging adverse childhood experiences in adult safeguarding work to achieve outcomes that are more positive than might otherwise have been the case.
- Promote learning in relation to actions which may be relevant for all Providers from the findings of Serious Adult Reviews. Raise awareness of and consider the impact of ' 2nd victim ' to ensure that Providers are supported within a positive culture of learning.
- Collaborate with and support the 'Communications and Engagement group to ensure that registered Providers across Lancashire are reached, informed and contribute to the work of the LSAB and its sub groups.
- Continue to promote with the 'LSAB guidance for Safeguarding Concerns' with registered providers by ensuring that it is referenced within and promoted through the Multi-Agency safeguarding Policies and Procedures which are in development
- Continue to promote and share best practice guidance from the Social Care Institute for Excellence with care providers to improve the safety and quality of care and reduce the incidence of safeguarding concerns.
- To update and refresh these priorities in light of the LSAB objectives and or issues that may emerge and will benefit from input and action by this sub group.

6.6 Leadership Sub Group (LSAB)

Role – a multi-agency forum to discuss the wide safeguarding agenda following amendments to the Care Act, with a view to raising awareness and sharing learning across agencies and providers.

Key achievements for 2016/17

- Successful transfer of 3 area based Leadership Groups to one countywide group.
- Established effective links with Advocacy Focus

- Enabled partners to recognise the importance of the prevent strategy
- Ensured information relating to policy/procedures updates are effective shared
- Improved working with Trading Standards
- Development of an Easy Read Safeguarding leaflet
- Contributed to the LSAB website with members of the board and identified requirements.
- Developed Self-Neglect guidance in conjunction with Principal Social Worker
- Increased awareness of online safety in vulnerable adults
- Provided insightful presentations and information from multi-agency partners on areas such as:
    - Clare's Law and Coersive Control;
    - Safeguarding in Prisons
    - Modern Slavery Act 2015 and the implications for all partners
    - Guardian Angels dementia project
    - Safeguarding and refugees and the impact of this
    - Financial abuse and working with adults with care and support needs
- Awareness of the new domestic abuse audits

Priorities for 2017/18

- Share learning from SARs and ensure learning embedded within the work of agencies
- Strengthen links with wider partners who are not represented on the sub group
- Further develop joint learning and networking
- Improve communication and engagement
- Develop a Safeguarding poster
- Share anonymised case examples.

6.7 Lancashire Child Sexual Exploitation Operational Group (LSCB)

Role: Operational multi-agency group to ensure a coordinated multi-agency response to CSE.

Three Operational Groups (Lancs/Blackpool/Blackburn with Darwen) were established in February 2016, with accountability to their respective LSCBs, and the Pan-Lancs CSE and MFH Strategic Board. The Lancashire Operational Group met for the first time in April 2016 and has developed over the reporting period, contributing to the following:

Key achievements for 2016/17

- A Business Co-ordinator with responsibility for CSE is now in post with the LSCB and supporting the work of this agenda.
- External review of the pan-Lancs CSE Strategic Action Plan. Many priorities marked as completed and Operational Groups tasked with focusing on those RAG rated as Amber or Red via local level action plans;
- Initiated a pan-Lancs review of Standard Operating Procedures for CSE. This work is ongoing via a multi-agency Task and Finish Group;
- Working towards a multi-agency Dataset to build a live picture of CSE in Lancashire. Group are utilising a tailored Sefton model to analyse a full year's data prior to review of the tool.
- Positive engagement in CSE Awareness Week in November 2016. The thematic focus of the week was around children and young people with disabilities and those from BME communities. Well attended multi-agency conference took place during the week, with a parallel

conference for young people. LSCB supported the week of action via attendance and promotional activity via Twitter.

- National CSE Awareness Day took place in March 2016, agencies of the Operational Group were engaged in the process, and again the LSCB took to Twitter to promote key messages of the National Working Group and agencies within Lancashire.

Priorities for 2017/18

- Successful completion and implementation of SOPs Review;
- Further develop an effective multi-agency data set;
- Implement learning from recent multi-agency CSE Audit;
- Development and implementation of a pan-Lancs Communications Plan;
- Engagement in Lancashire CSE Awareness Week (w/c 13 November) and National CSE Awareness Day;
- Consider and address findings and issues raised via the research project around the views and perceptions of CSE within minority communities;
- Assist and support the roll out of the 'Taxi Driver Workbook', and implement methods to analyise the impact
- Remain sighted on JTAI assessments
- Exploration of the problem of Child Criminal Exploitation and County Lines in Lancashire

6.8 Pan-Lancashire Online Safeguarding Sub Group (LSCB)

Role – To raise awareness and support agencies in protecting young people from the risks associated with the use of the internet and social media.

Key Achievements for 2016/17

- Successful production of 'Making Sense of…KCSIE'. Highly popular resource both within and outside of Lancashire region developed in response to school HT requests for guidance re: online aspects of Keeping Children Safe in Education 2016. Positive Ofsted feedback received on resource during school inspections.
- Development of new (Pan-Lancashire) Online Safeguarding section on LSCB website – formal launch on Mon 6th Feb 17 prior to Safer Internet Day (Tue 7th Feb 17)
- Governor session demand has seen substantial increase since publication of KCSIE in Autumn 2016. Implications of KCSIE 2016 delivered to series of Lancashire Governor Forums during Autumn 2016. Development of supporting School Governor Online Safety Self Review (Checklist) Tool released as part of Safer Internet Day 2017 activities has been well-received and has been adopted beyond Lancashire.
- Co-ordination and successful hosting of 4 x Online Safety Briefings (OSB) across Lancashire region during January 2017 - (5th iteration in Lancashire with highest attendance to-date (c. 350). Blackpool attendance significantly improved over 2016). In total, over 560 multi-agency professionals attended sessions which were again very well-received and feedback extremely positive.
- OSB events produced valuable multi-agency survey evidence from professionals across the children's workforce, highlighting areas where professionals would like to see further support.

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- Updated Online Safeguarding Strategy 2017 – 2019 agreed and in place. Renewed Action Plan under development to focus on key Risk Areas and encompass support priorities identified in Lancashire multi-agency survey evidence from OSB 2017 events.
- Series of LSCB Safer Online Behaviour multi-agency L&D sessions commenced April 2017.
- Partnership activity with BwD LSCB includes delivery of Online Radicalisation/Counter-narrative sessions (series of 3 x sessions planned) for 2017/18.
- Enhanced links with NSPCC colleagues has resulted in increased partnership activity and promotion of national 'Share Aware' campaign and in-school support sessions for pupils.
- Media engagement opportunities including Lancashire Evening Post article (November 2016) and BBC Radio interview as part of Safer Internet Day 2017 promotional activities (February 2017).
- Commission to deliver series of (mandatory) Online Safety courses for foster carers.
- Continued development of Prevent for Schools (P4S) website as a nationally-recognised resource for schools. Development of dedicated Online Radicalisation/Extremism guidance for schools published in 2016. Site usage continues to increase both within and outside of Lancashire with highest ever access statistics recorded during March 2017.
- Continued requests for session delivery successfully met including recent increased demand for Online Radicalisation/Extremism and School Governor sessions.
- General feedback indicates increasing school acknowledgement of Online Safety identified as a Safeguarding rather than ICT issue (a recurring key message in Lancashire over recent years).
- Active engagement with School PSHE Networks has resulted in a number of YP from Lancashire schools being selected for both National focus groups and a European research project.
- Requests for consulting-advisor input into development of (national) projects and resources has continued and supports Lancashire input into national developments.
- Increasing multi-agency engagement and recognition of LSCB central hub of expertise. Particularly useful engagement from Health colleagues - online aspects increasingly appearing around Health & Wellbeing priorities.

<u>Priorities for 2016/17</u>

- Continue awareness raising activities for key Risk Areas including Online CSE, Bullying, Sexting, Online Radicalisation and wider developing Social Media-related issues (e.g. false news/misinformation).
- Progression of LSCB Online Safeguarding web presence including development informed through site analytics and Lancashire survey evidence.
- Development of agreed Pan-Lancashire Action Plan reflecting priorities and agency activity informed by existing and developing Online Safety risks and results of children's workforce survey. Build upon OSB data to evidence and support multi-agency priorities and subsequent activity.
- Develop and encourage increased multi-agency partner commitment to co-ordinated activities, including liaison with related organisations (e.g. CPB).
- Reflect LSCB joint-business approach through development of adult-focussed provision including vulnerable groups and associated risk areas.
- Build on current Govt focus and forthcoming UK Internet Safety Strategy and maximise opportunities to support Lancashire C&YP and associated workforce.

- Maintain core recommended resources and guidance to support progression. Review (historical) Tri-X guidance for currency to ensure reflection of agreed policies and processes.
- Secure commitment to repeat Online Safety Briefing events across Lancashire region for 2018. Co-ordinate and support events including repeat of children's workforce survey.
- Support embedding of Online Safety aspects within DSL responsibilities and associated training delivery.
- Ensure national developments and evolving nature of online agenda and associated priorities (e.g. factors influencing online radicalisation) are reflected in future priorities.
- Ensure existing and developing Online risk areas are appropriately reflected in Lancashire Continuum of Need. Investigate potential inclusion of Online Safety within future S11 revisions.
- Continue to provide central hub of Online Safety expertise and guidance across Lancashire to support positive outcomes for C&YP and Parents & Carers.

Demand for support around Online Safety agenda is likely to remain high. Substantial update to DfE Keeping Children Safe in Education is anticipated in 2018.

UK Digital Strategy currently under development will include UK Internet Safety Strategy (Green Paper expected Summer 2017) – central Government focus on Online Safety is currently at all-time high.

6.9 Pan-Lancashire Child Death Overview Panel (CDOP) (LSCB)

Role – Reviews all child deaths in Lancashire to identify themes and trends to inform preventative developments

Key Achievements 2016/17

By far, one of the biggest achievements in 2016/17 was the introduction of the eCDOP database. From January 2017 all deaths are now notified to the CDOP team via the new online system and all Form B requests for completion are also requested online. All agency contacts who complete CDOP forms received training on the system and a user guide was also developed.

CDOP also held a Development Day which included presentations from RoSPA about current campaigns and how it can link into the CDOP. The Blackburn, Hyndburn and Ribble Valley Coroner also delivered a presentation around the role of the coroner and CDOP members had the chance to ask questions in relation to queries raised during case discussions meetings.

The Review of SUDC Service was completed and it was agreed by CDOP to extend the service. The review and options paper were subsequently presented to the Collaborative Commissioning Board in December and all CCGs across Pan-Lancashire agreed to the extension of the service. A multi-agency SUDC Steering Group was formed to oversee the implementation of the new service.

Priorities for 2017/18:

- Oversee the proposed changes to the SUDC Service
- To implement the recommendations from the ACE Audit
- Update the safer sleep materials timeline; secure future funding for the campaign and also link into the wider public health events calendar
- Hold a Safer Sleep CDOP Conference for professionals

- To scope out undertaking further thematic reviews and look into possibility of building on suicide thematic review
- Secure funding for Safer Sleep campaign and also link into wider public health events calendar to further promote the campaign and materials
- CDOP to have oversight of implementing the recommendations in the NW Infant Mortality sector Led Improvement report

6.10 Joint Communication and Engagement Sub Group

Role – to enable the effective delivery of key messages and awareness raising around issues of safeguarding for the residents of Lancashire

The LSAB/LSCB Joint Development Day in March 2017 agreed the need for a joint sub group to focus on communication and engagement of key safeguarding issues. Although established outside of the reporting year (June 2017), it seems appropriate to update on communication and engagement activity to have taken place during 2016/17 and the priorities the group will work towards for 2017/18.

Key Achievements for 2016/17

- Website development – a new LSAB website was developed during 2016/17, going live in January 2016. The website offers information and resources for practitioners and providers alike.
- Press engagement – the Boards have trialled engagement with the local press as a mechanism of sharing key safeguarding messages with the general public in order to raise awareness of important issues, help people 'spot the signs' and take appropriate action. The following articles were published:
    - Suicide – the LSAB worked with the Lancashire Evening Post as part of a three-day special investigating the high rates of suicide in Preston, and other areas of Lancashire, with a view to heighten the awareness of the issue and campaign for further work to address it.
    - Emollients and Fire Safety – following the tragic death of a care home resident, the LSAB launched a campaign with the Lancashire Fire and Rescue Service to raise awareness of the potential dangers in fire safety when using emollients containing a high level of paraffin. The article was published across various local newspapers across Lancashire, resulting in the issue being picked up nationally and the LSAB Chair being interviewed for a feature on Radio 5.
    - Online safeguarding – an article was published in November 2016, following an interview with the LSCB Chair and Online Safeguarding Advisor, to highlight possible online dangers to parents, and to provide them with tips on the most effective ways to address the issues with their children.
    - Dangers of button batteries – in the lead up to Christmas 2016, the CDOP Chair and Designated Doctor were involved in an article to heighten the awareness of the potential dangers of button batteries when swallowed. The article gave examples of where the batteries could be found – for example in children's toys – and the best action to take in the event one is swallowed.

- Twitter – both the LSAB and LSCB took to Social Media in May 2016 as another mechanism for promoting key safeguarding messages. Over the reporting year, the platform has been used to support many national and local campaigns and signpost users to information and support. Examples of campaigns include:
    - Child Safety Week – June 2016
    - Exam Results support – August 2016
    - Lancashire CSE Awareness Week – November 2016
    - Safer Internet Day – February 2017
    - National CSE Day – March 2018
    - Baby Loss Awareness Week – October 2016
    - Road Safety Awareness Week – November 2016
    - Safer Sleep Week – March 2017

<u>Priorities for 2017/18</u>

- Sub Group – agree Terms of Reference and Work plan for 2017/18;
- Development and implementation of a Communication and Engagement Strategy;
- Establish and publish quarterly newsletters regarding safeguarding matters;
- Support the sharing of learning from SARs and SCRs, and lead on any specific campaigns needed to fully embed learning. Campaigns agreed so far focus on:
    - Cannabis use and its effect on parenting capacity;
    - Adverse Childhood Experiences;
    - Prevention of non-accidental head injuries in babies;
- Develop a suite of 'Safeguarding Leaflets' to promote an awareness and understanding of safeguarding in various settings to assist practitioners and members of the public in recognising that safeguarding is everyone's business, and what to do when there is a concern;
- Further develop the LSAB website, and review and update existing content of the LSCB website;
- Establish effective methods of engagement to gain the views and input of service users;
- Identify methods to measure the impact of communication and engagement activity.

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7. Budget

The below details the contribution and expenditure against the LSAB/LSCB budget during 2016/17.

INCOME	Outturn 16/17
Contributions to Board	
North Lancashire CCG	33,164
Fylde & Wyre CCG	33,164
Greater Preston CCG	26,864
West Lancashire CCG	14,850
Chorley & South Ribble CCG	23,265
East Lancashire CCG	66,329
Police	76,723
National Probation Service*	0
Community Rehabilitation Company 15/16	9,189
Community Rehabilitation Company 16/17	11,633
Cafcass	550
Lancashire County Council	255,813
Lancashire Teaching Hospitals NHS Trust	4,000
Training income	7,950
Miscellaneous Income	3,254
Deficit funded from reserves	6,539
	573,287
*National Probation Service contribution delayed due to ongoing discussions re national formula.	(6,745)
	566,542
Child Death Overview Panel	
Lancashire County Council	74,000
Blackburn with Darwen Borough Council	14,700
Blackpool Borough Council	9,800
	98,500
Contribution back to BWD & BBC from reserves	**(24,500)**
Following an in year review of CDOP budget, a reserve of monies built up from previous years was repaid proportionately to contributing authorities.	
TOTAL LSCB/LSAB INCOME 16/17	**640,543**

EXPENDITURE	Outturn 16/17
Central	
Staffing Costs	238,529
Transport	4,463
Supplies	95,496
Training	10,169
Other Expenses	12,421
	361,078

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Child Death Overview	
Staffing Costs	42,316
Transport	236
Training	330
Supplies	21,724
Other Expenses	833
	65,439
Serious Case Review	
Staffing Costs	21,011
Supplies	53,583
Training	723
Transport	262
Other Expenses	892
	76,471
Training	
Staffing Costs	78,679
Training	42,537
Supplies	12,817
Transport	1,364
Other Expenses	2,158
	137,555
TOTAL LSCB/LSAB EXPENDITURE 16/17	**640,543**

8. Contact Details

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Appendix 1 – Findings from the MASH Diagnostic

Multi-agency Safeguarding Hub (MASH) – Diagnostic June 2016
Executive Summary

- No ownership in terms of strategic governance;
- No joint commissioning;
- No single management function;
- Stage one running since April 2013 on basis of police only referrals;
- Original vision was for Pan-Lancashire and across full age-range but the Unitaries subsequently split off (has achieved viable approach at that scale).
- No clarity as to function i.e. is this a referral unit, a triage system or a problem solving function?
- Scope expected 30,000 police referrals – reality is 50,000;
- Scope for stage 2 onwards was projected as likely to be 60,000 now known to be more like 90,000+
- Original vision to include all groups but reality is only children's work at present;
- Multi-agency team in place, broadly cover the ground for children's cases – needs different approach to fully encompass adults;
- Original vision was to screen all agency incoming work and identify the vulnerable – the reality is even taking only police referrals where vulnerability is already identified it is clear the process doesn't necessarily add value in a significant number of cases;
- Of the above around50,000 cases 50% are not subjected to full MASH process and would benefit from Early Help
- Unwieldy processes (more than 60 steps in police process alone if fully "Mashed") result in slower processes and increased cost;
- Commonality of language and definitions of risk are still issues;
- The process has resulted in backlogs which can itself generate risk;
- Significant commitment and investment has been forthcoming from agencies. (e.g. £1.7 million from Police alone for MASH service)
- Only the police cover 24/7
- Single site/single service has brought consistency but reduced local connections;
- Safe service (inspectorate view) - but this really relates to cases where safeguarding issues are clear from outset – much more complex issues about recognition of risk.

BUT - clear evidence of improved safeguarding in relevant cases and much richer information sharing.

Moving to stage 2:

- Stage 2 work is currently processed via Customer Access and then CART – issues here about decision making and duplication;
- Likely to be even greater proportion of cases which would benefit from Early Help;
- Managing 90,000 cases via MASH is not viable as the one size fits all has proved to be unhelpful and caused a delay in service – diversion of those needing "early help" and clear service pathways are needed.

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- Adult services– current team (who are co-located) receive all “safeguarding” alerts and both collect a limited amount of multi-agency information, assess risk and where possible provide a problem solving service – There is lack guidance around thresholds.
- Location/locality need to be considered – consistency is important but the loss of local interaction across service providers has a negative impact.

Recommendations:

1. Identify high level accountability and establish effective strategic group to drive forward to stage 2;
2. Re-visit vision, objectives and customer cohort for MASH;
3. Scope likely workload and identify resource requirements;
4. Commission service redesign;
5. Agree areas for joint commissioning - including non-service specific staff e.g. referral assistants;
6. Agree multi-agency partners and single agency contribution/resource commitment;
7. Explore integrated agency approach with single line management chain;
8. Explore options re single/central versus locality based arrangements;
9. Identify and align under-pinning areas:
    - Redesign e.g. Customer Services and Police Contact management
    - Establishment of refreshed thresholds
    - Development of common language and common risk assessment measures;

Jane Booth, LSCB Chair June 2016

Full MASH Diagnostic Report:

MASH Diagnostic FINAL REPORT July 1

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Appendix 2 – Service Area Annual Reports

1. Local Authority Designated Officer (LADO)	LADO .pdf
2. Common Assessment Framework (CAF)	CAF.pdf
3. Wellbeing, Prevention and Early Help (WPEH)	WPEH.pdf
4. Counter Terrorism	CT.pdf
5. Domestic Abuse	Domestic Abuse.pdf
6. Independent Reviewing Officer (IRO)	IRO Annual Report 2016-17.pdf
7. Multi-agency Public Protection Arrangements (MAPPA)	Mappa LSCB 2016 2017.pdf
8. Secure Estate (Young offenders institutes)	- YOT.pdf
9. Private Fostering	Private Fostering.pdf

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Appendix 3 – Attendance Breakdown 2016/17

Lancashire Safeguarding Adult Board meetings Member representation	% Atn
Independent Chair	100
LCC – Director of Adult Services	60
LCC – Lead Member	40
LCC – Director Public Health	60
LCC – Head of Patient Safety and Quality Improvements	80
LCC – Principal Social Worker	80
LCC – Quality Improvement and Safety Specialist	100
LCC – County Operations Manager	100
Lancashire Constabulary	100
Chorley and South Ribble, West Lancs and Preston CCG	80
East Lancashire CCG	100
Fylde and Wyre CCG	100
Lancashire North CCG	100
Lancashire Care Foundation Trust	100
Lancashire Teaching Hospitals	40
Merseycare NHS Foundation Trust	20
NHS England	80
NW Ambulance Service	0
Probation	80
Cumbria and Lancs Community Rehabilitation Company	50
Lancs Fire & Rescue Service	100
Healthwatch Lancashire	100
Prison Services	20
Rep of Housing Providers	100
Rep of Independent Providers	100
Overall	**76**

Lancashire Safeguarding Children Board meetings Member representation	% Atn
Independent Chair	100
LCC – Director Children's Services	100
LCC – Lead Member	50
LCC – Director Public Health	67
Lancashire Constabulary	100
Chorley and South Ribble, West Lancs and Preston CCG	100
East Lancashire CCG	83
Fylde and Wyre CCG	83
Lancashire North CCG	67
Blackpool Teaching Hospitals	100
East Lancashire Teaching Hospitals	100
Lancashire Teaching Hospitals	83
Lancashire Teaching Hospitals (GP Rep)	33
Lancashire Care NHS Foundation Trust	100
Southport and Ormskirk Hospitals	33
University Hospital of Morecambe Bay	17
NHS England	50
Probation	100
Cumbria and Lancs Community Rehabilitation Company	83
Wyre Borough Council	67
The Children's Society	67
HARV	0
Cafcass	67
Primary Schools	50
Secondary Schools	50
Further Education	67
Lancashire Association of School Governors	67
Lay Member 1	25
Lay Member 2	50
Overall	**68**