CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2014-2015

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Foreword from the Chair

I had the privilege to take over as the Independent Chair on 1st April, 2014, from Richard Simpson, the interim Chair who had laid a very solid foundation for me to take forward. I have found my colleagues on the LSCB to be collaborative, challenging and determined to improve the safeguarding of Cumbria's children and young people. Our work has led to significant improvements in the functioning of the LSCB, with improved outcomes for children.

We are proud of what has been achieved in the past year to help keep children and young people safer. However, we are by no means complacent, and know that we have much more to do.

There is a strong sense of an improved partnership culture, with clear accountability, and strong leadership of the subgroups, where so much of the LSCB work is done. We have made significant improvements in the Safeguarding Hub, the development of the Early Help offer, and the development of a strong quality assurance function. We are working hard to improve our communication with practitioners at all levels and in all agencies, and we hope that the introduction of the Practitioner forums and the development of the newsletter have gone some way to meet our aim. We have also established a children and young people forum, to ensure that we hear the voice of or children and young people and that they influence our work.

Like our colleagues throughout the country, we continue to work to improve our response for children and young people at risk of Child Sexual Exploitation (CSE), and those vulnerable young people who go missing. We are also working to improve our learning from the tragic cases where children and young people have died.

Our business plan for the next three years sets out what our key priorities are. By the nature of this annual report, it is a retrospective look at what we did in 2014 – 2015. I hope that you find it interesting and helpful. I look forward to the continuing challenges for 2015-2016 to working with all of our many agencies in Cumbria, and to continue to improve the safety of children and young people in Cumbria.

Gill Rigg
Cumbria LSCB Independent Chair

Introduction

Welcome to the Cumbria Local Safeguarding Children Board (LSCB) Annual Report 2014-15. This Annual Report is a retrospective look at the work of the LSCB in the year 2014-15, and Working Together 2015 outlines what should be covered in this report. The report identifies the local context for children and young people growing up in Cumbria, and outlines the state of safeguarding in Cumbria. It describes the work of the LSCB over the past year, and the structure and work of the sub groups.

The report also outlines the learning and development which the LSCB wants to provide for the many staff who work with children and young people in Cumbria, and how the LSCB works with the other Boards within Cumbria. It outlines what has been achieved in the past year, and what the LSCB plans to achieve in the next three years.

A brief word from the LSCB Members

As part of the Chair's role, Gill has met with all members of the LSCB, and their feedback has been used to ensure agencies in Cumbria are doing the right things to discharge safeguarding duties and that the Business Plan reflects the areas that they are most concerned about have all been fed into the 2015-18 Business Plan.

They were asked a number of questions, and the answers to all of them are contained in a report on the SCB website – LINK

The answers to two of the questions are reported here as they demonstrate the work of the Board over 2014-15:

Strengths of the Cumbria LSCB

- A real programme of improvement that puts children at the centre
- Supportive and collaborative
- More business-like
- Well attended
- Genuine commitment
- LSCB is now leading change and providing direction
- Multi agency partners in one meeting with safeguarding at the centre
- Commitment of agencies around the table
- Good relationships
- Development of the business group
- Better connectivity between other Boards
- Open discussion
- greater sense of shared ownership of issues
- Willingness to challenge
- Vibrancy
- Increasingly seen as the vehicle for integrated working

What do you feel you have personally achieved for the Cumbria LSCB in the last year?

- Chairing the sub groups
- Membership of subgroup and providing information/challenge
- Membership of Business Group
- Membership of the SCR Panels
- Contributed to the development of the learning and development strategy
- Ensured that staff are aware of their statutory responsibilities in relation to child safeguarding
- Conduit between the LSCB and other statutory/partnership boards
- Ensured my staff are using the Safeguarding Hub/Triage to refer children appropriately and have fed back any issues to the LSCB
- Developing the Neglect Practice Guidance and Strategy
- Challenge in respect of appropriate use of thresholds
- Revision of some key policies
- Feed in the voice of the community
- prioritise the resources from agencies
- Raised the issue of domestic violence
- Created the conditions for success
- Improved the CDOP processes
- Response to whistle blowing complaint
- Annual Report/Business Plan.
- Developing practitioner forums
- Contribution to Early help
- link national work with the work of the LSCB
- Raised profile of safeguarding in GP's and the primary care service

Links between the LSCB and Cumbria's Strategic Boards – in relation to Safeguarding Children

The LSCB and other strategic partners have signed up to a Memorandum of Understanding to set out how they work together to safeguarding children.

This document makes explicit the key responsibilities and accountabilities relating to the way Cumbria links the key strategic public service partnerships in Cumbria relating to Safeguarding both Children, namely:

- Health and Well-being Board (HWBB)
- Cumbria Children's Trust Board (CTB)
- Cumbria Local Safeguarding Children Board (LSCB)
- Cumbria Safeguarding Adults Board (CSAB)
- Safer Cumbria Partnership (SCP)

Cumbria Health and Well-being Board - HWBB

- HWBB is responsible for producing the Joint Strategic Needs Assessment (JSNA), which will identify and set the commissioning priorities for our vulnerable population.
- The Business Plans and Annual Reports from both Safeguarding Boards will be presented to the HWBB.
- The HWBB takes a lead in Cumbria for Suicide Prevention, which includes Suicide in Children

Children's Trust Board - CTB

- CTB sets out the strategic priorities for children and young people in Cumbria.
- This will influence the priorities set by LSCB and their published levels of need.
- The LSCB has a role in influencing the priorities of the CTB.
- The LSCB Annual Report and Business Plan will be scrutinised and challenged by the CTB.
- The CTB takes a lead for Emotional Well-being and Mental Health of Children, Children with a Disability and Child Poverty.

Safeguarding – LSCB and CSAB

- The key accountability and responsibility for safeguarding lies with the two Safeguarding Boards (LSCB and CSAB);
  - LSCB in relation to children and young people up to their 18th birthday
  - CSAB in relation to safeguarding adults 18 years and over
- However the other bodies referenced in this document all have significant roles in safeguarding.

Safer Cumbria Partnership (SCP)

- This partnership combines the work of the Domestic Violence Board, the Safer and Stronger Thematic Partnership and the Criminal Justice Board.

- The SCP is responsible for producing the annual Community Safety Agreement which is based on the findings of the Cumbria Strategic Assessment (SA) and the SA's from the four Community Safety Partnerships. Building on previous successes in crime reduction the focus remains firmly on Anti-Social Behaviour, Reducing Reoffending and addressing Domestic and Sexual Abuse/Violence.
- The key accountability and responsibility for Domestic Abuse rests with this group, and takes account of the impact on Children living with Domestic Abuse.

Formal links

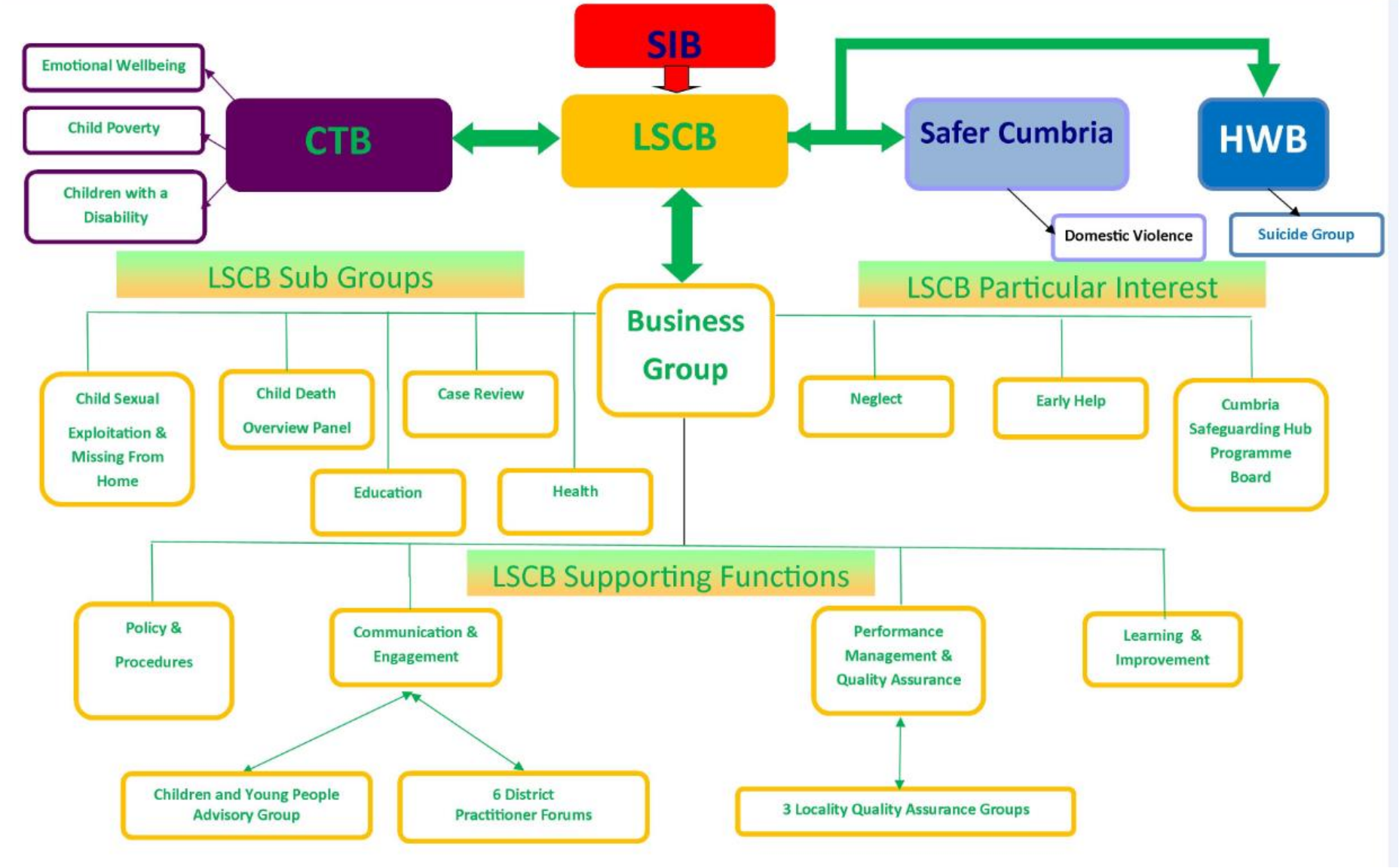
In order to make formal links there are members of each Board that sit on the other Boards. These dual roles ensure that Children and Young People are at the forefront of decision making across all of these Boards.

There are standing agenda items on all Boards to ensure "key messages" are shared across all meetings.

Additional responsibilities for safeguarding vulnerable people in Cumbria

- The two Safeguarding Boards are independent of each other but need to ensure that they take a whole family approach to setting their priorities and reporting performance.
- The Chair of the LSCB attends the Council's Overview and Scrutiny Committee on request and they receive the Annual Report and Business Plan of the LSCB which adds further to the oversight of the LSCB
- The Local Authority Chief Executive is responsible for the appointment and performance of the Independent Chair of the LSCB as laid out in Working Together 2015 and agrees the Chair of the CSAB.
- Each Chair will meet with the Chief Executive and the respective Corporate Director, and lead member on a quarterly basis.
- There is a requirement for LSCBs to work together particularly in relation to children living in Cumbria known to other Local Authorities as well as Cumbrian children living elsewhere.

LSCB Structure (Health subgroup added in April 2015 – details included in the 2015-18 Business Plan) (see previous page for Acronyms)



LSCB

The LSCB has a 3 year Business Plan aimed at delivering both the statutory requirements of the legislation governing the work of LSCBs, and the needs of local children and young people. In order to manage this, set direction and monitor progress, the LSCB has established a number of subgroups that are accountable through the LSCB.

LSCB

The overall LSCB has membership from across the partnership as defined by Working Together 2015 and is independently chaired.

Section 14 of the Children Act 2004 sets out the statutory objectives and functions of LSCBs as being:

- To coordinate what is done by each person or body represented on the board for the purpose of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes

The core business of the LSCB is to:

1. develop local multi-agency policies and procedures that promote and result in effective multi-agency working to safeguard and protect the children and young people of Cumbria.
2. monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve
3. oversee and challenge partners in carrying out their safeguarding responsibilities under Section 11 of the Children Act 2004, to make sure that they are doing that work effectively
4. plan, co-ordinate, commission and evaluate multi-agency training.
5. promote effective multi-agency early help to identify and appropriately support children and their families.
6. monitor and evaluate the effectiveness of partner agencies individually and collectively and advise on ways to improve performance and quality.
7. undertake reviews of serious cases and child deaths, advise the Board and our stakeholders of the lessons to be learnt.
8. communicate effectively to our stakeholders regarding the need to safeguard and promote the welfare of children.

To do all of this – the LSCB has established a number of subgroups and working groups.

Subgroups

Business Group

This group has membership from across the partnership, every subgroup chair is a member, as well as the LSCB Vice-Chair and Chair, the group is chaired by the Chair of the LSCB.

The Business Group links the work of all the subgroups to ensure momentum and delivery of the work programmes – providing mutual support covering the operational processes and coordinates the work of sub-groups to deliver the Business Plan.

The group also oversees the development of the Self-Assessment, Annual Report and the delivery of the actions associated with any Serious Case Reviews.

Policy and Procedures

1. Revision of Policies in Line with Working Together 2015 reporting of major revisions and points of "tension" or disagreement to the Board
2. Commission and analyse Section 11 Audits to ensure that agencies and organisations are operating in safe arrangements
3. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

Communication and Engagement

1. Oversight of the work of the Practitioner Forums to ensure two-way communication between the Board and the front-line
2. Recruit and maintain a list of "Touchstones[1]" to allow us to assess the impact of policy, communications, etc.
3. Maintain and continually improve the LSCB website
4. Devise creative ways to bring the function and work of the Board to the public's attention
5. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

Learning and Improvement

1. Develop and implement a Safeguarding Learning and Improvement Strategy
2. Recruit and maintain a "training pool" to ensure delivery of a range of Safeguarding Development opportunities and training
3. Work to incorporate learning from Case Reviews and work from the Particular Interest Groups into training courses offered
4. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

Child Death Overview Panel (CDOP)

1. Critically examine all child deaths and ensure that significant cases are identified and the LSCB is able to take forward learning
2. Ensure full analysis of all Child Deaths to ensure learning from these cases is captured and absorbed

Case Review Group

1. Examine individual cases referred to the LSCB and decide if they meet the criteria for Serious Case Review (SCR) and make recommendations to the Chair of the LSCB

[1] **Touchstones** - a group of practioners/teachers/health workers and some managers from across the partnership, who are used as a sounding board for new initiatives, are surveyed for their opinion and are used to test out new procedures. There are currently 40+ across Cumbria

2. Commission and contribute to such SCR
3. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

Performance Management/Quality Assurance

1. Collect, collate and analyse multi-agency performance data and report exceptions and areas of concern to the Board
2. Alongside the Board commission multi-agency Quality Assurance audits around areas of particular interest or concern
3. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board
4. Ensure data sets are fit for purpose and reviewed regularly to ensure they meet the LSCB priorities and outcomes are evidenced.

Education subgroup

The Education subgroup is chaired by a Primary Head teacher and the vice-chair is a Secondary Head teacher. There is representation from across all education sectors including independent schools, post 16 education. The Forum for Independent Schools and Children's Homes now report through this subgroup, offering this established group some further governance.

1. Provide advice, information and support for schools, Education services Colleges, Work Based Learning providers and other educational establishments.
2. Monitor the safeguarding arrangements for Children in Our Care and Children that are home schooled.
3. Ensure appropriate lines of communication and contributing to establishment based work relating to policy, practices, curriculum, recruitment and selection of staff, materials and resources.
4. To maintain the designated persons register, including their status and training.
5. Monitor Governing Body responsibilities and involvement in safeguarding arrangements.
6. To identify and disseminate good practice.
7. To support the work of designated persons in educational establishments.
8. Collation of training figures and other key data to feed into the Learning and Improvement Sub Group and/or other Sub Groups as appropriate

Safeguarding Hub Programme Board

1. Set the strategic vision, operation model, deliverables and direction for the Safeguarding Hub.
2. Give direction to the Development Group.
3. Manage peer reviewing of single parts of the system to ensure 'whole system approach'.
4. Use national guidelines, best practice while developing the service.

Neglect

1. Develop a Shared understanding
    a. Raising awareness of strategy and guidance (Practitioner Forums, newsletter, conference etc.) (Communications and Engagement lead)
    b. Learning and Improvement Workshops (Learning and Development lead)

   c. Use of data/indicators and shared audit; (Performance Group (PMQA lead)
2. Develop shared assessment
   a. Use of tools (Neglect Practice Guidance)
   b. Assessment of disguised compliance/non-compliance (Policy and Procedures/learning and Development leads)
3. Develop shared way of working
   a. Use of tools (Neglect Practice Guidance)
   b. Learning and Improvement Workshops (Learning and Development lead)
   c. Sharing good practice (Practitioner For a/LSCB newsletter) Communications and Engagement lead)

Early Help

1. Oversee the work required to embed an integrated multi agency approach for all partners working with children and families which focuses on early identification and early support and is based on the needs of the child in order to prevent escalation of need.
2. Coordinate the work of statutory partners in helping, protecting and caring for children in our local area and that there are mechanisms in place to monitor the effectiveness of those local arrangements.

Child Sexual Exploitation (CSE)/Missing From Home

1. Identify and monitor performance data in relevant areas, making intelligent use of performance
2. Monitor the effectiveness of multi-agency working, including monitoring practices of agencies to ensure procedures are followed
3. Establish and maintain effective links with other strategic and service plans to prevent duplication
4. Identify relevant partnerships tackling associated issues and where there are gaps in provision in order to inform commissioning of services
5. Provide the LSCB with all information necessary for them to provide the annual report on the work of the child sexual exploitation sub group including information on how the work of this group has directly impacted on children
6. Establish and maintain links with the North West lead on child sexual exploitation

Cumbria's Children and Young People

Approximately 94,000 children and young people under the age of 18 years live in Cumbria. This is 19% of the total population in the area.

Approximately 15% of the local authority's children are living in poverty.
Children and young people from minority ethnic groups account for 2% of all children living in the area, compared with 22% in the country as a whole.

Children and young people live in communities which range from isolated rural settlements and farms to market towns and larger urban conurbations. Of the county's population, 51% live in rural areas, compared with 19% of the population in England and Wales.

Child protection in this area

At 31 March 2015, 325 children and young people were the subject of a child protection plan. This is a reduction from 595 children and young people at 31 March 2014.

At 31 March 2015, 3,444 children had been identified through assessment as being formally "in need" of a specialist children's service in the year. This means that they need specialist help to achieve or maintain a reasonable standard of health or development without the provision of services from the Local Authority (LA) this is a reduction from 3,888 at 31 March 2014.

Children looked after in this area.

At 31 March 2015, 678 children are being "looked after" by the LA, a rate of 72.1 per 10,000 children. This is a marginal increase from 31st March, 2014 when 663 children were looked after a rate of 70.5 per 10,000. This is significantly higher than the national average and has been an area of focus for some time. The LSCB has agreed to prioritise this cohort, for the whole partnership, in a whole system approach.

There are also 175 (March 2015) Cumbrian children and young people who are in placements outside Cumbria.

Key LSCB Performance Indicators

The LSCB scrutinises a number of performance indicators - with responsibility for this function delegated to the Performance Management and Quality Assurance Group (PMQAG). A number of key areas remain a priority to ensure the children we must safeguard are appropriately protected in Cumbria. The indicators below are a selection of the indicators that the PMQAG oversees:

The EHA figures have continued to increase, helped by the continued dedication of an Early Help Team which has made significant differences to the process; ensuring that agencies are supported in all aspects of early help. This includes supporting professionals to complete EHAs and providing training. Early Help continues to be a focus of the LSCB through the Early Help Subgroup.

Early Help Assessments (EHAs) initiated	March 2013	March 2014	March 2015
Rate per 10,000	17.3	46.9	131.1
Number	**178**	**443**	**1234**

The Quality Assurance Groups (1 in each district) were commissioned to conduct a quality assurance session regarding Early Help Assessments and there were some key findings around the plans being produced and regarding the forms. All sessions identified from the findings that there were some significant training needs and that the form being used did not enable professionals to provide all information that would be useful. The groups identified changes required to the form and training needs. These were included in the QAG action plan and monitored through the PMQAG, all actions from the quality assurance activity were completed and some, such as training needs are ongoing.

The number of actual referrals continues to increase which in itself is an issue for the LSCB, but this has improved since the beginning of The Hub. October re-referral % was 34% so we have seen a decrease since they have been in place. Our actual number of re-referrals has also decreased in comparison to March 2014.

Re-referrals/Referrals *	March 2013	March 2014	March 2015
Number of referrals received	**419**	**633**	**473**
Referrals where the same child had been recorded within the previous 12 months	114	163	126
Percentage	**27.2**	**25.8**	**26.6**

The PMQAG identified the number of re-referrals as an area of concern and commissioned an audit of re-referrals to ensure full understanding of the issues and if any areas of improvement could be identified. The audit identified that overwhelmingly the case was closed appropriately and not too soon but in some instances where closing was appropriate, at that point a multi-agency Early Help Assessment should have been initiated.

***Good performance for this measure is low.**

These indicators continue to enable the Child Sexual Exploitation (CSE) Subgroups to monitor prevalence and risks to young people. The CSE Working Group have been tasked with developing a scorecard that will enable the LSCB to do more than monitor prevalence and through the CSE Oversight Group work has begun to identify 'hot spots' and action has been taken where necessary.

Findings from a CSE themed QAG audit were that The QAGs saw evidence of appropriate threshold application across step up but step down was not so clearly evidenced. Children were identified as being safe but some children would have benefited from an Early Help Assessment, which could have resulted in better outcomes for the child.

Child Sexual Exploitation (CSE) and Missing from Home (MFH) (full year)	March 2014	March 2015
CSE reports to police*	77	221
Children MFH and absent**	n/a	532

There was some evidence of good engagement with Children and Young people and the voice of the child was clearly evident in a number of cases. Children had benefitted from improved practice, knowledge and understanding in the more recent cases reviewed, with improved evidence of Multi-Agency Sexual Exploitation Meetings and the use of Chapter 12 tools.

It was clear from the exercise that practice is improving, and overall multi-agency responses were appropriate and practitioners are working together effectively to support children, who are experiencing CSE, to achieve their outcomes.

Missing from home has a renewed focus. NYAS, Inspira and Barnardo's have been commissioned to conduct the Return to Home Interviews (RHI) once a young person has returned home. The LSCB scorecard going forward will include the timeliness of the RHI as it is a statutory requirement that these are conducted within 72hours of the young person's return. Children's Services are monitoring the missing from home notifications and subsequent return to home interviews centrally.

*All Sexual offences and obscene publications offences with a victim under the age of 18
** The number of children (under 16) where missing from home reports have been recorded

An audit of children subject to a child protection (CP) plan on 30th April 2014 took place following challenge from the LSCB owing to a significant increase in the number of children on a CP plan in 2013-14. This audit identified that approximately 30% children did not meet the threshold and have since been safely "stepped down". The LSCB needs to be assured that those children who **meet** the threshold for a plan are subject to one. Two Audits have been undertaken to test this; the first an audit of children stepped down from a child protection plan and the second is an audit of children who were the subject of an initial child protection conference but not made subject to a child protection plan. The audit regarding children stepped down identified that children

Number of Children on a Child Protection Plan	March 2013	March 2014	March 2015
Rate per 10,000	36.1	62.5	34.6
Number	**345**	**591**	**325**

were appropriately stepped down however it also noted that step down plans were not yet consistently robust. This is an area for improvement.

The number of looked after children remains high and significantly above national averages and our own Cumbrian target.

Children Looked After	March 2013	March 2014	March 2015
Rate per 10,000	70.2	67	72.1
Number	**663**	**640**	**678**

The number of children looked after is higher than statistical neighbours and so the Council has put in place a programme to ensure that only those children who should be looked after enter care, that whilst being looked after they have access to appropriate placements that meet their needs and that they leave care in a timely and safe way. The Better Placements programme was put in place to deliver the actions required to ensure that only those children needing to be looked after were in the care system. Whilst the programme has delivered improvements, e.g. an increase in babies being placed for adoption and young people moving from expensive residential placements that do not meet their needs, overall numbers of children have not reduced as anticipated. The programme has been renamed the Children Looked After Recovery Plan and the governance has been refreshed.

The objective remains as before: to safely reduce the number of children coming into care, ensure that children only stay in care as long as necessary and that when they are looked after they have good quality placements in-county.

LSCB Budget

Partner agencies contribute to the work of the LSCB in many different ways through:

- involvement or leading activity and specific pieces of work
- chairing or participation in the LSCB and its subgroups
- 2014-15 the LSCB has had a larger than anticipated number of Serious Case Reviews (SCR's), and partners have contributed by chairing these reviews, therefore saving the LSCB considerable costs
- some agencies also make a financial contribution as detailed below

Contributions 2014-15

Children's Services (staffing/board support)	£96,814
CCG	£61,079
CPFT	£7,800
NCUH	£7,800
UHMB	£3,000
Probation	£10,180
Police	£13,811
CAFCASS	£550
Total Partner Agency Contributions	**£201,034**

LSCB Spend 2014-15

Office costs	£85,000
Independent Chair	£22,755
Fees	£3,500
Vice Chair (Barnardo's)	£3,000
Child L	£7,878
Child M	£17,288
Child N	£7,800
Child O	£8,476
LSCB Meeting Expenses	£3,354
Multi-agency Training for LSCB Members (inc. venues, trainers)	£15,989
Virtual College - online training	£6,500
Multi-agency procedures Manual – Tri-x	£19,494
Total LSCB costs	**£201,034**

The Shape of Safeguarding in Cumbria

Inspection

Ofsted

Services for children in need of help and protection, children looked after and care leavers, and review of the effectiveness of the Local Safeguarding Children Board - (Inspection date 3 March – 25 March 2015)

What Ofsted said about the Cumbria Local Safeguarding Children Board (LSCB)

A review of Cumbria's LSCB was undertaken by Ofsted, as part of the inspection of children's services, judged the LSCB to be "requires improvement".

Inspectors also highlighted a number of strengths, including:

- The positive impact of the new independent Chair, appointed by Cumbria County Council in April last year;
- The greatly strengthened governance arrangements which are ensuring the LSCB is functioning properly;
- The improved understanding across partners of their roles and responsibilities;
- The strong relationship with other multi-agency boards which oversee related service areas, such as the Health and Well-Being Board;
- The increasing effectiveness of its challenge to the performance of member organisations; and
- The key role the LSCB has played in the development of the county's Safeguarding Hub, the first point of contact for anyone with concerns about a child.

As reflects the 'requires improvement' judgement, inspectors also identified areas where further work was needed, noting particularly the need to strengthen the way partners respond to children at risk of sexual exploitation and those living in households where domestic abuse occurs. These areas had already been recognised in the LSCB Self-Assessment and plans were in place to address.

Children's Services

Ofsted published a report, on 13 May 2015, following an inspection in March of services for children in need of help and protection, children looked after and care leavers. It concludes that despite significant improvements in many areas, particularly in safeguarding, overall Children's services in Cumbria County Council remain inadequate.

Two previous inspections in April 2012 and May 2013 also concluded services were inadequate. Ofsted have four ratings: inadequate, requires improvement, good and outstanding.

In this latest report, of the five sub-areas of work inspected, three were judged to be requiring improvement and two were judged to be inadequate:

- Children who need help and protection – **Requires Improvement**
- Children looked after and achieving permanence – **Inadequate**
- Adoption performance - **Requires Improvement**
- Experiences are progress of care leavers - **Requires Improvement**
- Leadership, management and governance – **Inadequate**

Background

The previous 2013 Ofsted inspection report was highly critical and identified widespread failures in children's services. Most significantly inspectors said the council could not be confident that children we were working with, particularly those on child protection plans, were safe. In this latest report inspectors have recognised that significant progress has been made to improve safeguarding and child protection services and that these services, while not yet good, are no longer inadequate and children are not being left at risk.

Inspectors also highlighted a number of strengths, including:

- Political leadership which has prioritised and invested in children's services at a time of financial austerity. This has resulted in the creation of additional social worker posts, expansion of the Edge of Care service model, creation of the early help team, and development of the social work academy;
- The impact of the Chief Executive and new Corporate Director for Children's Services in driving improvement and developing a more open and positive culture;
- The openness to scrutiny and challenge from outside organisations;
- The quality of face to face work with children and ensuring that the child's views and wishes are heard and acted upon;
- The improvement in our "Early Help" services which work with children and families to prevent problems developing that could require intervention;
- The work of our 'Virtual School' which supports children in care to achieve the best possible educational outcomes;
- The increasing effectiveness of Cumbria's Local Safeguarding Children Board which has moved from being inadequate to "requires improvement";
- The quality of work with children and families to prevent them being taken into care which was recently judged "outstanding"; and
- The effectiveness of the adoption service in finding families for children, especially older children and those with complex needs

Inspectors concluded that while focusing on improving child protection services the council did not give sufficient priority to services for children in care, whether living with foster parents or in residential homes. While there was no question about their safety, inspectors found that in some parts of the county our work with these children was not helping them like it should. As a result services for looked after children were judged inadequate.

Inspectors also concluded that weaknesses in this area of Children's Services should have been spotted, and acted upon, sooner. Because of this and despite recognising the significant impact

of the Children's Services' leadership in driving improvement, leadership, management and governance was rated as inadequate.

Next steps

The Local Authority must produce an Improvement Plan within 70 working days (by 19th August 2015) - actions from this plan have also been incorporated into the LSCB Business Plan.

Other key messages and learning will be used to further develop services in Cumbria.

Section 11 Audit

One of the key mechanisms LSCBs have to demonstrate the state of Safeguarding in the local area is through a robust Section 11 audit process.

Background

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions – and any services that they contract out to others – are discharged having regard to the need to safeguard and promote the welfare of children. Working Together 2013 required LSCBs to gather data to assess whether partners are fulfilling their statutory obligations, including under Section 11.

Summary

43 agencies from across the children's workforce returned completed Section 11 audit tools to the 30 September 2014 deadline.

The Audit

The Policy Group developed an audit tool designed to seek an overview of compliance by agencies with the requirements of Section 11 of the Children Act 2004. The tool was also designed to help agencies ascertain their compliance with the requirements, by generating an action plan to address any gaps that they may identify.

Previously the LSCB had required agencies to submit evidence alongside their completed audit; however this placed an administrative burden on all parties involved. This time around it was agreed it would be a more efficient process for the auditors to conduct peer challenge/QA visits to review the evidence from a random sample of returns.

The Themes from the Audit Returns

The audit identified some excellent practice which will be used to produce and share an exemplar toolkit. It was also evident that the process of undertaking the audit had been used to promote safeguarding. The majority of challenges by the group of the returns were in relation to strengthening evidence and action plans rather than suggesting amendments to the scoring.

Responses required scoring against each standard (which had a number of questions) as not met/partly met/fully met. There was a further option of "not applicable" Examples of what was meant by each option were given.

In summary the scoring showed the following fully compliant scores against each standard:

77%	a clear line of accountability for provision and/or commissioning of services designed to safeguard and promote the welfare of children (this score may have been higher as some confusion was identified in the QA visits about what was meant by "commissioning")
98%	a named person responsible at a senior level
77%	a culture of listening to children and taking account of their wishes and feelings
80%	arrangements in place for sharing information with other professionals and the LSCB
90%	Had a designated professional lead
75%	Had safe recruitment processes
78%	Appropriate supervision and support available for staff
90%	Had clear policies in line with those from LSCB for dealing with allegations against people working with children

Within the eight sections, the tool also asked additional questions in respect of local issues. Findings were

- Agencies seemed to be up to date with high profile national SCRs but lesser so with local SCRs from Cumbria.
- There was a lack of awareness and use of the Conflict Resolution Policy.
- There was a lack of awareness of Learning and Improvement opportunities.

Key Themes from Quality Assurance Visits

The Policy Group made eight QA visits. The sample included small third sector agencies through to large public sector organisations. The visits were undertaken by two members of the Policy and Procedures Group; the pairings varying in order to maximise the learning opportunities.

Feedback indicated that those completing the audit found it a valuable exercise. Agencies also advised that the audit acted as a prompt, reinforcing their obligation to protect and safeguard children and young people - with some agencies revising their own policies and procedures to address gaps identified by the audit. Visits identified that there had been some confusion/ misunderstanding about which activities "safeguarding" related to and as a result it was agreed that some scores may have been different to that initially presented. As a result the summary of findings above may be an underestimate. The meetings provided an opportunity not just to have dialogue about the agency's Return but about their involvement in the work of the LSCB. The extent to which agencies understood this varied; providing valuable information to inform the work of the Board and its sub groups.

Visits highlighted that the Returns are completed by a member of each agency without seeking input from children and young people Dialogue also identified that there were providers who had not been asked to complete a return e.g. Registered Social Landlords, Leisure providers. The interface with other safeguarding processes e.g. the CCG self-assessment on safeguarding was also raised

Recommendations

Practice

Awareness raising across all agencies in Cumbria is required to ensure that:

- Staff and volunteers are aware of when and how information should be shared to ensure that children and young people are kept safe through making informed decisions. In particular staff must be aware that 'safeguarding overrides confidentiality'.
- Staff involved in recruitment are suitably trained (e.g. at least one member on the short listing / interview panel must have been on safer recruitment training).
- All staff are aware of the LSCB Conflict Resolution Policy for the informal and formal resolution of disputes between agencies.

Training/development

All agencies need to evidence the number of their staff and volunteers attending LSCB multi-agency training and the impact this training is having on their practice.

Conclusion

The Audit has demonstrated that on the whole agencies are complying with Section 11. The extent to which they fully comply varies and the findings will be used to improve compliance; taking the opportunity to promote engagement in the LSCB and enabling agencies to share their practice with each other.

In this way, partnership and individual agency working to safeguard children will be further improved.

The views of Children and Young People

We believe that it is important for children and young people to take an active role in the design and development of services provided for them. It is important that all young people have access to an effective mechanism through which they can influence policies, services and decisions that affect their lives. Good practice identified by Ofsted shows that in some of the best examples, LSCB's have focussed on a programme of initiatives involving children and young people. With this is mind we have developed our LSCB Young People's Advisory Forum to provide a platform for conversations with children and young people about issues that are important to them.

This involves young people age 12 years and up who have had experience of receiving support from services at a range of levels including Early Help, Child In Need, Safeguarding and Children Looked After. They will help us to ensure the voice of children and young people is listened to and taken seriously in all that we do.

We held our first meeting on the 18th February 2015 and some members of the Youth Parliament were also present. The theme for the first meeting was 'emotional wellbeing'. The forum was well attended and the young people were able to learn more about the aims and objectives of the advisory group, there was information from speakers (Richard Simpson - LSCB Vice Chair), presentations and fun activities led by young people.

When considering the state of Safeguarding in Cumbria, the LSCB's Children and Young People's Forum were asked to say what they through of Safeguarding, especially in relation to what was important to them. The picture below shows what they felt – represented as a Word Cloud:

Bullying, Exploitation and Emotional wellbeing were the 3 top things Children and Young People were concerned about and this information has been fed into the new Business Plan 2015-18 and has resulted in some changes to the overall priorities of the LSCB.

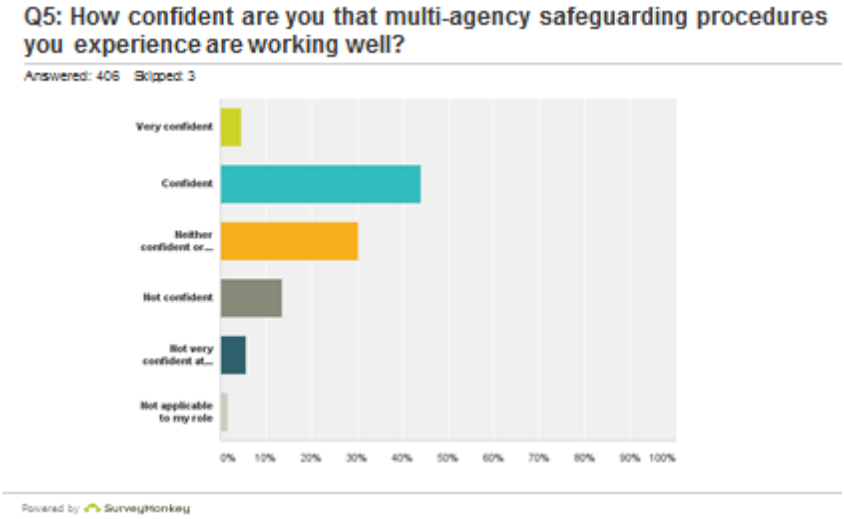
Front Line Staff

How staff feel is paramount to how well services are delivered to safeguard children, their confidence in systems and processes, their ability to manage risk and their knowledge and understanding were all tested in a staff survey of front-line staff – commissioned in October 2014 as part of the Local Government Association Peer Review into Early Help.

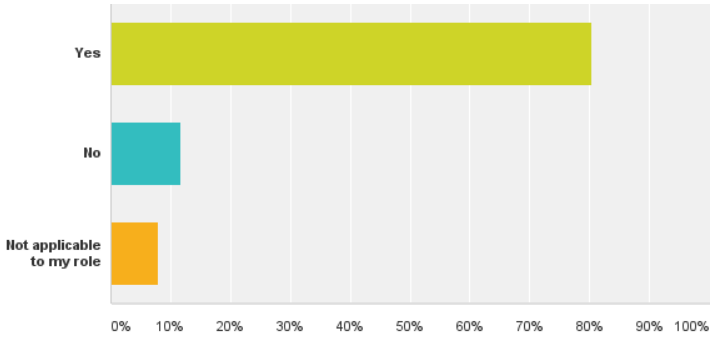
400 plus responses were received and the findings have been used to further develop training, policies and procedures and communication channels.

Some of the key findings are detailed below:

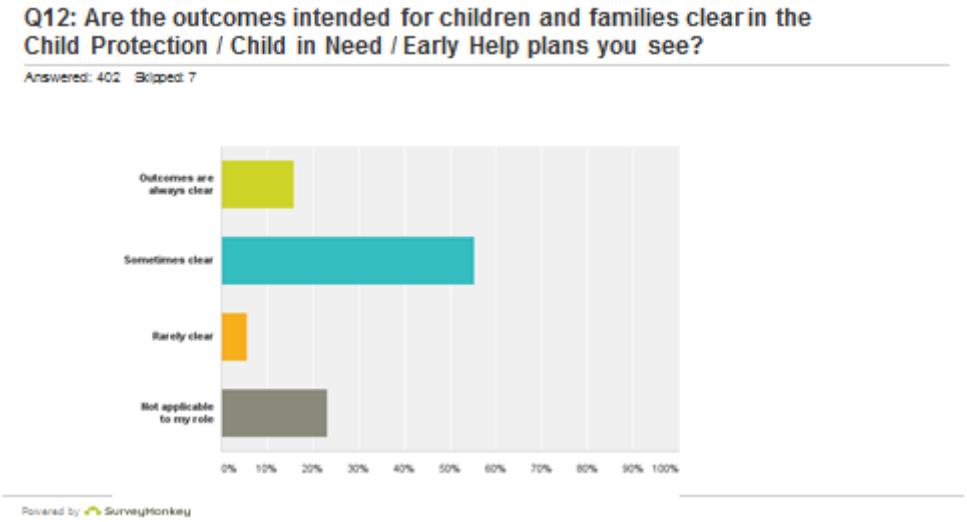
Confidence in the Multi-agency Safeguarding procedures: less than 20% of respondents said they weren't confident.



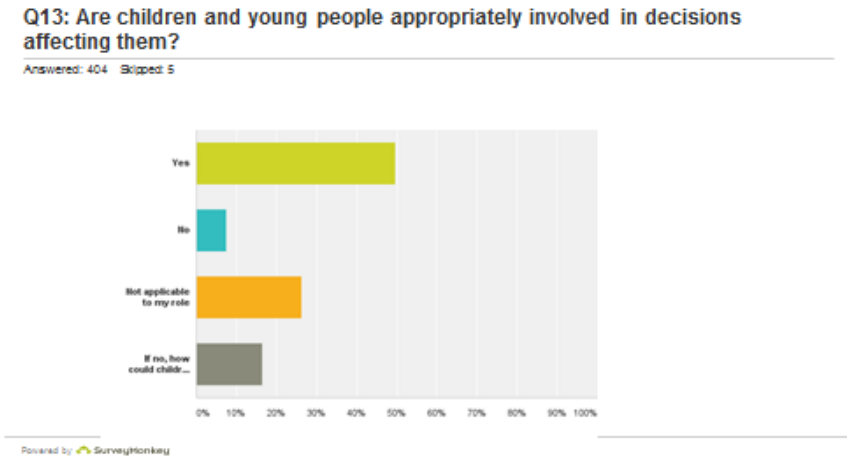
Staff were asked if they were clear about who can make safeguarding decisions in respect of individual children. The result gave some confidence to the LSCB - given that only 11.72% answered negatively.



In terms of outcome clarity in plans. The majority of staff felt that these were only "sometimes" clear - but less than 6% said they were "rarely" clear. This remains an area of work for the LSCB.



When asked about the voice of children and young people, 7.43% (30) of respondents felt that CYP were not appropriately involved in decision making and this therefore remains a key area of focus across the LSCB.



And similarly the involvement of parents and carers, where again this was part of practitioner's role, there was a very positive response to this with only 8.91% (35) of respondents answering in the negative.

Answer Choices	Responses	
Yes	**60.81%**	239
No	**8.91%**	35
Not applicable to my role	**30.28%**	119
Total		**393**

Full details of this report is available on the LSCB website.

Learning and Improvement – including Multi-Agency Training

2014-15 Developments

The LSCB self-assessment for 2014 identified a number of areas of development for the Learning and Improvement sub-group. These included the need for a learning and improvement framework, the provision of sufficient and the evaluation of high quality training and that all LSCB members support access to training opportunities in their agencies. The 2014-17 Business Plan reflected these areas of development as well as a review of training offer around neglect.

During 2014-15 the LSCB has had to prioritise extensive recruitment to the training pool as its main priority. This has included taking responsibility for developing a revised train the trainer programmes for both current and new trainers. By the end of 14/15 only 6 had attended the refresher training and 8 the new trainer's course.

In addition a range of eLearning courses were offered including awareness of child abuse and neglect and risk taking behaviours. Safeguarding children core courses were delivered at level 2 and 3.

Specialist courses were delivered including a 5 day Achieving Best Evidence Course (ABE) and Domestic Abuse Awareness and Action.

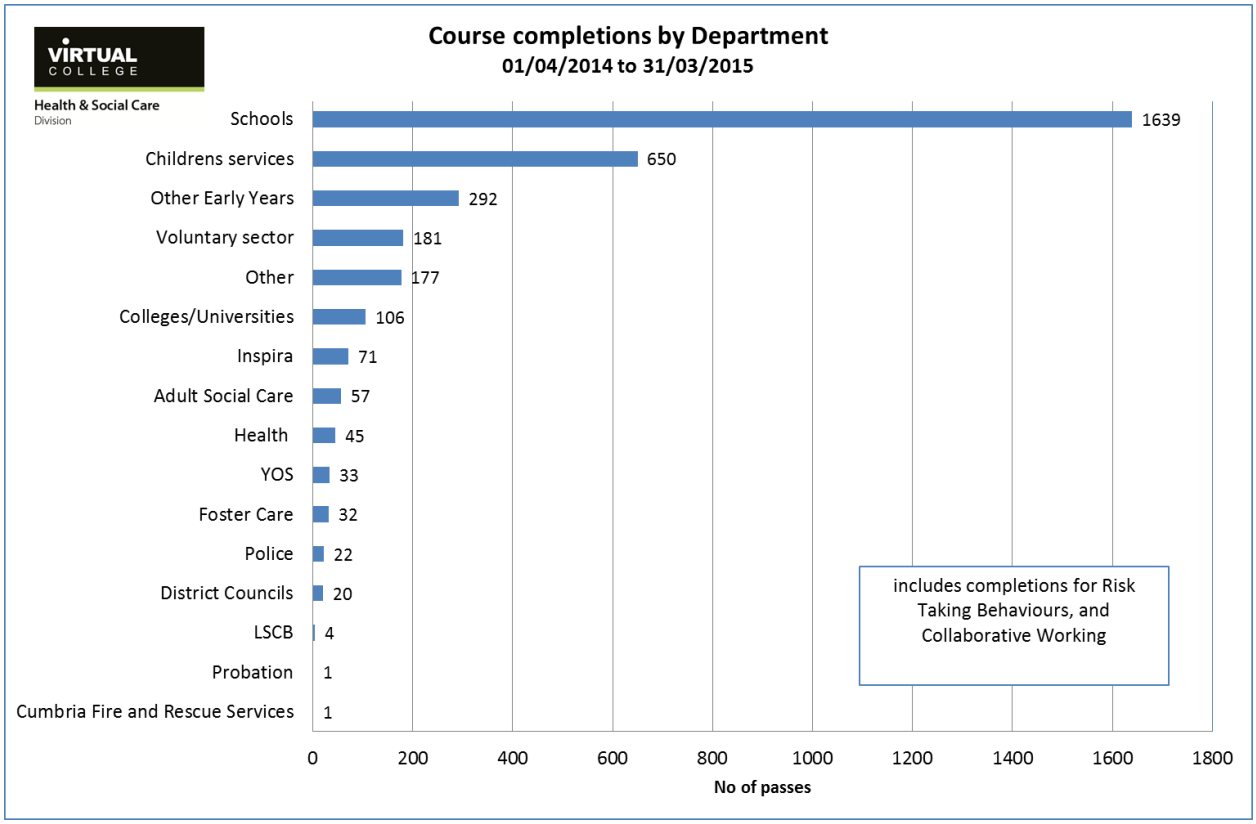
A range of other multi-agency learning opportunities were also provided. These included a number of multi-agency workshops aimed at both practitioners and managers entitled 'Working Together,' in addition to a Lessons Learnt from SCRs course and Disclosure and Barring Scheme (DBS) awareness events

2014-15 saw developments in the Early Help team's role in delivery of training and this was also incorporated into the wider learning programme

In response to each local Serious Case Review, Practice Learning Review and the findings of child protection audits the LSCB has provided regular briefings on lessons learnt. The LSCB website has also enabled practitioners to access the training programme, newsletter updates and new guidance information to enhance their learning/knowledge.

2014-15 training and learning opportunities

During 14/15 over 3000 practitioners accessed the range of eLearning packages available, the majority from the Local Authority, schools and private nurseries. Over 1300 attended face to face core courses.



Of those places booked on face to face courses only 5% (n=70) did not attend a booked course indicating that overall attendance rates remain high.

In addition to the core training programme of the LSCB a total of over 160 practitioners and 150 managers from across Cumbria attended the LSCB 'Working Together' workshops. Many of these sessions were delivered by members from the LSCB.

Notably during 14/15 the Early Help team delivered multi agency training to 1163 practitioners across the County and training to individual teams in the South (n= 693), North (n=622) and West (n= 694) a total of 3172.

Over 130 practitioners attended awareness raising events from the Disclosure and Barring Service across a wide range of organisations.

Initial evaluation from the new Trainers for Trainers course has also been positive.
The sub-group have agreed and endorsed a template for practitioners to share examples of good practice, this is now being piloted with the countywide Practitioner Forums.

Training Evaluation

During 2014-15 the LSCB piloted a new impact evaluation approach via the use of Survey Monkey for a 6 month post evaluation of level three training. Whilst a small sample size (n= 25) the results highlighted that a large proportion of respondents would not change practice as a result of the learning. The main impact of the learning was focussed on how practitioners would contribute to multi agency meetings (44% would change practice) and how work more effectively with other agencies (52% would change practice). The findings from this evaluation

have directly informed a new approach to the provision of multi-agency learning at level three for 2015-16.

The LSCB undertook a survey of each agency to assess which platform/application was being used to deliver level one eLearning. This along with the evaluation of the Virtual College courses offered by the LSCB informed the revised learning programme for 2015-16 which extends both the range of awareness raising modules on offer and the opportunity for all LSCB member agencies to access.

The LSCB have agreed the elements that will make up the evaluation framework including reactive evaluation, survey monkey for post evaluation and a deep dive approach reviewing practice change focussed on specific themes or practice areas. The finding will also be linked/cross referenced with wider LSCB evaluations including the outcome of audits both LSCB and from individual agencies, the staff survey and the messages from the new Young People's Advisory Forum.

Child Sexual Exploitation

The Cumbria response to CSE has been a whole system approach with engagement from all relevant partners. This includes taking on specific pieces of work, attending subgroups and leading on particular areas or actions.

Implementation Plan

There is an implementation plan in place, managed and monitored through the LSCB CSE Strategic Group; which is largely completed. This was presented to the LSCB on 17 March 2015.

A further plan will be developed a year on from the review of the CSE Strategy.

Strategy

The LSCB has a strategic sub group devoted to CSE and Children Missing from Home. The subgroup is chaired by the Targeted Youth Support - Senior Manager, Deborah Royston and has membership from all agencies represented at the LSCB, demonstrating that this is a partnership response to the problem.
The LSCB has had in place since April 2014, a revised CSE Strategy which shows a very clear commitment to working together to prevent CSE and how to respond collectively to it.

The CSE strategy contains a number of strands:

- Providing Leadership and Working in Partnership
- Training and awareness raising
- Identification and understanding risk
- Engagement, intervention and supporting victims

Awareness Raising and Training

There is a specific area on the LSCB website for CYP and professionals. Newsletters from the LSCB include CSE key messages. LSCB Twitter feed (650+ followers) has a dedicated #CSECumbria hashtag, linked to the partnership campaign. Additionally, there have been two very successful awareness raising conferences attended by 200+ staff and managers from across the partnership.

Chelsea's Choice (CSE awareness raising performance for CYP) delivered in all 33 secondary schools (7000+ children), with excellent feedback and disclosures made which are now being dealt with appropriately. All LA Children's Homes have received CSE awareness training and Best Evidence training for social workers completed.

Procedures and Tools

Alongside the strategy, the CSE Subgroup developed procedures for staff to follow, should they identify anyone they feel may be at risk. This has been recently updated and the procedure (now available on the LSCB website) was launched as part of the CSE Awareness Day on the 18th March.

To ensure good engagement across the frontline, an operational group has been established, reporting directly to the strategic subgroup, tasked with implementing the strategy on the ground. The chair of this group (Police Public Protection Unit) sits on the Strategic Group.

This group is ensuring effective and co-ordinated service delivery and they are tasked with implementing the strategy on the ground and reporting back any barriers, highlights and exceptions. This group looks at issues such as, Children Looked After placed in Cumbria from other authorities, training and raising awareness. The operational subgroup monitors CSE intelligence, including CSE reports to police, numbers of children missing from home, return interviews and number of CSE cases reported through the Hub. This is helping the LSCB understand the nature and extent of the issue in Cumbria. Some evidence of disruption is now available with warrants having been issued for a property in Cumbria as a direct result of a Return to Home Interview.

Operational Delivery

Barnardo's have been commissioned to undertake return to home interviews for children aged 0-12 and young people aged 13-18 who are looked after. Included in this is the offer to other authorities to commission them to conduct any return to home interviews that are required for children placed in Cumbria by another authority. NYAS are commissioned to do this for Out of County Placements from Cumbria and Inspira undertake them for all other children.

Sexual Assault Referral Centre

A joint CQC/Ofsted inspection of Children's Safeguarding and Looked After Children's Services in Cumbria recommended that Local Authority and NHS agencies should take action to "ensure a comprehensive range of support to young people who have been sexually abused". Over the past 2 years, a significant amount of work has been done to start to develop that range of support and its integration, as well as the development of a Sexual Assault Referral Centre for the county. This work is covering the whole range of sexual violence and is there being linked closely with specific work to develop processes and support for those at risk of or experiencing child sexual exploitation.

The LSCB has been involved in the development of pathways to provide joined-up referral of children and young people who are victims of sexual assault and abuse. This includes referral to and from the Sexual Assault Referral Centre, which is expected to be open by the end of 2015, and the links with specific risk assessment and support for victims of child sexual exploitation. Plans are in place to develop training to ensure professionals have the knowledge to identify and refer on children and young people experiencing sexual to the right services, as well as further development of clear referral pathways.

Impacts

Aggregated reporting is done to the police and intelligence gathered, any emerging group issues are reported to the Hub and dealt with on a somewhat ad-hoc basis. There is already evidence that this is having an impact as issues have resulted in warrants issued and action taken in some areas. Early indications show that this is picking up CSE issues effectively.

In the future this will be done through the newly established LCSB CSE Oversight Group where hotspots and activity themes will be identified.

The Hub has established links with neighbouring authorities, intelligence now being efficiently shared. Cumbria CSE categories now brought in to line with other authorities to further improve cross border understanding and information sharing.

Thematic CSE audit undertaken and programme of Hub audit now includes CSE on monthly schedule.

Protect and Respect

NSPCC started delivering the "Protect and Respect" program in Cumbria on a county wide basis in May 2014. The Protect & Respect service offers preventative and protective initiatives to young people who have been sexually exploited or who are vulnerable to this form of abuse. At the preventative end, staff will work with young people to provide information on the risks of sexual exploitation, including its definition, signs and indicators and their rights. They will also assist young people in accessing services around, amongst other things, sexual health, housing, faith and/or education. At the protective end, staff will undertake an assessment of risk with the young person and develop a tailored intervention plan, (including one-to-one and / or group work).

The service will work with young people for up to 6 months, and in some instances longer if there are good reasons for doing this. After this period, it is expected that the young person will have significantly reduced their vulnerability to sexual exploitation by securing a safer environment and/or a more stable lifestyle. They will also have a greater insight into sexual exploitation and the grooming process and will have become more resilient to sexual exploitation. Although NSPCC are delivering this program they are working in partnership with others from Children Services, Cumbria Police, Health, Barnardo's, Inspira and others from the multi-agency professional network as well as parents and carers.

Next Steps

In the Ofsted Report, following the March 2015 review of the LSCB –said "The Board does not yet provide sufficient challenge or urgency in its oversight of arrangements for missing children and those vulnerable to child sexual exploitation".

This was reflected in a CSE Self-Assessment completed by the LSCB to ensure the responses to these issues were being fully addressed.

A full action plan has been developed as a result of the Ofsted findings and our own Self-Assessment; and this will be managed through the LSCB Business Group.

Missing from Home

The Ofsted Inspection in March 2015 clearly identified issues in Cumbria with how children who had been missing from home were supported once they returned, in that the majority of the return to home interviews had extended beyond 72 hours before they are sent through to service providers. Improvements in the timeliness of this process will have a significant impact on their ability to meet the national statutory guidance.

Process

- Every missing child is tracked through a spreadsheet in the hub, managed by the Police.
- Every child returning from a missing episode is given a return interview**.**
- Since 1st January 2015, this has been through Barnardo's, NYAS or Inspira – dependent on their age and where they are placed.
- This should be done within 72 hours of the child returning home (policy has been amended to reflect statutory national guidance)
- There is evidence to suggest that this hasn't always been done in the statutory timescale - this is a priority for improvement.

Return Interviews 1st January 2015 – 6 March 2015.

	Barnardo's (Children known to children's services over 13 and all children under 13)	**Inspira** (Children unknown to children's services over 13)	**NYAS** (Children placed out of county who go missing)
Number notifications	59	36	11
Number of Young People Seen	35	25	5
Timescales			
Under 72 hrs	25%	62%	9%
over 72 hrs	75%	38%	91%*

Barnardo's

Reported reasons for delay in completing return to home interviews in 72 hours include:

- Late notifications from LA/Police
- Young person's preference on when and where to meet
- Difficulties making contact with social worker to establish key info before completing the return
- Difficulties establishing contact with young person to arrange the interview
- Issues gathering parental agreement to return interview being undertaken

Inspira

Reported reasons for delay in completing return to home interviews

- Late notifications from LA/Police
- Difficulties establishing contact with young person to arrange the interview
- Interviews scheduled to take place

NYAS

Reported reasons for delay in completing return to home interviews

- Late notifications from LA/Police

The recent developments are that:

1) Barnardo's and the Police are confident that they know all the children open to Cumbria Children's Services aged over 13 years and all children under 13 years living in Cumbria who have gone missing and require an interview and that each YP is being offered the opportunity of a return interview.
2) The return interviews are being undertaken effectively and the completion rate is high (85%)
3) The independence of the interviewer is enabling intelligence to be gathered and acted upon by the police and for CSE and other significant risks identified to be assessed by Social Workers and addressed.
4) We are increasingly becoming more aware of hot spots, connections between missing young people and key addresses and/or individuals. This is evidenced in both Barrow and Penrith.
5) There are robust processes for the management of missing by social workers being introduced within the local authority.
6) The timeliness of the returns should improve as the notification process becomes embedded and the new ICS systems prompt staff and team managers to follow the time bound process more efficiently.

Conclusion

It is not acceptable that the majority of notifications are already beyond 72 hours before they are sent through to service providers. Obviously improvements in the timeliness of this process will have a significant impact on their ability to meet the national statutory guidance.

Providers have all assured us that whilst they will seek to meet this, targets will need to be set that make allowances for the fact that a rigid approach to the 72 hour completion timeframe will not always engage the most vulnerable young people in participating in a return interview.

Effective engagement is critical and that includes being persistent and meeting with the young person at a time of their choosing.

Next steps

Strategic Group

Data reported to the Strategic Group from the operational group (data set was agreed through the strategic group). This has not been systematic to allow proper assurance and challenge to partners. Going forward this will improve as the Operational Group will present themes, highlights, exceptions and include specific agency challenges.

Operational Group

RHI information has been going to the Operations group, however this has not been monitored systematically and there have been some problems collecting the data. Full arrangements are now in place with Barnardo's, Inspira and NYAS to cover all children, and with representative on the CSE Strategic sub-group this will improve. Further developments of the CSE scorecard is underway as described in the CSE Implementation Plan.

CSE Oversight Group

This group (1st meeting planned for April 2015) will receive information about individual children and potential hotspots. Intelligence from this group will be used to identify themes and to improve disruption of perpetrators that will be used to expedite action in communities and improve outcomes from children.

LADO - Local Authority Designated Officer (2015-15)

Context: The Role of the LADO.

Cumbria has 2 full time dedicated workers who carry out the statutory duties of LADO. The LADO receives management oversight from a Service Manager in Child Protection Services.

Working Together 2015, places a responsibility on all LSCB's to have clear policies for dealing with allegations against people who work with children. This includes both paid employees and those in unpaid voluntary roles. An allegation is where a concern has been raised in respect of a professional who works with children and their actions can be deemed to have

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

The LADO is responsible for the oversight and scrutiny of individual cases, the provision of advice and guidance to employers and liaison with other agencies to ensure that the allegation is dealt with in an effective manner through a fair and due process. LADO do not undertake investigations as this responsibility lies with the employer or the governing body of the organisation.

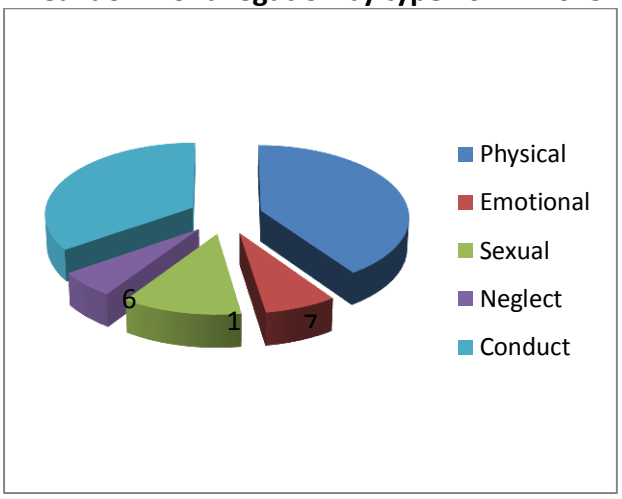
Analysis

For the period 1st April 2014 to the 31st March 2015 a total of 513 allegations were recorded by the LADOs. This is a reduction from the previous two years where the total numbers of allegations received were 560 in 2013/2014 and 616 in 2012/2013.

One of the recognised reasons for this reduction is the implementation of a standardised recording system. Previously allegation forms were recorded for every setting that an employee worked within, which at times did result in the same allegation being recorded 4 times if the individual held a number of posts. However, the LADO's now open 1 allegation period but clearly identify and record if the professional works in other venues and they record that these settings have been notified of the allegation.

The highest numbers of allegations received were in respect of Local Authority School Staff, with a total number of 143 recorded allegations. The next highest category was Residential Workers (non-Local Authority placements) with a total of 114 allegations and then School staff (non-Local Authority). The higher number of allegations recorded in schools reflects the high number of children that school staff come in to contact with each day. The data recorded in the last year does not demonstrate any new trends in referrals, but reflects the high number of non-Local Authority providers within Cumbria who cater for children with additional needs and behaviour difficulties. LADO regularly review trends of referrals and meet with any setting where it is deemed an unusual amount of referrals are received. If there are concerns, the LADO attends the setting and share concerns with the management team and action plans are agreed to improve practice if applicable.

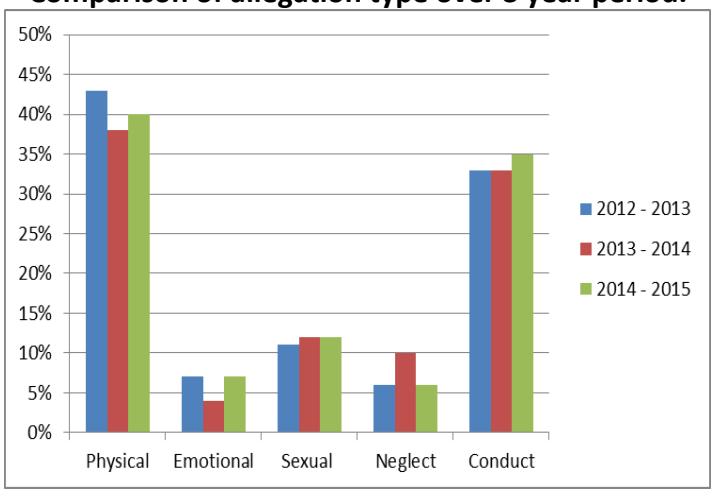
Breakdown of allegation by type 2014 - 2015.



As per previous years the highest number of allegations has been in relation to concerns in respect of physical abuse. A high majority, but not all of these referrals, are from settings where children with behavioural difficulties are either educated or placed. A young person is advised following any physical restraint that they can make a complaint, these are reported to LADO and information sharing will take place with the child's main worker, the police and the setting to assess if the restraint was appropriate and if the placement still meets the child's needs.

Figures from April 1st 2014 through to March 31st 2015 showed that of the 513 allegations, 80 related to allegations of physical abuse following a member of staff undertaking a physical intervention or restraint. Further analysis shows that 275 allegations relate to the Barrow in Furness and South Lakeland District. 54% of total referrals (69 of these allegations) related to the undertaking of a physical intervention or restraint. These figures demonstrate the impact of the independent children's home and residential school sector on the LADO service as a whole.

Comparison of allegation type over 3 year period.



In respect of trends over the last 3 years, physical abuse remains the highest category for referrals. However, there has been a slight increase in the number of allegations made in respect of staff conduct and neglect.

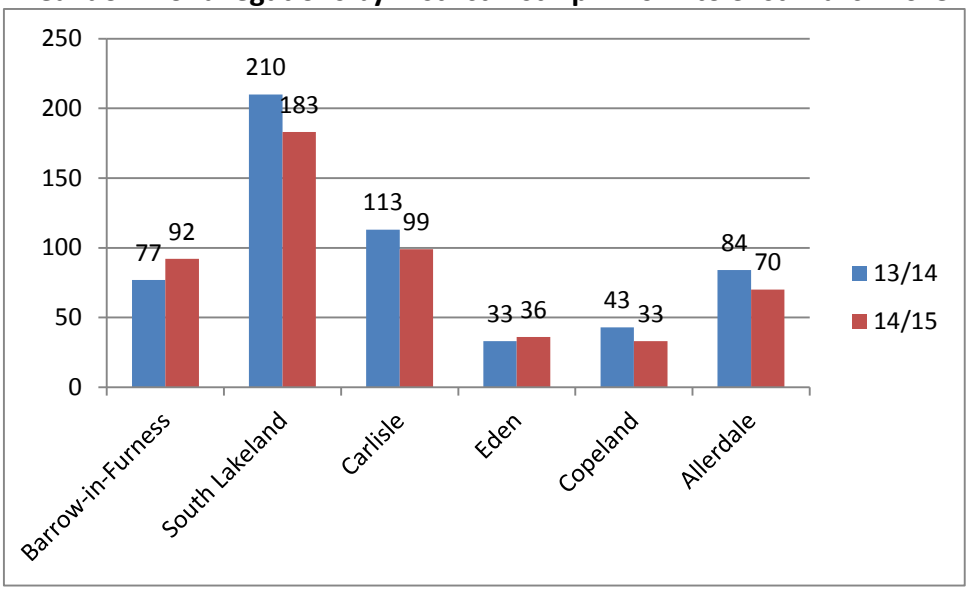
Despite the high number of prosecutions that have been reported in the media over recent years, reports of sexual abuse remain relatively low.

However, Operation Tweed, a police investigation into historical physical and sexual abuse in residential settings has commenced and it is possible that the investigations may lead to an increased number of allegations in respect of sexual abuse.

Records of referrals to the LADO service highlight that 234 were made by Children's Services, Social Care teams, 156 by education, 22 by Health, 12 by the Early Years sector, 31 by the police, 4 by the NSPCC, 14 by Voluntary organisations, 3 by Faith groups, 2 by the Armed Forces, 7 by Ofsted and 28 from other sectors. 95% of all LADO referrals are made within one working day which is the expected timescale for referral.

There continues to be delays in referrals received in respect of children who are placed in Children's Homes or Residential Schools by other Local Authorities. The LADO will attend the FISCH (Forum for Independent Schools and Children's Homes) to highlight the importance that settings must comply with the referral process which includes notifying the placing authority, the family of the child and the Safeguarding Hub.

Breakdown of allegations by District: 1st April 2014 to 31st March 2015.



As can be seen from this data, the figure for South Lakeland of allegations is disproportionate to the other Districts. Analysis of this data shows that this discrepancy is as a result of the high number of allegations from independent residential providers, both schools and children's homes, which are located in South Lakeland.

Number of referred cases that resulted in:

Final Result	Number
No further action after initial consideration	117
Training needs identified	157
Being unfounded	76
Being unsubstantiated	178
Being malicious	25
Substantiated	169
Suspension	69
Dismissal	31
Deregistration	4
Cessation of use	26
Resignation	26
Section 47 enquires/investigation	30
Criminal investigation	68
Disciplinary procedures	62
Criminal prosecution	8
Caution	1
Conviction	15
Acquittal	4
Referral to Barring Board('ISA')	42
Referral to regulatory body	38

Of the 513 allegations, 117 were concluded with 'no further action' after initial consideration/discussion. These were Initial discussions are undertaken with the referrer or an employer by the LADO. After the 'Initial Discussion", they did not warrant further action but may have required action by the employer. The LADO maintains a record of these, to detect themes and patterns. These are recorded on the same database as all the other allegations that are referred to the Cumbrian LADO service and not captured in a separate system, as some LADO's across the North West have in place. This provides a 'one stop shop' for all LADO figures on an annual basis, including, Initials Discussions which result in no further action at the point of contact.

Developments

Since April 2014, LADO referral forms have been accessible from the LSCB website. The LADO requests that a referral form is completed in respect of each allegation to ensure that records are correct.

The LADO service revised Chapter 7 guidance for the Management of Allegations and this was implemented in October 2014 and launched on the LSCB website. The LADO policy has now been aggregated to the new Tri-X document bank which will enable Cumbria County Council to continue to update and review the policy as required.

As part of Chapter 7 procedures, the LADO service provides an 'Initial Discussion service' for employers and referrers. This service enables providers to have consultation prior to submitting referrals to boost confidence and help avoid inappropriate referrals.

Privately Fostered Children (2014-15)

The LSCB has a duty to ensure "the co-ordination and effective implementation of measures designed to strengthen private fostering notification arrangements including; raising awareness of private fostering across partner agencies, third sector organisations and commissioned services: ensuring that any relevant training practices are developed and followed up at multi-agency level: reviewing and responding to the findings of the annual private fostering report submitted by the local authority to the Chair of the LSCB; acting upon the findings of Ofsted inspections and research evidence on effective practice; providing effective leadership and challenge in this area; and reporting on fostering in their own annual report as appropriate."

The Ofsted Report following the March 2015 inspection of says …. "The Board has held the local authority and partners to account for their performance over private fostering. Too few children are identified and referred to the local authority by partner agencies. The Board has increased its level of oversight in this area since the 2012 Ofsted inspection, when it was identified as an area of weakness. The local authority private fostering annual report to the LSCB shows that notifications have increased from 15 in 2012–13 to 20 in 2013–14.

There has been a decrease in the number of notifications – 13 - compared to 20 the previous year (2013-2014). It had been anticipated that the increased publicity may lead to an increase in the number of private fostering referrals from LSCB organisations. In 2013-14 none of the notifications came from LSCB organisations. In 2014-15 one referral was made by a partner agency. East Cumbria Family Support identified that one of the families with whom they were working with was a Private Fostering arrangement and referred them to Children's Services. The figures are monitored monthly by the Lead Officer who reports progress internally within Children's Services. At 31st March seven children were living in Private Fostering arrangements.

Number of children reported as being under private fostering arrangements at 31 March							
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Cumbria	8	9	5	7	6	8	8
North West	160	170	180	170	150	160	TBC
England	1,530	1,590	1,650	1,560	1,500	1,610	TBC

NB – data in SFR is not broken down by individual authorities, so statistical neighbours' data not available.

The Private Fostering leaflets and posters are available to download for staff and service users from the Cumbria County Council website The E-learning package has continued to be promoted as a mandatory component of all Children's Services new staff members induction.

Private Fostering is regularly promoted in the LSCB Newsletter and through their webpage. The Private Fostering policies and procedures were re-formatted for the LSCB and Children's Services launch of Tri-X in March 2015. Following the launch of Tri-X schools via the County Council Education portal schools will receive the electronic Private Fostering pack. All schools

will be asked via the LSCB education sub-group to check whether they have any children who are Privately Fostered and report back their findings.

Quality of Practice

All Private Fostering cases open to Children's Services on 31st March 2015, a total of seven, were audited to inform this annual report.

In the annual report 2013/14 it was recommended that the DBS check, parental responsibility and the carer's medical check forms were uploaded onto the child's record on the Children's Services Database (ICS). The 2015 audit found these in five out of the seven cases. This issue therefore remains a recommendation and will be raised internally with Children's Services managers and through the one to one meetings that the lead officer will conduct with social workers when they are allocated new cases.

The audit found that there may be children for whom Private Fostering is not the correct option for them; for example, if they would be at risk of significant harm if the arrangement ends and they return home. A review is to take place in May 2015 of all open Private Fostering cases to check that children/young people are correctly placed under Private Fostering and the relevant Regulations for Looked After Children.

The audit also found that the statutory visits were not being all completed within timescales. The figures for the first year of placement have risen from 53% to 62% and for second year of placement statutory visits have risen from 43% to 60%. This falls short of the target of 100%. This issue was also picked up by the Performance Team, which are still waiting for information from some managers about the recording of the visits. The area of greatest concern is that the initial visit within seven working days has dropped from 76% to 23%. Further work with ICS and the Performance Team will be completed to assess what is causing this low performance. These issues will also be raised internally with Children's Services managers and through the one to one meetings that the lead officer will conduct with social workers when they are allocated new cases.

Summary

There has continued to be a concerted push to publicise and embed Private Fostering via the LSCB. Although the LSCB has appointed lead agency officers for Private Fostering it is unclear why the activity request sent out was only completed by five agencies. A briefing has been sent out and delivered by Senior Advisers, General Advisers, Early Years staff and Governor Service's staff in schools, nurseries and Children's Centre settings. Publicity has also been delivered to targeted settings such as large employers in Cumbria. However actual notifications and Private Fostering cases continue to remain static in Cumbria and are still predominately generated by Children's Services staff.

Case recording of Private Fostering cases has improved but it is not yet a uniform picture across the County. There has been mixed performance for statutory visiting with a concerning drop in initial visits and a small improvement in six weekly visits and second year twelve weekly visiting. The reasons for this are be reviewed and action taken via management to progress the matter.

Case Reviews

The LSCB has a robust and well-defined case review process in order to develop a culture of continuous learning. There are four types of review agreed and implemented by this group:

- Serious Case Review (SCR)
- Practice review
- Internal management review
- Child death overview review.

The LSCB have completed one SCR in 2013-14, and adopted the SCIE review process in order to review the death of a young person known as Child J. The findings from this review were reported to the Board in January 2014, and a Learning and Development Plan has been developed. The report and Learning Plan are available on the LSCB website at: http://www.cumbrialscb.com/professionals/scr.asp

Serious Case Review 2014-15 – for Child J.

Child J began at School 1 in September 2011 aged 15 years. She settled well into her new school and quickly revealed herself to be academically able and gifted in sports and music.

In November 2012 she disclosed that she was suffering from an eating disorder bulimia, the start of which she attributed to an assault that she had experienced about 18 months earlier. Following this disclosure Child J self-harmed (taking a Paracetamol overdose) and she was referred to Child and Adolescent Mental Health Service (CAHMS) for help and support.

There was delay in Child J being seen at CAMHS and in the intervening period there was at least one (and possibly two) further incidents of self-harm. During this period also school based staff became aware of evidence of Child J's suicidal ideation and planning through the emergence of suicide letters that she had written and disclosures by her friends that she intended to kill herself.

Child J was seen at CAMHS in early 2013 and a plan was agreed to offer her ongoing assessment and treatment. Child J killed herself before the plan could be implemented.

The SCR was completed and presented to LSCB in January 2014, publication was delayed (in consultation with the family) until the week of the inquest to minimise the impact on the family and her friends as there was significant media interest.

Learning

The SCR resulted in an action plan for the LSCB with some single agency actions. This has been largely implemented as presented in the report to the LSCB Business Group in February 2015.

Training has been changed to reflect the learning regarding social media and "professional parents".

Learning has been discussed with individual practitioners and the school involved. The learning is on the LSCB website, and was included in newsletters. It has been used in workshops, practitioner forums and training.

In addition, as a result of this case and other failings around CAMHS, emotional well-being for children is a priority area for the CTB (reported to the LSCB). There is a subgroup, chaired by a secondary school head-teacher that has developed a whole system approach to these issues, which has included a Big Lottery Fund bid and the development of significant services and support for CYP across the County.

Practice Reviews

The LSCB conducted a further Serious Case Review (Child M) in 2014-15, but this review was re-categorised by the incoming LSCB Chair as the criteria was not met for a Serious Case Review.

Child M was seventeen when her baby was born. She had been involved with a range of agencies in Cumbria for almost all her childhood including being the subject of child protection plan, in foster care, subsequent adoption and then further foster placement.

When Child M became pregnant she was homeless and then spent the rest of her pregnancy living in a homeless hostel, three other recorded residential addresses and was in bed and breakfast accommodation awaiting a new foster placement when she went into premature labour.

When she was 26 weeks pregnant she reported to professionals that she had been hit by an object thrown at her. Child Ms baby was born prematurely later the same day in hospital; despite specialist care tragically her baby died 3 days later.

Child M was seen frequently during her pregnancy by a range of practitioners including social workers, hostel support workers, A and E staff, gynaecologists, Family Nurses, GP, CAMHS practitioner, CHOC, CRISIS team, Midwives, and Police.

At the time of the birth Child M's partner had a known history of domestic abuse and was a Class B drug user. Child M also disclosed that her previous partner had recently made threats to kill her

The **practice review** identified a number of priorities for learning:

- Routine **communication** must be maintained between practitioners to ensure that there is a coordination of both plans and crisis response to avoid poorly co-ordinated **risk management**.
- Practitioners should **share information** with agency colleagues on a regular basis and in particular where circumstances are changing quickly in order to inform effective decision making and planning.
- Professional frustrations about poor inter agency relationships need to be channelled upwards via line management. The escalation processes and LSCB **Conflict Resolution Policy** should be used by practitioners and managers to effectively challenge the professional practice or decisions of another agency, so that poor or inappropriate practice is appropriately challenged and children remain safe.
- Practitioners must keep children at the heart of **decision making** however 'hard to reach' they may be and this must recognise long term behaviours take time to change and that parents cannot always be relied on to do the right thing.
- Practitioners should be alert to the incidence and **impact** of intimate partner violence in young people.
- Practitioners should be clear who is responsible for coordinating **risk assessments and plans** when a large number of practitioners and agencies are involved.

Good progress has been made in the delivery of the actions from previous reviews and this has been managed through the Business Group.

New SCR underway

It is worth noting that Cumbria has a number of historic SCR that means large number of SCR are currently underway. A further 5 SCR have commenced in the 2014-15 year:

Child L
Child N
Child O
Children P
Child R

These reports will be published in due course, when they have been completed and any other proceedings have taken place.

Learning from Child Deaths (2013-14) (always a year in arrears)

Introduction

This is the annual report for the Child Death Overview Panel of all child deaths that occurred in the year ending 31st March 2014 for the local authority area of Cumbria. The deaths that are reported here are for all children, from birth up to 18 years old, who were normally resident in Cumbria and died during the stated period. It excludes planned terminations of pregnancy which were carried out within the law and still births.

The Cumbrian Child Death Overview Panel (CDOP) meets bimonthly to review information that has been collated regarding the cause, location and other circumstances of each child's death.

Any child's death is a terrible occurrence. The CDOP review process aims to ascertain whether a child's death was thought to be preventable by identifying what are called modifiable factors that may have contributed to a child's death.

Thankfully not many children in Cumbria die each year. This means the annual report involves small numbers so as a consequence only limited conclusions can be drawn from the data.

Descriptive summary of child death data

The data which follows relate to a review of child deaths for children who were normally resident in the local authority area of Cumbria that occurred from 1st April 2013 to 31st March 2014 (2013/2014).

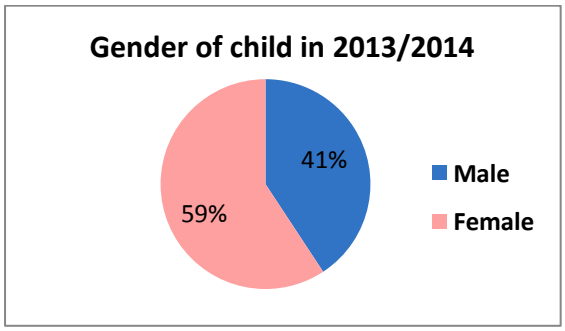
Number of child deaths

Twenty-seven children died during 2013/2014 which is fewer than during 2012/2013 when 29 children died who were normally resident in Cumbria.

Gender

During 2013-2014 girls accounted for more deaths (16 female) than boys (11 male) in Cumbria; 59% were female and 41% were male. These percentages **contrast** with national English data for 2013/2014; 56% of child deaths in England were male and 44% female. There has been a persistent trend in England for boys to account for over half of child deaths.

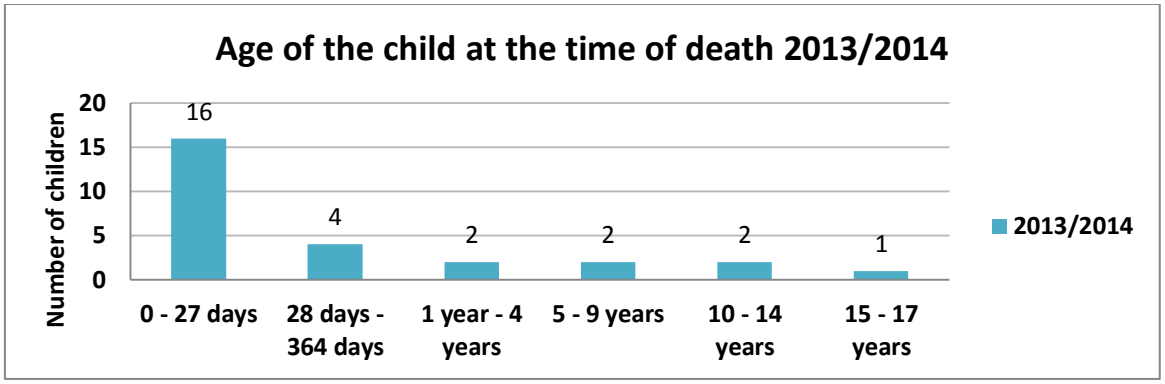
In the previous year Cumbria 2012/2013 data followed the national English trend and there were a higher number of male deaths then female.



Age of child at the time of death

In 2013/2014 the majority of Cumbria child deaths (16 children, 59%) occurred in the neonatal period (deaths under 28 days old). Of these 16 neonatal deaths, 15 occurred in the early

neonatal period (death under 7 days old). Cumbrian data follows national English 2013/2014 findings with the majority of deaths also occurring in the neonatal period, followed by children being 28 days – 364 days old being the second most frequent age group.



Category of death (as decided by CDOP)

There are ten categories used to classify the event which led to a child's death. For each child death, the most appropriate category is decided by the CDOP panel.

Category Number	Category of death
1	Deliberately inflicted injury, abuse or neglect
2	Suicide or deliberate self-inflicted harm
3	Trauma and other external factors
4	Malignancy
5	Acute medical or surgical condition
6	Chronic medical condition
7	Chromosomal, genetic and congenital anomalies
8	Perinatal / neonatal event
9	Infection
10	Sudden unexpected, unexplained death

Ethnicity

The seven cases where ethnicity is known were all White British. It is difficult to make a true comparison to the national English data for 2013/2014 at this time but nationally the majority were White British.

The most common category of death was for perinatal/neonatal events (14 child deaths, 52%) with chromosomal, genetic and congenital anomalies being the second most frequent category of death for children in Cumbria (7 child deaths, 26%).

Modifiable deaths

Ascertaining whether a child death was modifiable is a key part of the CDOP review process. All six (100%) were deemed non-modifiable deaths. National English data reports that overall 23% of child deaths were deemed modifiable in 2013/2014. It is difficult to compare the six Cumbria deaths with a few thousand deaths in England, but it suggests that Cumbria has fewer modifiable deaths.

Modifiable death status is not reported in the Cumbria 2012/2013 annual report and therefore no comparison can be made.

Qualitative review

Eleven of the children who died in 2013/2014 had at least one parent who smoked. Ten children's parents did not smoke and for the seven remaining children parental smoking status is not known currently. Parental smoking is associated with various child health issues. In the previous annual report 2012/2013 only five out of 29 cases reported parental smoking. More deaths in 2013/2014 were associated with at least one smoking parent; one of these cases died age 35 days old from sudden infant death syndrome. Smoking is a known risk factor for sudden infant death syndrome. This death highlights the continued need for encouraging parents to stop smoking.

A sizeable proportion of child deaths relate directly to prematurity (11 cases appear to relate directly to prematurity). Better documentation of known risk factors for prematurity would help elucidate any trends that may exist already or may be emerging. This ideally should include age of mother, antenatal history, and obstetric history including prior abortions, stressful maternal working habit, smoking and alcohol intake.

Nearly 60% of child deaths in Cumbria 2013/2014 occurred within the first 28 days of life. This demonstrates the short time period available to discuss, plan and prepare for a child's death palliative input. There appears to be good palliative planning and open discussions with parents of childhood born with chromosomal abnormalities or prematurely and unlikely to survive.

There is evidence of great care from Cumbrian services and its tertiary referral centres. There have been cases when staff went above and beyond the call of duty, for example when faced with the unexpected birth of extremely premature triplets. Communication between tertiary referral centres and Cumbria in order to plan ahead for the birth in problematic and high-risk pregnancies appears to have been well thought out in all cases. Some communication concerns had been raised in a few cases but such situations were when separate discussions between parents and different specialists happened as opposed having the specialists together at the same time to talk to parents. In not one of these cases would the outcome have been different for the child.

Reflection

This is a difficult procedure as any child death is a harrowing experience but ultimately the aim of the Child Death Overview Panel needs to be remembered at all times; to reduce future child deaths, by identifying whether a child's death was thought to be preventable, through the presence of modifiable factors that could be altered, by means of nationally or locally achievable interventions.

The CDOP will continue to consider trends and make recommendations to the LSCB. Lessons are shared through a variety of means including newsletters, the website, multi-agency and single agency training, and other learning events.

CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

2014-15 Business Plan Update

Update on delivery of Actions in the 2013-2014 Business Plan (anything not delivered is covered through the 2015-2018 Business Plan)

	Action	Who	When	Final Update	RAG
Leadership and Governance					
1.1	Governance arrangements to be agreed between boards with clearly defined reporting structures (Health and Wellbeing Board, Children's Trust Board and Adult Safeguarding Board) in order to scrutinise local arrangements to safeguard and promote the welfare of children and to ensure strategies are effectively coordinated.	Chair	Apr-14	Governance arrangements established and reporting structures clearly defined. A memorandum of understanding to was signed by all statutory boards to further strengthen the arrangements.	**Green**
1.2	New member induction process to be introduced including buddy system and the production of a LSCB induction pack that defines roles and responsibilities in relation to the LSCB	LSCB Senior Manager	Jun-14	Induction pack has been re-drafted. New lay member has been assigned a buddy and system is working well.	**Green**
1.3	Develop a programme to review the learning and development needs of LSCB members and systematically address these through annual appraisal	Chair	Jul-14	Addressed through the 1:1 process, that took place in September and learning needs were discussed. To be annually conducted going forward. 1:1 meetings between LSCB Chair and Members are complete. The feedback from Members has been fed into the Annual Report and reported to the LSCB/SIB and used as part of the evidence base for the Larch LSCB inspection from Ofsted.	**Green**
1.4	Review the membership of the Board to ensure that it fully meets the requirements of Working Together 2013	Chair	May-14	Membership reviewed and amended, meetings have now taken place with the updated membership. Working Together 2013 requirements are being met. Attendance at all LSCB meetings, including sub groups is monitored to ensure appropriate ongoing representation.	**Green**
1.5	Establish regular meetings between the Chair, the Chief Executive and key Members of the council to ensure the Chair is held to account	LSCB Senior Manager	May-14	Established and ongoing.	**Green**
1.6	Establish a programme of one to one meetings between members of the LSCB and the Chair	Chair	May-14	Chair has met with LSCB members on 1:1 basis and this programme of 1:1s is being implemented going forward. Linked to 1.3.	**Green**

	Action	Who	When	Final Update	RAG
1.7	Secure the appointment of a second lay member, with a remit for Children and Young People	Chair	Jul-14	2nd Lay member in post. One Lay member is chairing Child N SCR and sits on PMQAG and the other is a member of the Comms and Engagement Subgroup.	**Green**
1.8	Develop a mechanism for ensuring that appropriate challenge takes place and is logged so that it can be evidenced	Chair	May-14	Challenge at LSCB meetings is logged in a challenge Log and this is looked at the LSCB meeting to ensure impact is also recorded. This was strength in the Ofsted report from inspection in March 2015. The Business Group has been established to enable sub group chairs to ensure strong communication between the groups and to enable appropriate challenge between the sub groups. Public facing minutes are uploaded onto the website.	**Green**
1.9	Hold 2 six-monthly development sessions in order to ensure that members are working together to scrutinise and challenge local arrangements for safeguarding children (consider links to HWB and CTB)	LSCB Senior Manager	Mar-15	Development session held for LSCV members - following the Ofsted Inspection. Initial meeting for all Statutory Board Chairs was held 18.9.14 and this resulted in the agreement of the MOU which was signed off and is now published. This group has planned a workshop for Autumn 2015 for all Statutory Board Members that will being facilitated by CLIC (Cumbria Learning & Improvement Collaborative), and will be used to feed into the planning cycle and improve knowledge sharing across all Boards. The HWBB and Adult Boards are undergoing changes to their constitutions, the MOU stands but further joint work is still required.	**Green**
1.10	Implement the LSCB Communication and Engagement Strategy	Communications and Engagement Subgroup	Oct-14	The LSCB Communication and Engagement subgroup have been successful in re-establishing the LSCBs visible presence and raising its profile in Cumbria with key stakeholders. The group has successfully implemented a new website with elements for practitioners, parents and children. The group has released a series of newsletters and now have over 1300 subscribers (increasing by about 50-60 subscribers per week). There is an established social media presence with over 650 Twitter followers. A lot of work has been	**Green**

	Action	Who	When	Final Update	RAG
				carried out to promote Multi-agency Thresholds and what to do if you have concerns about a child. The group now recognises the need to promote messages further with a far wider campaign to reach other individuals and organisations working with children who are not always represented on the LSCB training and do not access the lines of Communication we already have. For example football clubs, youth clubs, scouting groups etc.	
1.11	Further develop the Communications and Engagement Strategy to include the use of the views of Children and Young People to inform service improvement and training	Communications and Engagement Subgroup	Jan-15	The LSCB are working to develop the Young People's Advisory Forum to provide a platform for conversations with children and young people about issues that are important to them. This will involve young people age 12 years and up who have had experience of receiving support from services at a range of levels including Early Help, Child In Need, Safeguarding and Children Looked After. They will help to ensure the voice of children and young people is listened to and taken seriously in the work of the Board.	**Green**
1.12	Commission third party supplier to provide the LSCB with all multi-agency policies and procedures	Policies and Procedures Subgroup	Dec-14	Whilst commissioning of Tri-x is complete and the new procedures manual is in place, there is still work to do to ensure our procedures are of high quality, support practitioners in their duties and that they are appropriately accessed/used. Shortly after the manual launched, Working Together 2015 and its supporting documents where published. Our procedures provider (Tri-x) will be dealing with this as part of our next scheduled update in August 2015. The LSCB Policies group works with Tri-x to ensure any changes (new legislation, practice etc.) are quickly and accurately reflected in the manual. The LSCB Business team will constantly collect feedback on the usability of the Manual and its relevance to practitioner's duties. The LSCB Policies and Procedures group will continue to take	**Green**

	Action	Who	When	Final Update	RAG
				responsibility for Policies and Procedures, contract monitoring of Tri-x and in identifying amendments and additions for the twice yearly update to the manual.	
1.13	Use established audit tool to undertake an annual internal review of the Board	LSCB Senior Manager	Annually	Audit tool used in first LSCB review and a further review took place in May. Going forward this was replaced by the use of the self-assessment. This has been updated quarterly.	**Green**
1.14	Commission a further review of the effectiveness of the LSCB and use this to review this Business Plan	LSCB Senior Manager	Jun-14	External review took place June 2014. The report was published on the website and actions were built in to the Business Plan and have now been largely completed.	**Green**
1.15	Align the support to the LSCB to the needs of the business of the Partnership	LSCB Business Group	Dec-14	Further development of Council restructure will impact on this and as of March 2015 the LSCB office is mainly temporary. Appointed permanent Business Support to LSCB - Deborah Hope. Developed a JD and PS for a CDOP co-ordinator.	**Amber**
Quality Assurance and Performance Management					
2.1	Review the Multi-Agency Performance Management and Quality Assurance Framework which is directly led by this plan and describes a review of the relevance of indicators annually	Performance Management and Quality Assurance Subgroup	Oct-14	This framework has been revised and went to the PMQAG, following 12th august meeting updates have been incorporated and are included in Chair's report to the Business Group 27.8.14	**Green**
2.2	Agree and deliver a prioritised audit programme based on clearly defined factors, and implement an audit tool that measures practice and impact, not just process, in conjunction with frontline workers and service users	Performance Management and Quality Assurance Subgroup	Mar-15	Forward plan in place and progressing as business as usual. Overseen by the PMQAG. This was strength in the Ofsted report from inspection in March 2015.	**Green**
2.3	Continue to undertake S11 audits on an annual basis, to be scrutinised by the LSCB and feedback to agencies and wider LSCB about themes, actions and issues	Policies and Procedures Subgroup	Annually	Section 11 audits are effective and closely follow the standards set out in guidance. The Board achieved a 100% completion rate of section 11 audits and has used the findings to improve safeguarding practice and identify multi-agency training and development needs for individuals and organisations. The process was well managed, and included follow-up compliance	**Green**

	Action	Who	When	Final Update	RAG
				visits to agencies from Board members and the identification of areas for development for the training and improvement sub-group.	
2.4	Establish a system for monitoring the implementation of recommendations from the section 11 audits	Policies and Procedures Subgroup	Dec-14	The report from s 11 Audit themes included an Action Plan for the Business Group who takes responsibility for making use of the findings in the future. The Audit has demonstrated that on the whole agencies are complying with Section 11. As a result of the Audit the LSCB has a baseline of self-reported compliance with Section 11 from which improvement targets can be set and monitored. In addition, the QA visits provided an opportunity to raise awareness of the work of the LSCB and highlighted issues to address that had not been previously identified.	**Green**
2.5	Establish web based S11 survey to enable greater engagement and compliance for the audits in 2015	Policies and Procedures Subgroup	Feb-15	The Section 11 audit in 2015 will see the LSCB use a more accessible, user friendly audit tool - The Policy sub group has recommended that the audit for 2015 is undertaken via Survey Monkey to remove the issues that arose with the previous audit tool because of agencies having different versions of Excel. LSCB sub groups are working together to further develop the previous audit tool using Survey Monkey and are on track to conduct the audit in July 2015.	**Green**
2.6	Develop the final version of the LSCB self-assessment against the Ofsted Framework, together with the actions required for improvement. Establish management mechanisms through the LSCB PMQAG	LSCB Senior Manager	May-15	Self-assessment against framework has been completed and is updated quarterly. When Ofsted came in March 2015 the LSCB was able to demonstrate they knew itself really well and had a good understanding of the issues to be overcome.	**Green**

	Action	Who	When	Final Update	RAG
Early Help					
3.1	Review and refresh the Threshold Framework document in line with the Early Help Strategy with the various levels of intervention clearly described and the types of services available outlined	Early Help Subgroup	Jun-14	Threshold document changes have been made and the document has been published, a task and finish group looked at the implications to other documents. The language used in the document has been sued to refresh other documents and the website, and the changes endorsed by the LSCB. This is now tied into the work on Neglect and the development of the Safeguarding Hub. The move to Tri-x manuals in march ensured there is a common language across the suite of policies and procedures for the LSCB.	**Green**
3.2	Implement the Early Help Strategy with success measures reported to assure Board of its impact	Early Help Subgroup	Mar-15	Early Help strategy signed off and implementation plan in place and being monitored through the early help sub group in July 2014. EH Officer appointed to be based in Hub. EH team are now permanent, and have been around county doing training/awareness raising. EH Audits were done as part of the QAG process and the LSCB (with the LA) commissioned a peer review of early help that showed some variable results, and the actions have been incorporated into the Improvement plans following Ofsted inspection - March 2015. Moving to ensure EHA are closed to help performance reporting/management. A refreshed Early Help Strategy was reported to LSCB in January. Amendments have been made and sign-off by the chair of LSCB is underway. It was officially signed off in March by the LSCB. The Ofsted inspection said that there was good ownership of the EH strategy, but the application of the thresholds remained "inconsistent".	**Green**
3.3	Develop the Cumbria Triage service, owned through the LSCB, into a multi-Agency Safeguarding Hub	LSCB Triage Programme Board	Nov-14	Hub launched on 3 November 2015, to timescale and initial feedback has been used to continually improve the service. The Programme Board is taking forward the development of phases 2 and 3.	**Green**

	Action	Who	When	Final Update	RAG
Developing the Workforce					
4.1	Review and refresh the local learning and improvement framework including a review of the current training programme	Learning and Improvement Subgroup	Jul-14	Framework complete including training plan and signed off by the L&I group and endorsed by the LSCB. Addressed the by producing Cumbria LSCB Training Strategy (2014) and the Safeguarding Learning and Development Framework (2014) - both are published on the LSCB website.	**Green**
4.2	Refresh/rebuild the repository of good practice on LSCB website, to include national learning, based on best practice from other LSCBs	Learning and Improvement Subgroup	Sep-14	Individual agencies and teams within agencies are good at sharing best practice and exemplars of good practice. Attendees of the countywide LSCB Practitioner Forums are encouraged to share examples of good practice, something the LA Audit and Practice Development Officers support. The Learning and Improvement group now need to capture these examples, alongside national example and disseminate them appropriately. Methods of dissemination have been discussed and include Q&A sessions, LSCB newsletter, LSCB website, training packs. This will require further focus in 2015-18 Business Plan to ensure sustainable systems are established.	**Amber**
4.3	Develop and implement a shared training evaluation methodology to assess the impact of training on practice and quality assure LSCB training delivery	Learning and Improvement Subgroup	Sep-14	The sub group have now agreed the elements that will make up the evaluation framework including reactive evaluation, survey monkey for post evaluation and a deep dive approach reviewing practice change focussed on specific themes or practice areas. The findings will also be linked/cross referenced with wider LSCB evaluations including the outcome of audits both LSCB and from individual agencies, the staff survey and the messages from the new Young People's Advisory Group. This alongside the Ofsted recommendations from the March 2015 inspection will be used to further develop this area in the 2015-18 Business Plan.	**Amber**

	Action	Who	When	Final Update	RAG
Learning from Case reviews					
5.1	Review the framework to which reviews are conducted to ensure it is fit for purpose.	Case Review Subgroup	Oct-14	Serious case review procedure has been reviewed and consulted upon by the Expert Panel for Child M. This was signed off through the case Review Group and implemented as part of the Tri-x policies. New SCR are now following the new processes which are going well. Further revisions will be made as part of the ongoing Tri-x updates (twice a year) to ensure continuous improvement and compliance with the Working Together 2015.	**Green**
5.2	Implement a model to carry out Serious Case Reviews (SCR) consistent with the principles of Working Together 2013, including participation from front-line practitioners	Case Review Subgroup	Sep-14	Web-site updated, briefing to be circulated to staff on the roles and responsibilities to those involved. There was a special serious case review newsletter that was published in the Autumn to capture leaning from practice reviews, local SCR and national SCR were all available to staff. In addition, the LSCB Web-site updated, briefing has been circulated to staff on the roles and responsibilities to those involved. A further SCR has been agreed. Children P.	**Green**
5.3	Review and implement process to manage the actions from all case and practice reviews.	LSCB Senior Manager	Jun-14	Serious Case Review action plan is updated regularly with progress and monitored through the Business Group. This has been working well - and was commended by Ofsted in their report following the March 2014 inspection.	**Green**
5.4	SMART action plans to be produced from practice reviews, case reviews and SCRs and the implementation of these plans to be monitored by the Business sub-group	Case Review Subgroup/ Chairs Subgroup	Ongoing – following a review	SMART Action plan produced following Child J and this has now been implemented - similarly for Child M which is now Practice Review - but principles remain consistent. No other reviews were completed in 2014-15.	**Green**
5.5	Ensure that the lessons from SCRs are communicated to front-line managers and practitioners, through effective dissemination and on-going re-enforcement	Case Review Subgroup	Ongoing – following a review	Staff briefings, quarterly newsletter updates, improved website utilised to share learning following Child J. National learning is also included on the website. Lessons from Child M (re-categorised to a Practice Review) have been developed into a newsletter update, briefing sheet, and website page.	**Green**

	Action	Who	When	Final Update	RAG
Learning from Child Deaths					
6.1	Annual data/report for 2011, 2012 and 2013 to be provided to the LSCB, including an analysis of themes. 2011 annual report to be presented to the Board July 2014, 2012 annual report to be presented to the Board December 2014 and the 2013 annual report to be presented to the Board in March 2015	Child Death Overview Panel	Nov-14	Annual Reports are now up to date and 2011-12, 2012-13, 2013-14 reports all having been presented to the LSCB, and are now published on the LSCB website. In addition, a composite report for the last 5 years has now been produced, and themes will be used in the 2015-18 Business Plan.	**Green**
6.2	Monitor learning and actions through exception reporting to ensure there is a clear audit trail evidencing that the lessons from child deaths are translated into measurable actions	Child Death Overview Panel	Jan-15	Learning has been incorporated into a single composite report and is reviewed regularly from by Business Group. Ofsted were satisfied with the dissemination of lessons from CDOP, however, further improvements are planned for 2015-18.	**Green**
Child Sexual Exploitation and missing from home					
7.1	Implement the new Chapter 12 (Child Sexual Exploitation) across the partnership	CSE/MFH Subgroup	May-14	Positive feedback from National Working Group on our revised Chapter 12: "I wish to compliment you on the good work achieved over the past year. Chapter 12 is substantial and well written and I was impressed by the use of the webinar last week and how this was put together."	**Green**
7.2	Develop a Child Sexual Exploitation (CSE) Strategy (including risks to children placed in Cumbria from other LA) and Implementation Plan	CSE/MFH Subgroup	Sep-14	Strategy complete including implementation plan. Implementation is monitored through the CSE & MFH sub group. Operational group also established to ensure issues can be discussed at the right level. Operating principles for the Hub have also been agreed.	**Green**
7.3	Develop the CSE/Missing from Home dataset based on the strategy – showing contextual, strategic and operational indicators	CSE/MFH Subgroup	Jul-14	Dataset developed. A suite of 8 indicators have been decided on with links to the LSCB PMQAG established. However, this has not been working as well as anticipated therefore this will remain a priority for the 2015-18 Business Plan.	Red
7.4	Review Chapter 12 and related procedures to ensure multi-agency involvement in CSE	CSE/MFH Subgroup	May-15	A further revision was completed ahead of the launch of the Tri-x manual to ensure lessons from the 9 months use were acted upon.	Green

	Action	Who	When	Final Update	RAG
7.5	Deliver the CSE strategy including a dataset to measure success, a communications and training strategy	CSE/MFH Subgroup	Mar-15	Overall report on progress with CSE presented to LSCB in November. CSE Strategy being monitored through the CSE & MFH LSCB sub group. CSE Self-assessment was developed and identified some key areas where progress was not as fast as hoped. Police undertook a CSE College of Policing Peer review which suggested there was some good work, but some areas need more focus - such as training. The CSE sub group of the LSCB has restructured to ensure effective delivery and monitoring of the strategy. There is now a strategic group, a working group and an oversight group. A development session is in the planning stages to ensure that all groups fully understand their remit and how this fits with the wider programme of work. This will remain an area of priority for 2015-18.	Red
Neglect					
8.1	Develop practice guidance based on the Practitioner workshop and national best practice	Neglect Subgroup	Jul-14	Neglect Strategy and Practice guidelines were produced and practitioner workshops have been completed.	**Green**
8.2	Review training offer to include identifying and working with children and families in which neglect is a factor	Learning and Improvement Subgroup	Sep-14	Frontline practitioners from all agencies were involved in developing the guidance and the strategy. At a meeting on 3 October 2014 it was agreed that partners will continue to promote the use of the tools in the neglect guidance because this will enable development of a shared language and an objective consideration of the impact on children to inform planning at the most appropriate threshold level. The LSCB Training Programme 2015/16 includes a face-to-face course on working with children and families in which neglect is a factor, delivered by the LA Audit and Practice Development Officers this course will cover the use of risk assessment tools such as the Graded Care Profile and Risk and Resilience Matrix. Supporting this, the LA Audit and Practice Development Officers will	**Green**

	Action	Who	When	Final Update	RAG
				continue to deliver a less formal presentation on working with children and families in which neglect is a factor. Basic awareness of abuse and neglect courses also remains as part of our eLearning programme.	
Health and Wellbeing of Children					
9.1	Review and evaluate the effectiveness of the Cumbria suicide prevention strategy with its progress to date	Performance Management and Quality Assurance Group	Sep-14	Report to the LSCB 23 Sept 14 from director of public health on progress of implementation of Cumbria suicide prevention strategy with recommendations for specific actions to improve outcomes for children. A refreshed strategy based on the six key areas for action in the new national strategy Preventing Suicide in England: a cross government outcomes strategy to save lives was endorsed by the HWBB in July 2014. In line with the national Strategy, the Cumbria suicide prevention strategy is led by Cumbria County Council's public health team. Training sessions on suicide and self-harm, tailored specifically to meet the needs of the Cumbria children's workforce, delivered by Cumbria County Council Children's Services Education Psychology service and administered by the LSCB. Cumbria LSCB have agreed a Memorandum of Understanding to describe the formal linkages with the Cumbria Suicide Prevention Leadership Group and the Cumbria Emotional Wellbeing and Mental Health Partnership Group, whose remit includes self-harm, and is governed by the Children's Trust Board. This will remain a key area of focus for 2015-18.	**Green**

	Action	Who	When	Final Update	RAG
9.2	Review best practice regarding professionals keeping up to date with the changing environment that teenagers' operate within and publicise the results across the partnership	Performance Management and Quality Assurance Group	Dec-14	Specific from Child J serious case review. Child J SCR has own learning and development plan, the Children's Trust Board held an event where the "inner world" of teenagers was the focus. Updates will continue to come to the Business Group. Fulfilling Lives: Head Start is a national programme funded by BLF and focused on equipping young people (target age 10-14 years) to cope better with difficult circumstances in their lives, helping prevent common MH problems before they arise. Cumbria has been selected as one of 12 national areas to apply for funding and a multi-agency partnership group has developed the project proposal. Four factors are to be addressed: - A young person's time and experiences at school; Their ability to access the community services they need; Their home life and relationship with family members; Their home life and relationship with family members). CYP at their forum have identified this as a key priority for them in 2015-18 and the LSCB has agreed to have this as a priority for the coming period. The Education Subgroup is leading on developing a conference on this subject in 2015.	**Green**
9.3	Evaluate the arrangements for safeguarding children and young people within drug and alcohol treatment services in Cumbria	Performance Management and Quality Assurance Group	Jan-15	The LSCB now receives information on "Children with parents receiving substance misuse treatment" - this is still in the early stages of development and we are at present unable to satisfy ourselves whether or not the data is showing "good" or "poor" performance as we have only received information for one period, and we have no national or comparator information. Public Health commission services and the Director of Public Health sits	**Amber**

	Action	Who	When	Final Update	RAG
				on the LSCB - and he also chairs the Child Death Overview Panel and is a member of the case review subgroup, this ensures that the commissioners are totally up to date with current issues for all the partners. In addition, Unity, the main provider of drug services in Cumbria are to be invited to participate and attend the new Safeguarding Operation Standards subgroup of the LSCB, this will ensure they are appropriately linked in to other related services. This will remain a priority for 2015-18.	

Conclusion

The Annual Report 2014-15 demonstrates that the LSCB has matured and is now able to evidence significant improvement across Safeguarding in Cumbria.

The Ofsted Report said that the previous Annual Report (2013-14) "lacked breadth and provided too little analytical detail about the range of responsibilities the Board". This was symptomatic of where the Board was and was reflective of the business plan that the Board had been working to.

The Business Plan 2014-17 was praised by Ofsted and has provided a much improved measure of the work of the Board, therefore this annual report is able to offer a more accurate and transparent assessment of the state of Safeguarding in Cumbria.

Highlights this year have included the development of a Children and Young People's Advisory Forum where the LSCB is able to engage with Children and young People; and the development of an Education Subgroup, which is already starting to help the LSCB understand the issues for schools especially around Early Help.

Further, the LSCB has invested in a new suite of Safeguarding Multi-Agency Policies and procedures. The procedures are clear and fit for purpose and are reviewed and amended twice per year to reflect changes in legislation, regulations and local policy.

Learning from Serious Case Reviews has been integrated into the business plan and has been incorporated into the training of the LSCB. This year, all actions and recommendations from completed case reviews from the last 5 years have either been signed off; the actions have either been implemented or included in other parts of the Board's planning with realistic timescales for completion.

LSCB Priorities 2015-2018

The LSCB has 9 themes for 2015-18. The actions to deliver on these in the first 12-18 months are included in the LSCB Business Plan 2015-18

1. Leadership and Governance
2. Quality Assurance and Performance Management
3. Early Help
4. Developing the workforce
5. Learning from Case Reviews
6. Learning from Child Deaths
7. Child Sexual Exploitation and Missing from Home
8. Emotional Health and Wellbeing of Children
9. Domestic Abuse