APPENDIX A

LANCASHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2013/14

Published: September 2014

1. Foreword by Independent Chair

It was my privilege to take on the role of Independent Chair of the Lancashire Safeguarding Children Board in at the end of March 2014. Nigel Burke had fulfilled this role for the previous five years and I am indebted to him for the commitment he showed to the work of the Board and the strong and effective structure I inherited.

This report covers the period from April 2013 to the end of March 2014, a period prior to my appointment. It presents information about safeguarding of children across Lancashire. This is no easy task as this is not a single picture. In reality there is a diverse picture with clear links between the prevalence of safeguarding issues and deprivation. Ensuring a clear focus on distribution of need and equitable provision of services is a key challenge.

The information in the report highlights an increasing level of need with an upsurge of referrals to Children's Social Care Services, more children being made subject of a Child Protection Plan and more becoming "looked after" by the Local Authority; all this at a time of shrinking resources across the public sector and significant budget challenges.

This report identifies good practice but also areas for development. The Board recognises that, in a climate where there is little likelihood of new resources, development and improvement of services will have to be achieved by agencies working together more effectively. A particular challenge is to refocus resources on early help for children and families and we have seen a continuing increase in the numbers of children and families supported by a lead professional using the Common Assessment Framework. The report also reflects the work of the Board and its sub-groups. Agency engagement with the Board is strong, with membership at an appropriately senior level. The sub-groups involve a large number of professionals and these groups drive forward the business of the Board.

My thanks go to the staff in the Board Management Team who keep all this work on track and to the very many professionals and volunteers who work to safeguard children and support families across Lancashire. It has become a cliché to say that safeguarding is everyone's business but it is none-the less true. Acts of abuse and neglect blight a child's life and it is for each of us to use our energies and influence to ensure children in Lancashire are as safe as they can be.

Jane Booth
Independent Chair,
Lancashire Safeguarding Children Board

2. Contents

1. Executive Summary

It is recognised that Lancashire is a large and diverse county with complex demographics and significant local variation in deprivation and levels of need. This annual report has sought to provide a clear analysis of these trends and characteristics in relation to the safeguarding of children on a multi-agency basis. The LSCB and its partner agencies have made significant efforts to address these issues and continue to provide good services in the face of difficult financial challenges and subsequent organisational re-structuring. Throughout these organisational challenges the LSCB has continually sought assurance from agencies that any re-structuring of services does not negatively impact on the safeguarding of children.

The qualitative and quantitative evidence from the analysis of data, audits and reviews summarised in this annual report highlight a number of strengths and areas for development.

Key areas for development and further analysis exist around:

1. The application and understanding of thresholds and the continuum of need
2. Continued awareness raising and analysis of the risks presented through use of the internet and social media
3. Embedding the use of the refreshed CAF process and ensuring timely and appropriate early support services
4. The effectiveness of the Multi Agency Safeguarding Hub (MASH)
5. Domestic abuse data and evidence of the effectiveness of services on a countywide basis
6. Awareness of Private Fostering requirements and monitoring of number of cases
7. Engagement with private sector children's homes
8. Accurate monitoring of single agency training (quality and quantity)
9. The incidence of self harm and causal factors
10. Alcohol use by young people
11. The higher than average incidence of smoking during pregnancy and infant mortality
12. Ensuring assessments are multi-agency and holistic; especially regarding: voice of the child, the role of men/fathers, accurate and up to date information, professional challenge / scepticism, consideration of historical information
13. Ensuring services target resources to areas of need effectively
14. Accurate and regular performance data on a countywide basis from health agencies

The LSCB needs to be sighted on these areas throughout the current year and continue to seek evidence of effectiveness so it can scrutinise and challenge agencies to ensure children are safeguarded as affectively as possible.

Notwithstanding these areas for development, there have also been significant successes and strengths identified through this analysis. Most notably:

1. The supervision audit found that nearly all agencies had good arrangements in place
2. All agencies are largely compliant against the section 11 audit indicators with no inadequate ratings
3. Multi-agency practice inspections have identified a significant number of strengths, particularly around support for frontline staff, multi-agency practice generally and particularly in response to CSE
4. The Esafety Live conferences received extremely positive feedback from all attendees (of which there were over 200) examples of comments received include:
   "Extremely valuable session and delivered in a pacy and engaging manner."

"This was probably the best, most worthwhile 2 hours spent out of school. It was highly detailed, up-to-date, a little daunting but ESSENTIAL."

"This was an excellent session that has given some fantastic information out, including free resources. I am really pleased I attended."

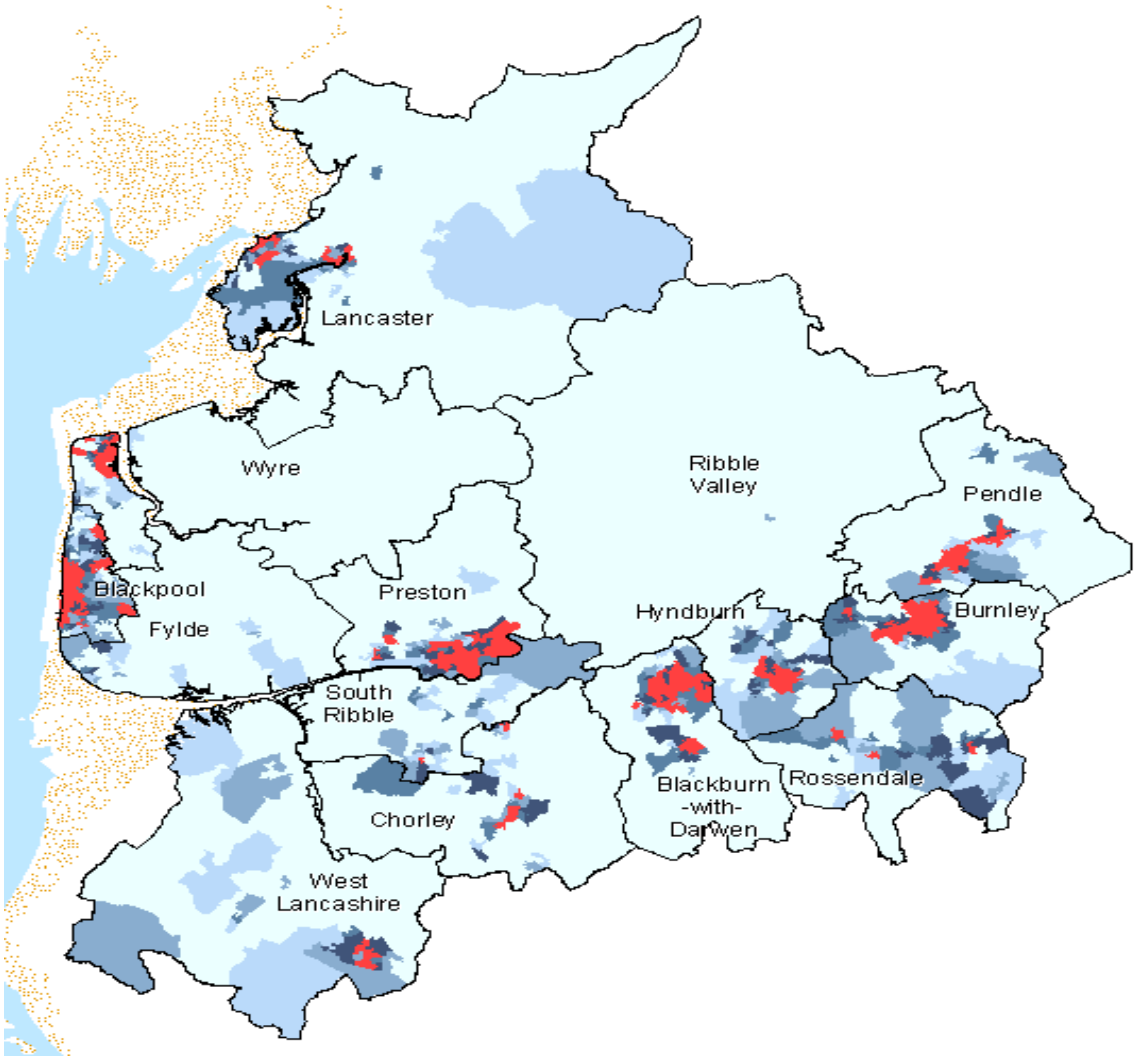
"Fabulous inspirational session. Lots of thoughts and plans to take forward."

5. UHMB have completed their action plan for improving safeguarding arrangements (though issues still remain for the trust in other areas)
6. 94% of attendees on LSCB training courses found them to be good / excellent
   Learners have stated that training provided them with:
   "A deeper understanding of the effect on children and young people who have suffered neglect"
   "Better understanding of DV relationships will help me recognise this as an issue and hopefully help with risk management/ strategy plans to address issues"
   "General knowledge gained from the course will help me to identify non-accidental injury sites and marks"
7. Ofsted's thematic inspection of neglect praised Lancashire's "whole-system approach to neglect" and was complimentary of the LSCB's Neglect Strategy
8. Lancashire Constabulary HMIC inspection of domestic abuse highlighted that:
   "*Police officers and staff provide a good service to victims of domestic abuse in all areas and help to keep them safe"* and *"staff demonstrated a high level of commitment and awareness and that they work well with partners"*
9. Practitioners feedback from SCR learning included the following comments:
   "I am more aware of multi-agency working and making sure that a full chronology is gathered on all aspects of the family"
   "It has reinforced a lot for me about not taking things at face value and being persistent"
10. The materials for the Safer Sleep Campaign have received some very positive feedback; for example the following quotes from parents:
    "Makes me want to pick it up and read it"
    "Love the bright colours – much less sombre and intimidating than the old one"
    "I like the way it is set out with 6 steps to follow and a lot more appealing with the images and colours. I also liked the sections on bed sharing and what baby should wear to sleep in"
11. The NSPCC delivered child abuse awareness raising sessions to children in 498 primary schools. Feedback indicated that 100% of schools would recommend the sessions to others and 80% of pupils could correctly identify abusive and non-abusive scenarios after the sessions.

2. Local Background and Context

Lancashire is a large and diverse Shire County with one County Council and 12 District Councils. Within the old county footprint there are two unitary authorities, Blackpool and Blackburn with Darwen who have separate administrations and separate Local Safeguarding Children Boards who provide their own Children Safeguarding Board Annual Report. The total population in Lancashire is approximately 1.9 million. Within Lancashire, there are pockets of severe social and economic deprivation. Four Lancashire Districts (Burnley, Hyndburn, Pendle and Preston) are in the "top 50" most deprived in England according to the Index of Multiple Deprivation 2010. There are also large areas of economic prosperity such as Ribble Valley and Fylde Borough. The map below shows the 'indices of multiple deprivation' across the county with dark and red areas identifying the most deprived places.

Figure 1

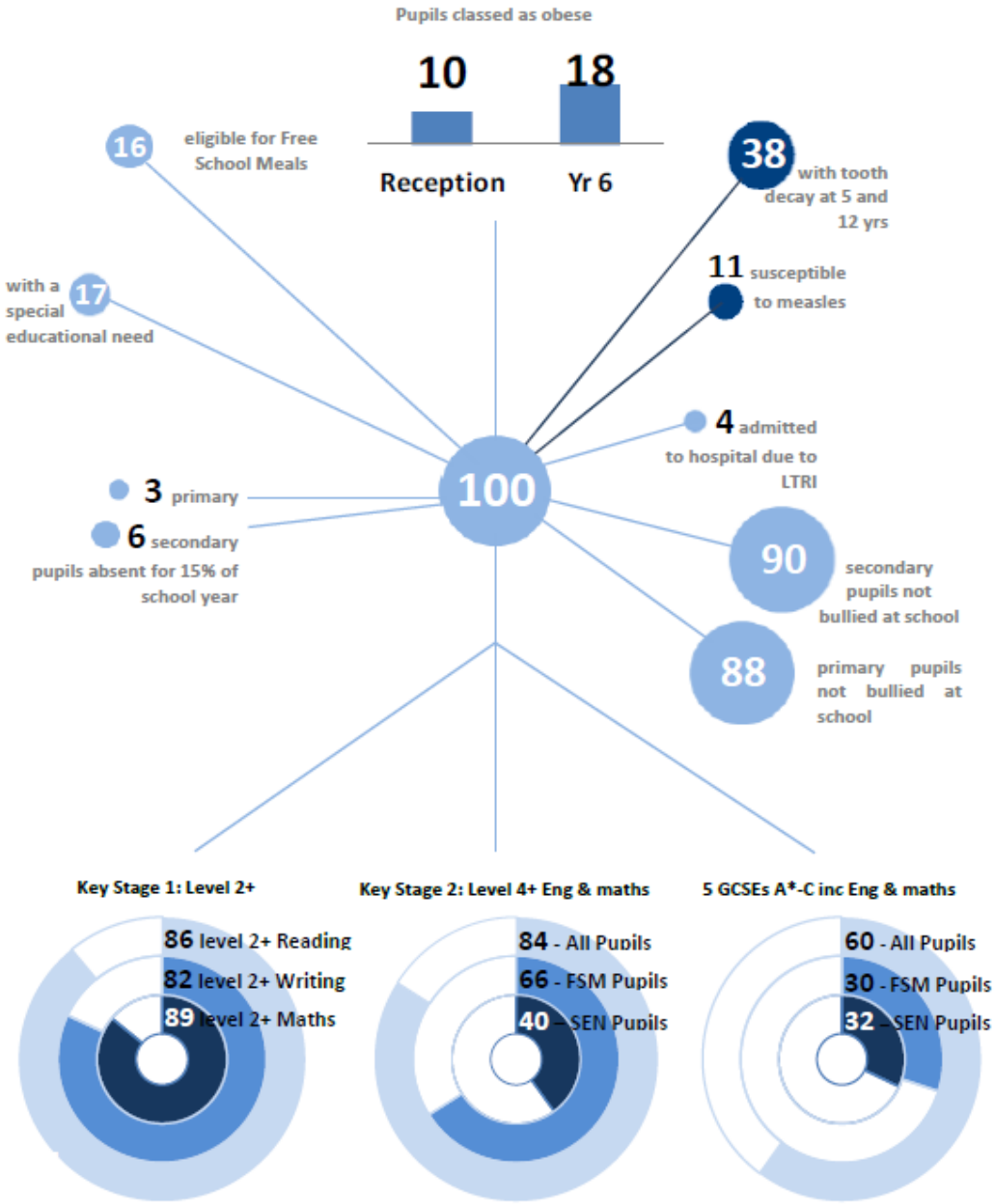


(Source – LCC JSNA 2013)

What do we know about Children in Lancashire?

Lancashire has a child population of around a quarter of a million and within this population. The Joint Strategic Needs Assessment identifies a diverse range of needs and demographic factors and has set these out diagrammatically:

If Lancashire was a Village of 100 children then:



(Source – LCC JSNA 2013) (LTRI – Lower Respiratory Tract Infection)

National comparator data shows that Lancashire is worse than the national average in:

- Tooth Decay rates
- Obesity rates (reception class)
- Teenage conception rates
- Educational Attainment rates (Key Stage 1)

And better in:

- Educational Attainment rates (key stage 2)
- Obesity rates (year 6)
- School Attendance rates
- Number of Pupils achieving 5+ GCSEs including Eng & Maths

What do we know about vulnerable children?

Safeguarding and related Health and Wellbeing indicators show a pattern of inequalities which closely correlate with indices of deprivation referred to above. Child mortality rates and educational attainment also closely correlate with these indices of deprivation.

The table below summarises key health and economic indices based on the most recent data available (2013)

Red = significantly worse, Green = significantly better, Amber = no significant difference

Indicator	Eng Average	Lancs Average
Low birth weight of term live births	2.8	2.7
Parental Smoking at time of delivery (SATOD)	12.7	18.8
Infant mortality (Rate per 1,000 live births)	4.1	4.8
Children aged 4-5 classified as overweight or obese	22.2	23.5
Children aged 10-11 classified as overweight or obese,	33.3	32.4
Children in poverty (all dependent children under 20)	20.1	17.8
Children in poverty	20.6	18.2
Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm	346.3	476.3
Rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years), per 10,000 resident population	103.8	138.8
Under 18s admitted to hospital with alcohol specific conditions: rate per 100,000 population	42.7	71.9
Accident and Emergency attendances for children aged 0-17 years (2010/11 – most recent data)	353.9	380.1

Self Harm rates give rise for concern as they are significantly above the national average. Further analysis into self harm data by Child and Maternal Health Intelligence (CHIMAT), 2011[1] gave a deeper insight into this issue, which is common to the North West Region. From their analysis the following key points emerge regionally:

- Rates for young females are 3.7 times higher than the rate for young males
- Emergency hospital admissions for self-harm increase as deprivation increases
- A&E attendances are highest between 10 p.m. and 1 a.m., between Saturday and Monday and in the first quarter of the year

Lancashire only analysis shows:

- Burnley General hospital has the highest rates, Royal Lancaster the lowest
- Lancashire's rate is slightly below the regional average

Additionally a research project conducted by the Lancashire Child Death Overview Panel looking at children who had died as a result of their own actions made the following key findings:

- 16 out of 21 cases were male

[1] Self-harm among children in the North West: accident and emergency attendances 2007–2009 and emergency hospital admissions 2007/08–2009/10

- Differential categorisation of deaths between coroners was evident
- Strong link with 'emotional distress' but not diagnosed mental health issues
- Inconsistency in support services for children with emotional distress across County

These recommendations have been taken forward by the CAMHS commissioning team in Lancashire County Council and used to inform commissioning arrangements.

It is therefore important that the issue of suicide and self harm remains a key strategic priority for the LSCB and partner agencies for the coming year and beyond.

Alcohol use among young people is also clearly an issue in Lancashire and this is reinforced by concerns expressed by young people in an LSCB survey in 2012 where alcohol was one of the issues they were most concerned about. Again the LSCB needs to consider how this features in its priorities and plans for the coming year and beyond.

Vulnerable Children

The table below provides a summary of the numbers of children / notifications under each category

Category	Number	Comparator	Comments
Privately Fostered Children	25	Not available	Previous years were 33, 25, 26
LADO Allegations / Investigations	715	Not available	A significant increase on previous years which were 652 in 2011-12 and 636 in 2012-13
IRO Caseloads	117	Not available	50-70 recommended caseload in national guidance (IRO Handbook)
Children Looked After[2] (CLA) (rate per 10k)	65.8	60 (Eng Avg)	Increase from previous year which was 60.9
Number of children identified as Children in Need	Not available	Not available	Data not available at present
Number of occasions on which children have been reported as "Missing From Home"	2,369	Not available	
Referrals regarding Honour Based Violence	28	Not available	
Referrals regarding potential Forced Marriage	16	Not available	
Percentage of Children with Special Educational Needs in Lancashire schools	17.2%	19.8% (Eng Avg)	
Young Carers	3,700 (est)	Not available	Youngest reported is 5 years old.
Children living in Private/Independent Children's Homes	97	N/A	Lancashire a net importer of CLA

Referrals to Children's Social Care

[2] A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

2014 saw an upsurge in child safeguarding activity. Rates of referrals to children's social care, core assessments, Section 47 enquiries, child protection plans and children being looked after all rose sharply.

NO/RATE	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Lancashire (average number/month)	1,659	1,470	1,389	1,175	1,370	1,677
Lancashire (rate per 10K)	778	724	606	548	726	827.2
England	**497**	**548**	**557**	**533**	**521**	**Awaiting**

Re-referrals

The proportion of re-referrals to children's social care in Lancashire had been fairly consistent for a number of years with some improvement between 2011 and 2013. However this trend has reversed in 2013-14 with a net 33% increase in this period. The Local Authority has examined reasons for this sharp increase and it would appear there have been some issues with how re-referrals are classified on the new ICT system and the process for 'contacts' being converted to 'referrals'. An audit conducted estimates that around a third of re-referrals were incorrectly categorized which would explain the sharp increase and bring the figure largely in line with previous year.

LANCASHIRE	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
%	24.6	25.8	25.4	23.2	20.5	30.7%

Referrals to Children's Social Care resulting in Initial Assessment

This indicator is a proxy for several issues: the appropriateness of referrals coming into social care, which can show whether local agencies are working well together; and the multi-agency understanding of thresholds which are being applied in children's social care at a local level.

Area	2007/0	2008/0	2009/1	2010/1	2011/1	2012/13	2013/14
Lancashire	39%	35%	48%	65%	74%	74%	64%
England	**59%**	**64%**	**66%**	**72%**	**79%**	**74%**	**Awaiting**

Number of Children subject to a Child Protection Plan (CPP) per 10k child population

Lancashire has experienced a rapid increase in CP cases and while the rate is still below the national average, it reflects a significantly higher demand for services. The current rate is more than 50% higher than in 2012-13.

AREA	2008-09	2009-10	2010-11	2011-12	2012-13	2013/14
Lancashire rate	26	27	27	23	36	44.4
England rate	**31**	**36**	**39**	**38**	**38**	**Awaiting**

The distribution of Child Protection Plans across the 12 districts of Lancashire varies significantly. Unfortunately data for 2013/14 is not available at present due to the Local Authority's new ICT system not being fully operational at the time of writing. Distribution charts will be published on the website once this information is available.

The vast majority of child protection plans in Lancashire arose from concerns about emotional abuse and neglect (46% of all plans). A minority of plans are put in place because of physical abuse (11%) and sexual abuse (8%). There are significant district variations in these figures.

Child Protection Plans Lasting Two Years or More

This measure provides in 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 – a long period on a CPP may reflect drift and lack of targeted support. This figure has risen since previous year but has consistently been lower than the national average.

Area	2007/08	2008/0	2009/1	2010/11	2011/1	2012/13	2013/14
Lancashire	5.0%	2.9%	3.8%	4.8%	4.4%	2.7%	3.7%
England	**5.3%**	**5.8%**	**5.9%**	**6.0%**	**6.0%**	**5.2%**	**Awaiting**

Children Looked After (CLA)

Lancashire's rate (per 10k) of CLA is now largely in line with national averages as illustrated below. This is as a result of a significant increase locally for the second year with an increase of 11% in 2012-13 and a further 10% in 2013-14.

Rate	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Lancashire	50	52	53	54	60.9	66.3
North West Rate	**71**	**76**	**77**	**76**	**79**	**Awaiting**
England Rate	**55**	**59**	**59**	**59**	**60**	**Awaiting**

There are significant variations in these rates across the County. Unfortunately data for 2013/14 is not available at present due to the new Local Authority ICT system not being fully operational at the time of writing. Distribution charts will be published on the website once this information is available.

The primary reason recorded for the child being looked after is illustrated in the table below:

	Abuse Or Neglect	Family Dysfunction	Family In Acute Stress	Child Illness Or Disability	Absent Parenting	Parental Illness Or Disability	Socially Unacceptable Behaviour	Total
Burnley	187	16	7	1	2	5	2	220
Chorley & S Ribble	123	21	7	0	2	3	0	156
Fylde & Wyre	125	12	7	1	2	1	0	148
Hyndburn & Ribble Valley	130	17	10	0	6	1	1	165
Lancaster	73	18	13	0	4	3	1	112
Pendle	142	20	7	0	0	7	1	177
Preston	129	20	14	1	6	0	0	170
Rossendale	63	13	8	2	1	1	0	88
West Lancs	89	18	5	1	0	4	0	117
Total	**1061**	**155**	**78**	**6**	**23**	**25**	**5**	**1353**

Abuse and neglect are clearly the most common reasons for children being looked after. As would be expected the more economically deprived districts have the highest rates.

Child Sexual Exploitation (CSE)

Lancashire has been collating data on the children referred to the Police or Children's Social Care for a number of years now. The table below shows the number of referrals made.

Division	April 2011 – Sept 2011	Oct 2011 - March 2012	April 2012 – Sept 2012	Oct 2012 – March 2013	April 2013 – Sept 2013	Oct 2013 – Mar 2014
West	260	218	156	141	214	272
South	219	160	164	136	146	121
East	306	328	338	372	362	313
HQ						2
Total	**785**	**706**	**658**	**649**	**722**	**708**

62% of referred young people were aged between 13 and 15 and 95% were white; similar to levels seen in previous reports. The majority of young people referred for CSE continue to be female. However, over the last 6 months of the year there has been a notable increase in the number of young males referred as potential victims of CSE. Boys now constitute 22% of referrals over the period compared to 8% previously and this will continue to be monitored to ascertain whether it is a longer term trend.

Children Missing from Home (MFH)

Breakdown of MFH Statistics October 2011 – March 2014

	Oct 2011 – Mar 2012	Apr – Sept 2012	Oct 2012 – Mar 2013	Apr – Sept 2013	Oct 2013 – Mar 2014
MFH episodes	3358	3269	2696	2779	2588
Number of individual children reported	1356	1453	1107	1203	1077
Mean missing episodes per month	2.48	2.25	2.44	2.31	2.40
Most frequent missing person	59 occasions	41 occasions	22 occasions	32 occasions	48 occasions
No of top 20 most frequent MFH cases also referred for CSE	18	17	9 (2 further intel) re potential CSE)	12	9

The number of children reported missing has fallen slightly compared to previous year's data. There is a relationship between CSE and MFH but this is not highly correlated with much of CSE occurring whilst not MFH. There has been a slight decline in the number of MFH referred for CSE compared to previous year.

Summary

Ensuring appropriate provision and equity of service access across the complex and diverse area that comprises Lancashire is a key challenge for all agencies providing services. There has recently been a clear increase in the demand for Children's Social Care services (which is also a national trend though the increase in Lancashire is largely above national averages on most indicators illustrated above) and the Local Authority and its partners are meeting this challenge effectively by largely maintaining performance levels and in some cases improving on previous years. Child sexual exploitation continues to be a priority for partner agencies in Lancashire and identification of young people at risk continues to be high. Lancashire has challenges around the use of alcohol by young people, self harm and smoking in pregnancy.

Engagement with private children's homes remains a challenge, especially in light of the number of establishments in Lancashire, and future activity will explore how the LSCB can engage with and hold them to account more effectively.

Case Studies

Child Protection Process

In this case there was disagreement between Children's Social Care and other agencies as to the need for an initial child protection conference, as opposed to continuing support under as part of a child in need plan. The IRO had discussions across agencies leading to the development and review of detailed chronologies to inform decision making. This led to an agreement that an initial conference would be convened; resulting in the development of a child protection plan, which by the first review was achieving a greater commitment from the parents and importantly improvements in the care afforded to the children.

Emotional Health and Well-being

The children and families team were asked to attend an initial case conference for a family that had recently moved into area, following mother fleeing her current partner who was abroad at the time. The family had suffered from a long standing history of domestic abuse, through various partners, including mother's current partner. The case was additionally complex as the family had moved to 22 different areas in the last 8 years.

Health agencies worked together across boundaries to provide historical information and records which brought to light CAMHS information regarding the oldest child, identifying that she was suffering from emotional ill health, self-harm and suicidal thoughts due to concerns with the relationship between Mother and her partner. This information was key in acknowledging the impact that the historical and current domestic abuse was having on the oldest child.

Following effective multi-agency planning through the CP process the children have been offered one to one appointments and their health assessments completed. This has enabled the children's physical and emotional health needs to be identified and addressed along with gaining details of previous names to aid the location of the children's full medical records. The children have been referred to CAMHS for support with identified emotional needs. The Children and Parenting Support Service are providing one to one support to the mother regarding the impact of domestic abuse, from these it was also identified that she has some issues with depression and low self-esteem and is now receiving treatment for depression along with counselling through the women's centre on the impact of domestic abuse and being aware of indicators for future relationships

CAF / TAF

At the beginning of the 2014 the family hit difficulties and were seeking support. One of the children in the family was showing signs of oppositional defiance disorder and ADHD although this had not been formerly diagnosed. Mum in turn was having difficulty managing this behaviour and understanding her actions. The older sister had moved out once reaching sixteen and there had been concerns surrounding her new partner. Dad had recently been made redundant and was unable to find work, causing financial hardship for the family. Mum was reaching the point where she did not know what else to do and was becoming extremely distressed.

Through the CAF and TAF process a number of needs were identified and the family have engaged well with a range of local services which has enabled the following outcomes to be achieved:

- Elearning courses have been identified for mum to improve her parenting skills and develop skills for employment
- Mum has been offered a place at college
- Dad has gained an HGV licence through support from the job centre
- Dad has received support with anger management and positive role modelling
- The families health needs have been reviewed and further support identified
- Improvements in the children's behaviour following parenting skills support
- The family have a TAF plan in place and feel things are improving

3. What do we know about the effectiveness of Local Services?

Services in Lancashire

A broad range of statutory and non-statutory services are available across Lancashire: Key services in terms of safeguarding are provided by the following agencies:

a) Lancashire Constabulary – direct policing and partnership services as part of the Child Sexual Exploitation teams, Multi-agency Safeguarding Hub, Multi-Agency Risk Assessment Conferences and Multi-agency Public Protection Arrangements. The HMIC conducted a thematic inspection of the Constabulary's arrangements for dealing with domestic abuse and violence in February 2014 which concluded in the following: *"The public in Lancashire can have confidence that police officers and staff provide a good service to victims of domestic abuse in all areas and help to keep them safe. Tackling domestic abuse is a priority for the constabulary which has invested in well-trained and specialist staff. HMIC found staff demonstrated a high level of commitment and awareness and that they work well with partners."*
(Pp6, Inspection Report, 2014)

b) Lancashire County Council – Support to vulnerable children through direct services from Children's Social Care, Care, Early Support Services, Children's Centres and Schools Services and specific support for children involved in the criminal justice system via the YOT. A range of other council services, including Adult Social Care also support families. The most recent inspection by OFSTED in respect of Safeguarding and Looked After Children in February 2012 where Lancashire was judged as being 'Good with outstanding features'. Not-withstanding this, a number of recommendations for improvements were made and a detailed action plan was developed by the Local Authority in collaboration with the LSCB. This action plan was overseen at the Quality Assurance Sub-group but was not fully signed of in 2013-14. Action continued to be monitored during 2013/14 and there have been a number of challenges made where progress has slipped or stalled. This has resulted in positive action to improve progress (but some actions remain outstanding in relation to: timeliness of health assessments for CLA, IRO Caseloads, equitability of sexual health services and CAMHS

c) Clinical Commissioning Groups x 6 – Clinical Commissioning Groups are responsible for ensuring that the healthcare services they plan, commission (buy) and deliver are safe, effective and of the highest quality. They are also responsible for making sure that these services are value for money. Services commissioned for patients include, planned hospital treatment; diagnostic tests and appointments; urgent or emergency care; community health services, such as specialist or district nurses, speech and language therapy or rehabilitation; mental health services; maternity and newborn services; children's healthcare services; services for people with learning disabilities. These organisations have only been established in 2013/14 and while they have not been inspected yet they all have been required to demonstrate effective safeguarding arrangements as part of their registration requirements

d) Acute Hospital Trusts x5 – Provide a range of community and acute services including: A&E, health visiting, school nursing, CLA nursing, neo/ante natal care, paediatric services and a range of specialist services

There are 5 acute hospital trusts that serve the Lancashire area as follows:

1. University Hospital Morecambe Bay
2. Southport and Ormskirk

3. Lancashire Teaching Hospitals
4. Blackpool Teaching Hospitals
5. East Lancashire

University Hospital Morecambe Bay (UHMB) has been subject to an improvement plan since their 2011/12 inspection found the organisation to be inadequate in a number of areas including safeguarding. The LSCB has maintained consistent oversight of these improvements and sought assurance through senior managers at the LSCB and the Local Safeguarding Group in the North of the County and through the section 11 audit process where it is evident improvements are progressing satisfactorily. Also during 2013/14 the LSCB has received detailed assurances, presentations and corresponding evidence from the UHMBT senior management team that these improvements are progressing well and at April 2014 were nearing completion. The LSCB has also provided a place on the Board for a UHMBT representative to further facilitate cooperation, scrutiny and challenge.

Southport and Ormskirk and Lancashire Teaching Hospitals Trust provide services through Preston Royal Hospital, Chorley & South Ribble Hospital, Ormskirk District General Hospital and Southport and Formby District General. Currently the CQC have not identified any concerns in relation to safeguarding at any of these services although there are some areas for improvement as identified in each inspection report. (See - http://www.cqc.org.uk/content/publications)

East Lancashire Hospital Trust (ELHT) and Blackpool Teaching Hospital Trust have both undergone CQC inspections during 2013/14. Although issues and improvements were identified at both trusts there were no concerns raised in relation to Safeguarding practice. There was an issue at ELHT with the number of A&E staff trained in safeguarding which has been addressed throughout the year and the Trust representative has provided assurance and evidence that these improvements are progressing as planned.

e) Lancashire Care Foundation Trust – Provider of children's (CAMHS) and adults' mental health services, Psychology Services and universal children and young people services such as health visiting and school nursing in East, Central and West Lancashire. LCFT were last inspected by the CQC as part of the Safeguarding and Looked After Children inspection where improvements were identified around access to CAMHS as referred to above.

f) NHS England – Commissioning of primary medical care, dental services (including secondary dental), community, pharmacy and primary optical services, some specific public health screening and immunisation services, some CAMHS services (especially tier 4)

g) Lancashire Probation Services – offender management services. Lancashire Probation Trust was last inspected in 2011 and judged to be 'Good'. There were no concerns identified in relation to safeguarding.

h) CAFCASS – court and legal support for children and families. CAFCASS were inspected in 2010 by Ofsted and found to be inadequate in a number of areas. The LSCB has had oversight of the improvement plan and been assured that the necessary improvements are progressing satisfactorily with regard to any safeguarding related issues. At the time of writing (July 2014) it is noted that CAFCASS has recently been re-inspected and judged to be 'Outstanding', further details in relation to this will be covered in next year's annual report.

i) Private/Independent Sector Providers – community drug and alcohol services, sexual health services, domestic abuse services

j) Housing providers – wide range of private providers, Registered Social Landlords, hospices and hostels, sheltered housing provision and local authority housing[3]

k) Voluntary Community and Faith Sector – over 100 different VCFS organisations providing a wide range of service on a commissioned and non-commissioned basis (Eg – carers support, advocacy, fostering agencies, lobbying, consultation)

l) Schools – over 600 schools including 30 special schools and 13 short stay schools
There are currently no Schools judged to be inadequate with regard to safeguarding

m) Over 100 children's homes with a high percentage of private providers and out of area placements (Lancashire is a net importer of CLA)[4]

n) 79 Children's Centres. There are currently no Children's Centres judged to be inadequate with regard to safeguarding. Indeed all are currently judged to be good or excellent

o) 909 child minders, 343 day nurseries and 161 pre-school play groups

Children and families are also supported by many of the smaller private and voluntary sector organisations who work on a local basis in response to local need. The larger organisations provide or commission a range of services on a countywide basis but given the size and diversity of Lancashire service equity is a significant challenge.

In addition to single service inspections Lancashire was selected as one of the Local Authority areas for a national thematic inspection of Neglect. Although the inspection did not provide an overall judgement for participating areas Lancashire was commended with a number of examples of good practice. Specific reference was made to the Local Authorities research highlighting the need for early intervention and the LSCB's Neglect Strategy, action plan and quality assurance activities.

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 children. These include:

<u>Multi-Agency Practice Inspections</u>
2 Multi-Agency Safeguarding Practice Inspection's have been completed in 2013/14 in the districts of Pendle and Hyndburn and Ribble Valley. These involved a range of activities such including case audits, focus groups, data analysis, interviews with key officers and observation of practice. A multi-agency inspection team carried out these activities together with a group of 'Young Inspectors' who provided feedback from the perspective of children and young people. The inspections highlighted a number of areas of strength and areas for improvement. Some of the key findings are summarised below:
The Pendle inspection:

- significant evidence of good practice leading to improved outcomes for children and families;

[3] A scoping exercise carried out in 2012/13 concluded that RSLs and Local Authority providers generally had good safeguarding arrangements but that private landlords often may not

[4] The LSCB receives notification of any provider that is judged to be inadequate by Ofsted with regard to safeguarding

- good multi-agency working and learning; relatively stable work force; and
- staff well supported by management on the whole

Areas for improvement:

- improving links with District Children's Trusts:
- participation of children;
- the to address the challenges related to agency changes – particularly the restructure of the Health economy.

The Hyndburn & Ribble Valley inspection:

- good evidence of a committed workforce
- good multi-agency working practices especially in relation to CSE
- CSC case management and involvement of children/young people commended.

Areas for improvement:

- staff turnover
- analysis of need in relation to agency resources/ demands
- availability of accommodation
- understanding of thresholds
- use of CAF

The areas for improvement are being considered by the District Children's Trusts and action plans have been developed to address issues identified. The delivery of these is being by the LSCB Quality Assurance Sub-group.

Section 11 Audit Process:

Section 11 of the Children Act 2004 sets out agencies responsibilities in respect of safeguarding children and the LSCB conducts and annual audit in all member agencies. The section 11 audit tool and quality assurance process were updated in 2013-14 to ensure all agencies are rigorously assessed with regard to having the necessary arrangements in place as specified. Almost all agencies were able to provide evidence of full compliance. Agencies who were not fully compliant with all sections of the audit – most commonly recoded deficits around training and supervision arrangements where not all staff have been trained to the correct level or have access to specialist safeguarding reflective supervision. Where these issues were present assurance has been provided that improvements are progressing and this has been confirmed through the quality assurance and challenge process. There are no outstanding 'red' indicators for any of the agencies at present.

Themed Audits

A Supervision Audit was completed in August and found that all agencies (except 1) had effective arrangements in place but there was an issue of consistency and a lack of a common approach. It was felt this would be improved by a greater awareness of the LSCB guidance. The Board issued a reminder or all agencies of the importance of ensuring all staff were familiar with policy and required action plans where there was not evidence of compliance. The lack of arrangements at UHMBT was raised as an issue which has been taken forward as part of their improvement plan (see above).

An audit of Common Assessment Framework assessments was completed in November. The use of CAF in recognising and responding to the 'toxic trio' (combined effect of domestic abuse, parental mental ill-health and parental substance misuse) is very mixed with significant variation between the localities. Good practice was observed especially when a multi-agency approach was taken. Key issues were identified around: lack of analysis, incomplete information, unclear outcomes, lack of historical information and the voice of child not being present. The audit took place prior to the revision of the CAF

assessment process. The findings of the audit confirmed issues which had already been recognised with remedial action built into the refreshed procedures.

Multi-agency Performance Information

The LSCB has developed a performance scorecard to present relevant safeguarding data and performance information from all key agencies. This scorecard has been reviewed in 2013/14 to ensure the most relevant and timely information is included. There still remains a challenge in obtaining regular performance data from the Health economy on a countywide basis which will continue to be pursued in 2014/15.

The end of year position is as follows:

Measure		Performance			Comparators		
		12/13	13/14	Trend	Eng	North West	Stat Neigh
Local Authority (based on availability of data at time of writing)							
LA1	Rate of Referrals	638	827.2	↑	520.7	619.7	-
LA2	% of Re-referrals	20.5%	30.7%	↑	24.9	26.4	25.7
LA3	No CAFs completed	2,659 (3/12-2/13)	2,829* (3/13-2/14)	↑	-	-	-
LA4	% of Referrals leading to no further action	25.1%	35.8%	↑	14.5%	16.4%	15.7%
LA5	No. of Children with CPPs	878	1,120	↑	-	-	-
LA6	% of Children with 2nd CPPs	12.3%	14.4%	↑	14.9%	-	15.2%
LA7	% of Children with CPPs 2 years +	2.7%	3.7%	↑	3.2%	3.3%	2.2%
LA8	No. of First Time Entrants to YJS (rate per 100,000)	964 (11/12)	672 (12/13)	↓	537	542	548
LA9	% of YP re-offending	41.2% (Oct-Sep 10)	40.3% (Jan-Dec 11)	↓	35.9%	-	32.6%
LA10	No. of Children in the household with a MARAC (MG)	TBC	2,965	N/A	-	-	-
LA11	No. of contacts and referrals due to domestic violence	12,120	5,331	↓	-	-	-
LA12	Troubled Families: No of families 'turned around' as %	28%	35%	↑	-	-	-
LA13	No. of CLA	1,482	1,612	↑	-	-	-
LA14	Rate of CLA (per 10,000)	60.9	66.3	↑	60.0	79.0	67.6
LA15	No. of CLA in	610	642	↑	-	-	-
LA16	No. of CLA out	485	479	↓	-	-	-
LA17	% of CLA with up-to-date Health Assessment	85.1%	74.7%	↓	87.3%	91.4%	82.5%
LA18	Average SDQ score (emotional health of CLA)	13.1 (11/12)	13.2 (12/13)	↑	14.0	13.0	-
Health							
H1	Infant mortality rate (aged under 1 year)	5.4 (11/12)	5.4 (12/13)	↔	4.1	4.5	4.3
H2	Smoking at time of delivery	18.4%	17.8%	↓	12.0	16.2	-
H3	A&E admissions for self harm (10-24yrs, rate per 100,000)	N/A	476.3	N/A	346.3	433.0	-
H4	Hospital admissions as a result of unintentional & deliberate injuries (0-14 Year olds)	142.3 (11/12)	138.8 (12/13)	↓	103.8	133.9	-
H5	A&E Attendances, 0-17 years, rate per 1000 (2010/11)	359.4	380.1	↑	359.4	-	-
H6	Under 18s admitted to hospital with alcohol specific conditions per 100,000	84.6 (09 - 12)	71.9 (10 - 13)	↓	42.7	69.1	-
H7	Crude rate per 1,000 (age 0-4 years) of A&E attendances	503.8	545	↑	510.8		
Measure		**Performance**			**Comparators**		
		12/13	**13/14**	**Trend**	**Eng**	**North West**	**Stat Neigh**

Police/MASH							
P1	Number of DA/V referrals where a child is present (MASH)	13,960 (11/12)	16,997 (12/13)	↑	-	-	-
P2	Number of vulnerable child referrals to MASH	N/A	6,793	N/A	-	-	-
P3	Number of CSE referrals	1,497	1,086	↓	-	-	-
P4	Children reported missing to Police	N/A	2,369	N/A	-	-	-
P5	% Children reported missing to Police who were CLA	N/A	14.9%	N/A	-	-	-
Young People							
Y1	% of primary school children reporting they have been bullied at school	8.6%	11.5%	↑	-	-	-
Y2	% of secondary school children reporting they have been bullied at school	8.2%	7.6%	↓	-	-	-
Y3	% of primary school children reporting they feel safe in and around school	96.9%	94.6%	↓	-	-	-
Y4	% of secondary school children reporting they feel safe in and around school	92.5%	90.6%	↓	-	-	-
Board Indicators							
B1	Number of cases reviewed by the CDOP	124	105	↓			
B2	Attendance at LSCB meetings	79%	75%	↓			
B3	Referrals to SCR Group considered within statutory timescale	100%	100%	↔			

The key findings from this noted by the Board are:

- Substantial increases in rate of referrals and percentage of re-referrals to CSC
- Considerable rise in the number of CAFs completed
- Greater proportion of referrals leading to no further action
- Much larger number of children with CPPs
- Notable decrease in rate of first time entrants to YJS
- Significant reduction in DA/V contacts and referrals
- Notable increase in percentage of troubled families turned around
- Number and rate of CLA rising
- Timeliness of CLA health assessments getting worse
- Significant reduction in rate of young people admitted to hospital with alcohol specific conditions
- Vast rise in the number of referrals in relation to domestic violence or abuse where a child is present
- Notable drop in the number of Child Sexual Exploitation referrals
- Higher proportion of primary school children reporting being bullied at school

Annual Reports

The Board also receives annual reports regarding the functions of the IROs, in report of Private Fostering, the work of the LADO, the secure estate (regarding children in custody), counter-terrorism / radicalisation and in respect of Local Authority Complaints, Compliments. There has been a significant increase in the number of complaints received directly from children and young people who are in local authority care; in 2013-2014 there were 22 compared to the previous year's figure of 11. There were 5 complaints with regard to the Safeguarding Process compared to only 2 in 2012/13.

Views of Children, Young People and Families

The LSCB identified participation and engagement with young people as a priority for 2013/14 and has now established effective links with the local Children and Young People's Participation Officer who meets regularly with the LSCB Coordinator to identify where the LSCB can be involved in planned activity and vice versa. The LSCB has involved young people in a number of initiatives throughout 2013/14 as follows:

a) Engagement in national 'take over day' via Lancaster Young Advisors - 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
b) Involvement of the Young Inspectors in multi-agency practice inspections (see above)
c) Commissioning Lancaster Young Advisors to complete a schools engagement project aimed at improving awareness of eSafety issues through a programme of peer tutoring. This work is currently ongoing and a full report will be available for the next annual report
d) Establishment of a young people's panel as part of the recruitment process for a new LSCB Chair

In addition to this the LSCB has consulted families through the local women's refuge as part of the Toxic Trio quality assurance activities.

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

Analysis of Child Deaths

The Child Death Overview Panel reviews every child death in the county and analyses any factors that may have lead to the death in order to identify themes and trends for preventative measures. A summary of the key findings for 2013/14 are as follows:

- 24% of Lancashire deaths had modifiable factors*
- Nationally 72% of cases are completed within 12 months; 79% of Lancashire deaths have been completed within 12 months of the death occurring
- 62% of Lancashire deaths reviewed are of children under 1 year of age, this is slightly below the national figure of 63%
- 60% of pan-Lancashire deaths were of male children and young people (56% national average)
- The largest categories of pan-Lancashire child deaths are perinatal/ neonatal event (34.2%), chromosomal, congenital and genetic abnormalities (24.5%) and sudden unexpected, unexplained deaths (8.7%)
- The largest category of death with modifiable factors in Lancashire is perinatal / neonatal event (23 %)
- The categories of death with the largest proportion of modifiable factors (pan-Lancashire) were Deliberately inflicted injury, abuse or neglect (89%), Trauma and other external factors (63%), Suicide or deliberate self-inflicted harm (52%), and Sudden unexpected, unexplained death (52%)
- The most common risk factors identified from the pan-Lancashire cases identified to have modifiable factors are:
    1. 35% service provision (including access to health care, prior medical intervention, communication and/or access to other services e.g. housing)
    2. 31% smoking (includes smoking in pregnancy and in the household by parent or carer)
    3. 31% alcohol/ substance misuse by parent, carer and/ or child

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

4. Statutory and Legislative Context for LSCBs

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2013 sets out the statutory objectives and functions for an LSBC as follows:

1. 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
2. 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:

1(a) 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;

(b) 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;

(c) 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;

(d) participating in the planning of services for children in the area of the authority; and

(e) 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.

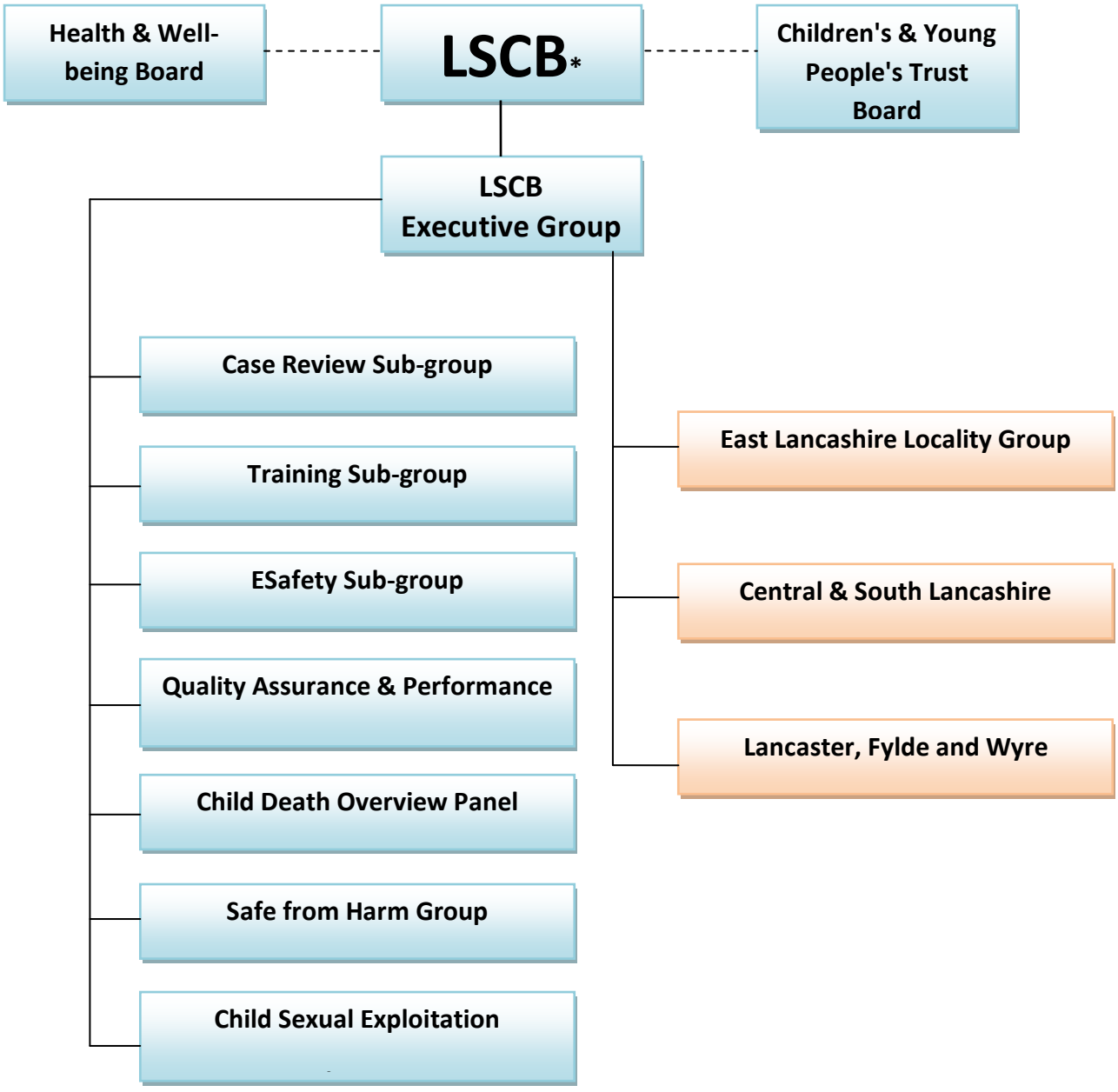
In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- 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

5. Governance and accountability arrangements

The LSCB is now inspected as part of the local area Safeguarding and Looked After Children inspection carried out by Ofsted and according to the most recent guidance will receive a separate assessment and judgement. Previously it was assessed within the wider framework, as per the 2012 inspection in Lancashire where the LSCB was referred to positively. Lancashire was not inspected during 2013/14 so there is nothing to report in this respect, however, the LCSB has devoted a significant amount of resource to preparing for inspection and ensuring it can provide evidence against the key lines of enquiry outlined in the guidance.

The LSCB is structured as illustrated below. The chair is held to account by the Chief Executive of the Local Authority and its partners through a process of standardised appraisal. A challenge for the coming year will be embedding an effective relationship with the Corporate Parenting Board.



* Full Board membership can be seen at:
http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20792&e=e

The LSCB Executive Group continues to carry out the executive function and deals with the general business of the Board and has oversight of the Budget, Business Plan, performance information, risk register and any themed reports or annual reports required by the LSCB. The LSCB holds the Executive to account and ratifies / challenges any decisions made by the Executive where necessary.

Strategic Priorities

Partnerships in Lancashire such as the 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. The LSCB has arrangements in place to share its annual report with these key strategic groups and join up the business planning processes so priorities can be shared and reflected accordingly.

The LSCB Chair is also a member of the Children and Young Peoples Trust and a protocol is in place to define the relationship between the 2 groups and their chairs.
The LSCB's broad strategic priorities are currently as follows:

The Board will *ensure* that:

1. We improve the way we work by listening to and responding to the views and experiences of children and young people.
2. We make sure that services work well together, taking and sharing responsibility, to keep children and young people safe.
3. We make sure that the way we recruit, train and supervise those who work with children and young people will keep children and young people as safe as possible.
4. We make sure that everybody who works with children and young people knows that keeping them safe is an important part of their job.

The Board will *take action* to:

5. Help children, young people, their families and communities keep themselves safe and know how to get help.
6. Monitor how well agencies safeguard and protect children and will challenge them when there are concerns about their performance.
7. Use Board resources effectively to give the best results for children and young people.
8. Implement necessary changes that come from research, serious case reviews and any national policy guidelines.

The following groups of children are recognised by the LSCB as potentially experiencing greater vulnerability:

- Children in Custody
- Children who are privately fostered
- Children experiencing neglect (see QA sub-group update)
- Children who are sexually exploited (see QA sub-group update)
- Children with disabilities
- Children Looked After, particularly those moving out of or into Lancashire
- Children of Travellers (especially educational outcomes, immunisations)

Based on these priorities the LSCB develops an annual business plan using the following planning cycle to ensure priorities and activity is up to date and reflects any changes in need or emerging issues:

The LSCB also has performance indicators which relate to the effectiveness of the LSCB, with the year end returns

Indicator	EoY 2013/13	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target	Direction of Travel (at Q4)
Number of cases reviewed by CDOP	Not Available	25	30	23	28	26	Improved
SCRs referrals considered within timescale	100%	100%	100%	100%	100%	100%	Same
Attendance at LSCB Meetings	79%	80%	82%	71%	75%	80%	Improved
Percentage of Business Plan Actions completed within timescales	95%	90	90	90	95	90%	Improved

The LSCB also has in place; a risk management framework and risk register which is reviewed twice a year to ensure the appropriate controls are in place to mitigate against key risks to the delivery of LSCB business and the effectiveness of the partnership.

6. Key Achievements from LSCB Sub-groups

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

Learning & Development

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

1. 2152 professionals learned by attending LSCB training events, and 11291 completed e-learning (Level 1 6372, Level 2 2844, CSE 2006, CDOP 69), making a total of 13443 professionals who came through the LSCB learning programme
2. In 2013-14, L&D sub planned 90 training events. Of those, 85 ran, and 5 were cancelled. In addition, a number of other events were added throughout the year, meaning that 103 events were delivered, lasting 126.5 days.
3. Held SCR briefings, jointly with Blackburn with Darwen and Blackpool LSCBs, which were evaluated and found to provide excellent learning
4. Provided advice/consultancy to 65 organisations which approached the LSCB Training Unit
5. Successfully engaged the 12 District Councils in the safeguarding agenda, with the result that all now have a safeguarding policy and most have training for their staff
6. Delivery of the three Neglect Conferences which involved Children and Young people
7. Provided three System-based Critical Incident Reviews (now renamed), this has included training up three facilitators
8. Developed new ways of getting messages over, for example by bookmarks and 'best advice' cards
9. Unit costs for training are £52.61per place if e-learning is excluded, £8.42 per place if it is included.

Priorities for 2014/15

- Run a core training programme of approximately 75 events covering at least 20 topics, potentially adding further events required by the LSCB
- Audit the single agency safeguarding training
- Review the training needs of all agencies in respect of safeguarding training
- Maintain the e-learning programme
- Support the training pool
- Implement and embed on line sign up to LSCB training
- Support learning from other LSCB sub groups

Quality Assurance

To provide the LSCB with a qualitative and quantitative evidence base to demonstrate how effective multi-agency safeguarding practices and arrangements are.

The group has continued to progress the activities outlined in the Quality Assurance Framework (QAF) to ensure a strategic and planned approach to activities around agreed themes and issues.

1. Completed 2 multi-agency safeguarding practice inspections in the districts of Hyndburn & Ribble Valley & Pendle which identified strengths and areas for improvement in relation to multi-agency practice
2. Developed a new pan-Lancashire section 11 audit tool
3. Obtained section 11 audits from all statutory agencies in Lancashire

4. Completed peer reviews on 6 agencies with regard to their section 11 audit returns and agreed a number of improvements
5. Completed multi- agency audits of CAFs across the County to determine its effectiveness in respect to the early identification of Domestic Abuse; Substance Misuse and Mental Health in relation to neglect.
6. Maintained an oversight of the Children and Young People's Trusts Lancashire Improving Futures programme in relation to CAF/Continuum of Need, Workforce Development, integrated working, Working Together with Families and MASH developments
7. Maintained oversight of the SLAC inspection action plan and challenged agencies where improvements have not progressed as planned
8. Completed a multi agency supervision audit to determine whether effective arrangements are in place to enable practitioners to receive regular and reflective supervision
9. Reviewed the LSCB multi-agency performance scorecard and agreed a revised / improved version
10. Held multi-agency workshop briefings across Lancashire in respect of the Lancashire Assessment Framework and changes to child protection processes to improve child protection conferences

Priorities for 2014/15

- Completion of further multi-agency safeguarding practice inspections
- Completion of audits and focus groups around this year's QAF themes – Esafety and Thresholds
- Development of effective QA arrangements around Early Help and CAF
- Continued QA of section 11 audits through multi-agency site visits
- Maintain oversight of the SLAC action plan and challenge areas of outstanding activity

Case Review Group

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

1. The completion of all relevant case reviews in a timely and thorough manner
2. Areas of work that need further review and examination by the LSCB have been identified through the process of reviewing cases
3. Improved procedures for transfer of case responsibility between agencies which will ensure children and families receive appropriate and timely services
4. Specific training courses have to help practitioners develop their skills in responding to particular issues for children and families
5. Improved procedures and guidance are helping practitioners in their work with children and families. An example includes promotion of information sharing guidance, to ensure that risks are fully identified and managed
6. Practitioner feedback providing evidence that involvement with reviews has changed their practice for the better. Some examples of this include:

i. I am more aware of multi-agency working and making sure that a full chronology is gathered on all aspects of the family
ii. It has reinforced a lot for me about not taking things at face value and being persistent

7. The identification of areas for development in agencies and with practitioners and the ongoing delivery of relevant briefings about case reviews (approximately two hundred people attended the general multi-agency SCR briefings alone – hundreds more attended other training events relevant to specific case review themes)

In the period 2013-2014 Lancashire LSCB published two Serious Case Reviews.

The first, child K, concerned a three year old child that died as a result of injuries caused by a blunt force trauma. The child's father was subsequently jailed for manslaughter and the child's mother was jailed for neglect of the child.

The review produced a number of findings and challenges for the LSCB. There has been a great deal of work completed about how we help practitioners to develop their understanding about their own cognitive frameworks and various methods of learning have been and continue to be trialled (such as group supervision, bite-sized briefings, traditional training courses, briefings, and so on).

The issue of information-sharing emerged as a theme and has been built into the various methods of training and developing practitioners. In addition, the way in which professionals and agencies share information has been incorporated into all quality assurance activity the LSCB undertakes. It is routinely examined during audit activity and addressed in Safeguarding Practice Inspections too.

Some specific development work about the understanding of cannabis use and also about the children of prisoners has followed from this review, with briefings and newsletters being delivered to several different forums and people.

The second serious case review published this year was about Baby E, a four month old child who died as a result of a heavy object falling on to him. His parents were both jailed for neglect as a result of the incident.

The actions following this review saw the roll-out of the single assessment framework, with findings from the review being incorporated into the development of the guidance and the assessment tool.

The Multi Agency Safeguarding Hub came into operation following this review and has shown to be making a difference to how cases are initially assessed and responded to on the basis of a fuller, multi-agency picture. In addition, the LSCB developed thresholds guidance for all practitioners that has been promoted and brought into operation.

The training and quality assurance work of the LSCB has taken all the findings from this review into account. Briefings sessions detail how practitioners can 'hypothesise' about what is happening for children, and healthy challenge and scepticism are promoted and encouraged.

The impact of all LSCB and single agency actions following all serious case reviews is monitored through s11 audits which are completed annually and all audit and QA activity. The lessons are built into all LSCB training and development activity.

Priorities for 2014/15

- Consider referrals against criteria for Serious Case Reviews
- Commission Serious Case Reviews as appropriate
- Commission multi-agency learning reviews as appropriate
- Complete Serious Case Reviews and multi-agency learning reviews and feedback learning to SCR Group and local agencies
- Continue to effectively monitor action plans and dissemination of learning from case reviews to ensure they make a difference
- SCR briefings to continue.
- Monitor agencies plans to disseminate information
- Newsletters to be published when new information is available
- Quarterly analysis of themes from SCRs to be shared widely, including with L and D sub and QA sub

- Survey of participants from reviews to be undertaken to evaluate the impact of involvement in reviews on their practice
- Leaflet to be produced to share with practitioners involved with future reviews

Child Death Overview Panel (CDOP)

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

1. Consistently the CDOP data highlights that more of the children and young people of pan-Lancashire die due to perinatal/ neonatal events than any other cause. As a result, Public Health undertook an in-depth analysis of some of these deaths and recommended an action plan be implemented, the recommendations of which are being monitored by the Pennine Lancashire Infant Mortality Group.
2. The Panel decided to continue to support the Safer Sleep Campaign, as many of the deaths in children under 1 year of age with modifiable risk factors were linked to inappropriate sleeping arrangements.
3. It was identified in the 2011/12 annual report that the SUDC protocol should be reviewed. Due to the national review of Working Together (2013) this was delayed by 1 year. The Protocol has now been reviewed to reflect changes in national guidance, changes in practice and learning from previous deaths with the aim of supporting families more effectively.
4. A function of the Panel is to disseminate learning. An e-learning package has now been developed which includes general information on CDOP, local procedures, the rapid response, themes and identified trends.

Priorities for 2014/15

- An analysis of the impact of service provision in areas of higher deprivation on child deaths
- In depth analysis of Category 3 deaths (trauma and other external factors)
- In depth analysis of Category 7 deaths (Chromosomal, congenital and genetic abnormalities)

Missing From Home (MFH)

Strategic multi-agency group to ensure a coordinated multi agency response to MFH.

1. Multi-agency review of the Pan-Lancashire Joint Protocol involving all relevant pan-Lancashire partners has provided a finalised document that is currently being submitted to each of the LSCB's.
2. Lancashire County Council Audit on a large number children MFH cases has enabled analysis of what is required in terms of data capture. This work is due to be formally released in the near future.
3. Joint Lancashire Constabulary/ LCC funding for The Children's Society 6 month pilot for Return Home Interviews, supported by the Missing From Home Co-ordinator for that area. Findings from this pilot will be published in the near future.
4. Single Point of Contact now in place for direct contact with OFSTED. Co-ordinated recording of requests for information are allocated to relevant co-ordinators and timely submissions of required data are returned to OFTSED to assist formal inspections.
5. Monthly downloads of information now routinely received from OFSTED in relation to the names and addresses of Care Homes in the county.

Priorities for 2014/15

- Implementation of the new guidance and responsibilities for agencies contained therein
- Embedding of the revised protocol pan-Lancashire

Child Sexual Exploitation

Strategic multi-agency group to ensure a coordinated multi agency response to CSE.

1. Increased work with all diverse communities regarding awareness of CSE and *c*onfidence in the service provided. The Children's Society continue to provide a service known as 'Respect U & Me' to assist young people in developing 'respectful and healthy relationships' targeting groups where concerns may have arisen
2. Further development of approach to targeted organised criminal groups/gangs committing CSE based on recommendations in the Office of the Children's Commissioner report "If Only Someone Had Listened" as detailed in the revised CSE plan
3. Delivery of a range of awareness raising initiatives including:
    a. A week long countywide CSE awareness campaign (in partnership with the Police and Crime Commissioner)
    b. A large CSE conference hosted by Lancashire Constabulary attended by over 200 professionals
    c. Engagement with a diverse range of communities to raise awareness about CSE and a focus on making sure the information is reached by young people
4. Production of a combined multi-agency action plan based on recommendations from a number of national reviews and strategies
5. Developed processes to obtain feedback from young people who have been exploited regarding the service they received in order to continually develop and improve services
6. Further development of local co-located teams to include statutory and third sector providers such as Brook, The Children's Society, PACE, and Barnardos
7. Intensive outreach workers, in the Children's Society's Street Safe Lancashire (SSL), provide valuable support to children and young people, at risk of or involved in sexual exploitation, from report through to the court process
8. Between April 2013 and March 2014, SSL supported 245 children and young people with interventions which raised awareness of grooming, CSE, healthy relationships and protective behaviours. These continued whilst they were needed by the victim and for varying periods from between 2-3 months and a few years, where young people struggled to cope and build resilience. They have also delivered a large number of group sessions in children's homes, schools, colleges and youth groups
9. SSL have employed a worker specifically for boys and young men who has engaged with 393 boys and young men over the 12 month period
10. There are now specialist teams within Early Break (voluntary provider service supporting young people) who are carrying out early intervention outreach work following a successful lottery fund bid being granted to East Lancashire CSE team
11. Parents Against Child Sexual Exploitation (PACE) parent support workers provide independent, non-judgmental and confidential support to parents
12. Review and Development of multi-agency training for all frontline professionals re awareness of CSE - The Children's Society and police continue to deliver a CSE training package on behalf of the LSCB to practitioners

Priorities for 2014/15

- Review and refresh of multi-agency action plan
- Repeat CSE awareness week including a multi-agency conference and range of partnership activities
- Build on and improve existing arrangements for prevention and responding to CSE

ESafeguarding

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

The Group has achieved a number of key achievements during the year including:

1. Delivery of 2 large scale multi-agency awareness events in April 2013 and January 2014 each event was attended by over 200 practitioners and received very positive feedback
2. Identified as National supporter of Safer Internet Day 2014
3. Development and agreement of Pan-Lancashire eSafeguarding Strategy
4. Development of quantitative dataset for Lancashire (issues faced + support required)
5. Increased involvement across related agendas and priorities (e.g. Anti-Bullying, CSE)
6. Participation in media opportunities to raise awareness of Online Safety issues (e.g. BBC Radio Lancashire - Cyber bullying)
7. Continued representation on National eSafeguarding Group to highlight Lancashire issues (e.g. Ask FM) and feedback emerging threats / changes in trends (e.g. Sexting)

Priorities for 2014/15

- Repeat of the Esafety Live Conferences
- Roll out and embedding of refreshed strategy and action plan
- Support and oversight of the Young Advisors project in schools
- Continued sharing of information / alerts to agencies with regard to emerging risks and developments

Local Safeguarding Children Groups (LSCGs)

The LSCB has 3 LSCGs which cover the following districts of Lancashire

- Lancaster, Fylde and Wyre
- East Lancashire (Hyndburn, Rossendale, Burnley, Pendle and Ribble Valley)
- Central & South Lancashire (Preston, Chorley, West Lancashire and South Ribble)

These locality groups provide a greater locality focus to the work of the LSCB and ensure LSCB priorities are informed by local information as well as Countywide. Key achievements of the groups for 2013/14 include:

1. Establishment of local representation and oversight in relation to the refreshed CAF process and Early Support initiatives
2. Attendance at the sub-groups by all local District Children's Trust (DCT) chairs to improve connectivity and provide scrutiny and challenge of delivery plans
3. Regular scrutiny of local Child Protection and safeguarding data to identify local concerns which have informed service developments and improvements
4. Completion of Toxic Trio themed audits of CAFs
5. Consideration of learning from LSCB Case reviews
6. Discussion and resolution of local multi-agency issues
7. Effective forum for sharing information between agencies in relation to agency developments and changes in service

At the time of writing a review of local partnerships, including the LSCGs and District Children's Trusts, is being carried out with a plan to discontinue the LSCGs as of September 2014. 'Children's Partnership Boards' (on a similar locality footprint) are planned to replace these groups and the LSCB will engage with and challenge these groups to ensure safeguarding is effectively embedded in the commissioning and delivery of services at a local level.

7. Equality and Diversity

Children and young people in Lancashire are less ethnically diverse compared to the rest of the country with 12.7% being from black and minority ethnic groups (compared to 21% nationally). However there is wide district variation, with Burnley, Hyndburn, Pendle and Preston populations displaying the greatest ethnic diversity.

Recent migration patterns have created some challenges to local services especially in terms of language issues. The LSCB has looked into this more recently and this will be reported more fully in the next annual report.

The LSCB and it members recognise that Lancashire is a large and diverse county with huge local variation in need and the composition of local populations. The LSCB has a lay-member who has a BME background and all members are required to comply with equality requirements as laid out in statutory guidance and legislation. (Note: a second Lay Member has more recently been recruited).

Recognition of the diverse needs of different groups of children is central to all areas of LSCB business. Every effort is made to ensure the views of all groups are gathered to inform service developments and business planning.

8. Priority groups of children

The following groups of children are recognised by the LSCB as potentially experiencing greater vulnerability:

- Children in Custody
- Children who are privately fostered
- Children experiencing neglect (see QA sub-group update)
- Children who are at risk of sexual exploitation or sexually exploited
- Children with disabilities
- Children Looked After, particularly those moving out of or into Lancashire

The LSCB receives an annual report from the County Youth Justice manager to be assured that young people in custody are being effectively safeguarded. The report assured the LSCB that 100% of YOT assessments were completed within timescales for young people prior to detention, during and post release. The LSCB was also assured that effective arrangements were in place to identify and respond to any safeguarding issues within the secure estate.

The LSCB also receives an annual report from the Local Authority on privately fostered children. The following key points were noted:

- 100% of cases were managed in line with the regulations
- The number of arrangements rose from 35 to 64 from previous year
- New webpage's and eLearning in place to assist professionals
- New ICT system has hampered accuracy of data reporting for the period

With regard to children with disabilities (CWD), a multi-agency audit of cases and agency arrangements in relation to compliance with national guidance is progressing and scheduled for completion in September 2014. Key findings will be available in the next annual report.

In addition to these priority groups the LSCB receives an annual report from the Local Authority Designated Officer (LADO) with regard to the management of allegations against people working with children and young people. The report was presented to the LSCB in November 2013 and the following key points noted:

- Increase in number of notifications taken forward as allegations (from to 636 to 715)
- Increase in allegations of physical abuse, especially in relation to restraint / physical intervention
- Social Care remains the biggest source of allegations
- Completion of investigations within 1 month remains at 71%
- Increased awareness raising has resulted in increased demand for LADO services
- LADO now located in the MASH 2 days per week

Overall it was felt the service is effective and robust though the increased demand and pressure on the LADO was noted.

8. Engagement with and participation of children and young people

The LSCB identified participation and engagement with young people as a priority for 2013/14 and has now established effective links with the local Children and Young People's Participation Officer who meets regularly with the LSCB Coordinator to identify where the LSCB can be involved in planned activity and vice versa. The LSCB has involved young people in a number of initiatives throughout 2013/14 as follows:

Engagement in national 'take over day' via Lancaster Young Advisors - 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.

Commissioning of the Young Advisors to complete a commission in relation to eSafety and safer use of the internet and social networking. (Ongoing in 2014/15)

Participation of the Young Inspectors in Multi-agency Practice Inspections including interviews with key managers and agency representatives.

A panel of Young People interviewing candidates for the role of LSCB Chair and contribution to the decision to appoint.

9. LSCB Budget

The LSCB Budget position at April 2014 is summarised below

INCOME	
Contributions to Board	
Central Lancs	37,835
East Lancs	37,835
North Lancs	37,835
Police	43,938
Probation Service	13,488
CAFCAS	550
LCC - CYP Directorate Funding	112,000
CDOP Contributions	98,000
Other	9690
Total	**390,490**

EXPENDITURE	
LSCB General	140,598
CDOP	98,000
SCRs	61,202
Training	115,894
Total	**415,695**

RESERVES	
Combined Reserve	**268,418**

10. Contact details

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✉ Address:
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East Cliff JDO
PRESTON
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☎ Phone: +44 (0)1772 530283

💻Website: http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20739&e=e

11. Appendices

LSCB Attendance

Attendance by agency for all Board meetings in 2012/13 is shown below.

Red= 50% and below, Amber = 51-75, Green = Above 76%

Agency	% Atn by mem	Dep Att Y/N	No Att	Number to which Invited
Cafcass	100		6	6
CDOP Chair	50		3	5
Council for Voluntary Services	33		2	6
Council for Voluntary Services	67		4	6
East Lancashire CCG	100		6	6
East Lancashire LSCG Chair	60		3	5
Independent Chair	100		6	6
Fylde & Wyre CCG	60		3	5
Lancashire Care NHS Foundation Trust	100		6	6
Lancashire County Council (Adult Safeguarding Board)	100		6	6
Lancashire County Council (Director of Children's Services)	100		6	6
Lancashire County Council (lead member - participant observer)	17		1	6
Lancashire Teaching Hospitals NHS Trust	67		4	6
Lancaster Fylde and Wyre LSCG Chair	83		5	6
Lay Member 1	75		3	4
Lay Member 2	67		4	6
Designated Doctor	83		5	6
NHS England	100		3	3
Police	100		6	6
Preston City Council	67		4	6
Preston, C&SR and West Lancs CCGs (Vice Chair & LSCG Chair)	67		4	6
Probation	83		5	6
Quality Assurance Sub-group Chair	67		4	6
Schools	50		1	2
Serious Case Review Sub-group Chair	100		6	6
University Hospitals Morecambe Bay NHS Trust	33		1	3
OVERALL	76			

Note – some members were only invited to the Board part way through the year due to ongoing decisions and reviews of membership

Author: Richard Matthews, LSCB Business Coordinator

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