CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

# ANNUAL REPORT 2016-17

Published - September 2017

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# Contents

# 1. Foreword from the Chair

I have had the privilege to be the Independent Chair of Cumbria's Local Safeguarding Children Board (LSCB) for over three years. I continue to be so fortunate to have such committed and experienced colleagues from all agencies to work with me on ensuring the safety of Cumbria's children and young people.

I would wish to start by paying tribute and offering my thanks to all of the LSCB member agencies, the chairs of all of our sub groups, our lay members, and our Young Perspective Board all of whom work tirelessly to improve safeguarding in Cumbria. Supported by a very experienced and dedicated LSCB team - there is a strong collective partnership dedicated to this work. There are very many members of staff in all agencies and settings across Cumbria who play a part in this vital work. Our work has led to significant improvements in the functioning of the LSCB which is strongly connected to improved outcomes for children.

This report provides a detailed description of the significant work that has been undertaken in Cumbria from 2016 to 2017 and it provides an open and transparent assessment of the state of safeguarding for children and young people in Cumbria. I am pleased to say that it describes significant and continuous ongoing progress, although, of course, we can never be complacent in such challenging work.

One of the key features of the year was the publication of five Serious Case Reviews (SCR), undertaken when children have either died or been seriously injured and where abuse or neglect is a feature. These are tragic and significant reviews and considerable work is required to ensure the learning is translated into improved practice. Three of these SCR were cases from some time ago which I describe as "legacy" cases, when the criteria for a SCR should have been met at an earlier point. All of the SCR are described in detail in the report.

The year has seen a significant increase in Early Help Assessments which are aimed to prevent families reaching crisis point, and to offer services at an early point. In addition the LSCB has developed and implemented an improved strategy for tackling domestic abuse and the impact on children and young people. The LSCB has also retained a strong focus on Neglect. We have strived to ensure that there has been a significant increase in staff being trained, and we have continued to improve our learning from auditing.

We have strengthened the voice of young people in the work of the LSCB through the Young Perspective Board, which is made up of young people from different settings and pathways – all of whom play a vital role in shaping the work of our Board. As a result of their work during 2016-17 they won the Police and Crime Commissioner's award for Outstanding Citizen of the Year (July 2017). I would wish to publically congratulate them and thank them for their significant contribution.

I regularly provide a report to the Minister of State for Vulnerable Children and Families and will continue to do so until we and external Inspectors are certain that the improvements are sustained and embedded within Cumbria. On each occasion that I write that report, I am pleased to report very positive progress from a LSCB perspective. However, I am by no means satisfied and we will continue to strive to improve further.

I hope that you find this report interesting and helpful. It is intended for everyone who has an interest in safeguarding Cumbria's children and young people. I look forward to the continuing challenges for 2017-2018 and to working with all of our many stakeholders in Cumbria, and to continue to improve the safety of children and young people in Cumbria.

Thank you for all that you do.

**Gill Rigg**
**Cumbria LSCB Independent Chair**

**22nd August 2017**

# 2. Introduction

Welcome to the Cumbria LSCB Annual Report 2016-17. This Annual Report is a retrospective look at the work of the LSCB in the year 2016-17, 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.

# 3. The views of Children and Young People (CYP)

Cumbria LSCB believes that it is important for children and young people to take an active role in the design and development of services provided for them. The LCSB has a young people's board that meets on a regular basis called the Young Perspective Board. The Board meets at least four times a year to plan larger young people's engagement events called Forums and work on specific projects. These events have provided opportunities to raise issues that affect children and young people and solve problems around safety and safeguarding. The Young Perspective Board say that they exist '*To make sure that young people have a say in services that are there to keep them safe'.*

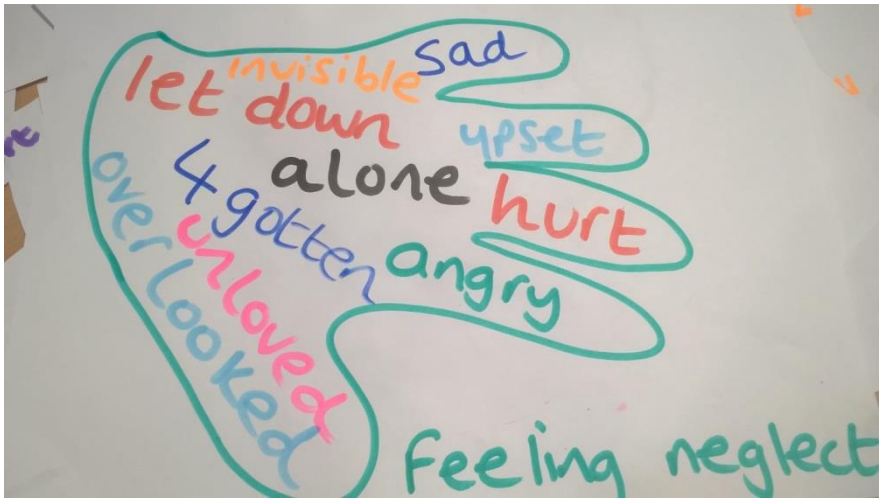
**Key Achievements**
The young people agreed their Terms of Reference and their priorities for the year which included; Child Neglect and the impact of parental mental health and substance misuse.

**Child Neglect**

On 25th July 2016 the LSCB Young Perspective Board ran the first young people's forum wholly created and delivered by young people. They ran 3 workshops: Neglect a saw, Badge it and Neglect matters, the workshops were designed to find out what young people living in Cumbria think neglect is and how it affects young people.

The day started off with a short film and a poem written by a shadow board member to introduce what is meant by neglect. Some of the young people felt sad when they learned more about neglect in Cumbria, they felt that one of our priorities should be about raising awareness of neglect to other children and young people; teaching staff and parents.

The views of the young people were incorporated into the Cumbria LSCB Neglect strategy and two young people delivered a presentation at the LSCB Neglect conference.




**Impact of parental mental health and substance misuse**

The Board ran an event called the good the bad and ugly which explored alcohol and its impact on children and young people. Over 30 young people attended and the key points were; young people felt that they needed more education at a younger age on drugs and alcohol as they want to understand how to keep safe and how to keep their friends safe. They designed a leaflet on staying safe throughout the summer. A key priority was to design bags that can be distributed to young people.

The Young Perspective Board has agreed that their priorities for 2017 / 18 will be internet safety and Domestic Abuse.

# 4. Cumbria's Children and Young People

Approximately 92,800 children and young people under the age of 18 years live in Cumbria. This is 19% of the total population in the area. (Source: Mid-2015 Population Estimates, ONS). Approximately 13.8% of the local authority's children (aged 0-19 years) are living in poverty (Source: HMRC).

Children and young people from minority ethnic groups account for 5.3% of all children living Cumbria, compared with 29.1% in the country as a whole (Source: School Census).

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, 53.6% live in rural areas, compared with 17.6% of the population in England and Wales. (Source: Office for National Statistics, 2011)

Cumbria faces the challenge of rurality and child poverty.

### Child protection in this area

At 31 March 2017, 523 children and young people were the subject of a child protection plan. This is an increase from 416 children and young people at 31 March 2015. This has been an area of focus for the Board over the past year, and will remain so for 2017-18.

At 31 March 2017, 3,081 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 from the Local Authority (LA) to achieve or maintain a reasonable standard of health or development: this is a reduction from 3,371 at 31 March 2016.

**Children looked after in this area.**

At 31 March 2017, 627 children are being "looked after" by the LA, a rate of 67.6 per 10,000 children. This is a decrease from 31st March 2016 when 661 children were looked, after a rate of 70.8 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 in a whole system approach.

There are 179 (March 2017) Cumbrian children and young people who are in placements outside Cumbria.

# 5. Who are members of the LSCB

The LSCB is a partnership made up of senior officers from a number of key agencies that work in the Children's Sector. The agencies represented at the Board are:

Cumbria County Council, Children's Services
Cumbria Clinical Commissioning Group (Cumbria has two CCG from 1 April 2017)
Cumbria Partnership NHS Foundation Trust
University Hospitals of Morecambe Bay
North Cumbria University Hospitals
Cumbria Constabulary
Secondary Head teachers Association
Primary Head teachers Association
Cumbria District/Borough Councils
National Probation Service
Cumbria & Lancashire Community Rehabilitation Company (CRC)
Public Health
NHS England
Voluntary Sector representative
Barnardo's
CAFCASS, Cumbria
Youth Offending Service
Lay Members

The work of the LSCB is done through a number of subgroups with representation from a much wider range of agencies than the ones listed above.

# 6. 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. Also that the Business Plan reflects the areas that the members are most concerned about that have all been fed into the 2017-20 Business Plan.

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

The answers to two of the questions are reported here as they demonstrate the work of the Board over 2016-17:

**Can you say what do you see as the strengths of the Cumbria LSCB and the areas to develop?**

**Strengths**

- Partnership working has improved significantly and is genuine with good constructive challenge in the system
- Voice of children and young people is more evident in the work of the LSCB

- Collective ownership and cohesive, with good ownership of the partnership working to ensure multi-agency focus on safeguarding children
- Strong and determined partnership to develop with significant improvements in the last 3 years
- LSCB website is easy to navigate and communication continues to improve
- Development of sub groups and the co-ordination of audits is bringing real benefits
- Learning from SCR's becoming embedded
- A strong and knowledgeable Chair
- Competency of the LSCB team with significant improvements in the administration in the last few years
- Continued development of organisational leads in supporting and enabling the work of the LSCB alongside the promotion of multi-agency understanding of the roles of each agency
- Continued engagement with the education sector
- CDOP process has improved significantly over the past 2 years
- Feels like a 'one team' approach

### Areas for Development

- Consistent understanding of thresholds
- Implementation of the 0-19 service – need to ensure that the newly commissioned service strengthens rather than weakens the safeguarding system
- Further development of multi-agency training
- Strengthen the action planning for next year to have system wide improvements
- Ensure the LSCB is sighted on the wider system leadership
- More to do on single agency responsibility for managing lower risk
- Further promote Emotional Health and Wellbeing
- Understanding the implications of the CCG boundary changes and implementing required modifications
- Capacity to manage the system remains a challenge, despite the LSCB team working so hard
- Early Help panels – great initiative to bring into Cumbria but there is variable effectiveness of the Panels across the County at present

### One of the requirements of the LSCB Annual Report is a transparent section on the "state of safeguarding in Cumbria". How would you describe this?

- Increasingly improving with a genuine collective commitment to consistently delivering good outcomes for children need to work on consistency across the geography
- Concerted commitment to considerable improvement, Cumbria knows itself well
- Real improvements in Early Help
- The direction is good and positive
- Ensuring the impact on frontline staff consistency remains a challenge but staff are more confident
- Good and developing,
- Much improved

- Safeguarding audit extremely helpful
- Partners are working together, this has developed significantly

# 7. 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 safeguard children. In addition to this, Cumbria Children's Services is rated as inadequate, and as such the work to improve is overseen by the Children's Improvement Board (ChIB) which is chaired by the Local Authorities Department for Education appointed Advisor. The LSCB Independent Chair attends this Board and is held to account by this body. This is a temporary arrangement until services in Cumbria are judged to have improved sufficiently.

This section 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 and Adults, namely:

- Health and Well-being Board (HWB)
- 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

- HWB 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 HWB.
- The HWB takes a lead in Cumbria for Suicide Prevention, which includes Suicide in Children

## Children's Trust Board

- CTB sets out the strategic priorities for children and young people in Cumbria and oversees the delivery of the Children and Young People's Plan.
- 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

- 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

- 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 (DA) 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.

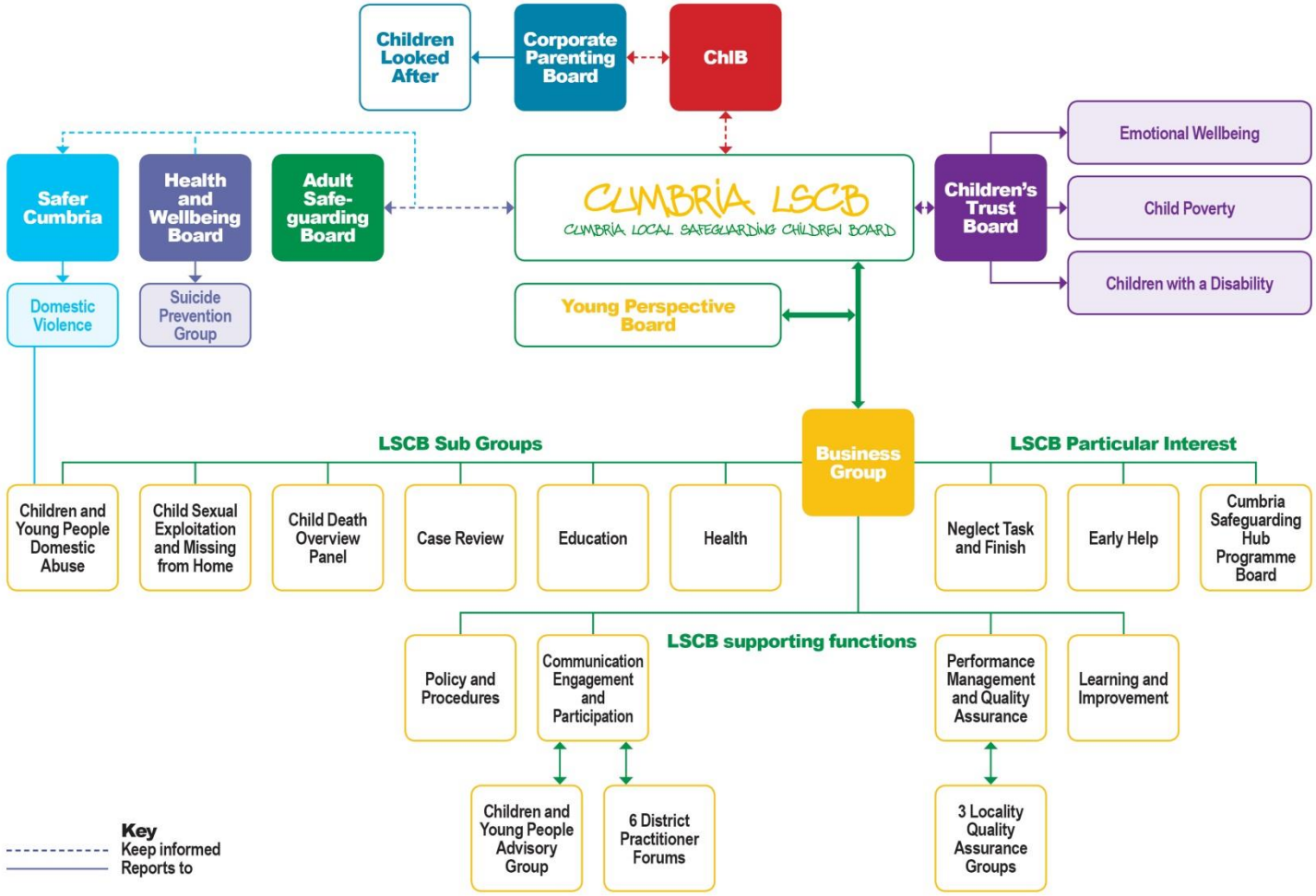
There are standing agenda items on all Boards to ensure "key messages" are shared across all meetings.

## 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 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.

# 8. LSCB Structure (see previous page for Acronyms)



# 9. Governance

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:

- 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.
- 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
- 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
- Plan, co-ordinate, commission and evaluate multi-agency training.
- Promote effective multi-agency early help to identify and appropriately support children and their families.
- Monitor and evaluate the effectiveness of partner agencies individually and collectively and advise on ways to improve performance and quality.
- Undertake reviews of serious cases and child deaths, advise the Board and our stakeholders of the lessons to be learnt.
- 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.

# 10. 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

| Contributions | 2016-17 |
|---|---|
| Children's Services (staffing/board support) | £96,814 |
| CCG | £61,079 |
| CPFT | £7,800 |
| NCUH | £7,800 |
| UHMB | £3,000 |
| Probation | £1,734 |
| Police | £13,811 |
| CAFCASS | £550 |
| NHS England | £20,000 |
| **Total Partner Agency Contributions** | **£212,588** |

| LSCB Spend | 2016-17 |
|---|---|
| Office Costs | £95,931 |
| Independent Chair | £23,640 |
| Fees | £2,919 |
| Vice Chair (Barnardo's) | £3,000 |
| SCR | £49,226 |
| LSCB meeting expenses | £3,200 |
| Young People's Forums | £1,081 |
| MA Training for LSCB Agencies (including venues) | £8,496 |
| Better Together Roadshows | £926 |
| SCR Conference (Neglect Conference) | £1,081 |
| Virtual College (online training) * | £12,333 |
| MA procedures manual (Tri X) | £9,660 |
| Survey Monkey (annual subscription) | £249 |
| SCIE (SCR AQ Consultancy) | £660 |
| Practitioner Forums (venues) | £186 |
| **Total LSCB Costs** | **£212,588** |

*three years membership paid in 2015-16

# 11. 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. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Communication, Engagement and Participation

The Communications, Engagement and Participation group provides a cohesive voice for the partnership. It exists to provide the support, guidance, planning and delivery of communications and engagement activity for the LSCB sub groups and their stakeholders. The Communications, Engagement and Participation group will use the wider network offered by LSCB members to communicate and engage with the multi-agency partnership.

1. Raise the profile of the LSCB in Cumbria with key stakeholders and the public
2. To provide timely and relevant information about the work of the LSCB to key stakeholders
3. Provide engagement opportunities for effective communication with, and between, stakeholders
4. Create opportunities for children and young people to influence and inform the work of the LSCB and its decision making structures
5. To communicate key messages across the LSCB to influence and improve best practice and to ensure consistency

## 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
2. Commission and contribute to such SCR
3. Oversee Cumbria's contribution to the SCR held in other LSCBs.
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. Publish an Annual Report of themes and learning from child deaths.
3. Collate and oversee the national returns
4. Ensure full analysis of all Child Deaths to ensure learning from these cases is captured and absorbed
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. To develop and review a multi-agency learning and development programme within the context of local and national policies, research and practice developments
2. To ensure standards are set for single agency basic training/learning and evaluate and review single agency provision
3. To commission the design, planning, organisation and implementation of the training/learning programme based on LSCB priorities, learning from SCRs and reviews of child deaths
4. Monitor and evaluate the quality and effectiveness of the LSCB learning programme
5. Support, develop and monitor the LSCB trainers pool
6. To ensure oversight and information about individual agency training that links to the LSCB priorities and to consider which could be accessed by partner agencies.
7. To ensure that the learning from serious case reviews is communicated in single and multi-agency training.
8. To ensure that individual agencies focus on how staff in their organisations are achieving and maintaining their competencies in safeguarding using a range of learning opportunities

## Performance Management/Quality Assurance

1. Collect, collate and analyse multi-agency performance data and report exceptions and areas of concern to the Board
2. Commission and analyse Section 11 Audits to ensure that agencies and organisations are operating in safe arrangements
3. Oversee and collate the findings from the LSCB staff Surveys – identifying areas of learning to incorporate into communications, learning and policies
4. Alongside the Board commission multi-agency Quality Assurance audits around areas of particular interest or concern
5. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board
6. 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. Monitor Governing Body responsibilities and involvement in safeguarding arrangements
5. To identify and disseminate good practice
6. To support the work of designated persons in educational establishments.
7. Collation of training figures and other key data to feed into the Learning and Improvement Sub Group and/or other Sub Groups as appropriate
8. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Health Subgroup

1. Delivery against the shared objectives of the multi-agency safeguarding arrangements outlined by the LSCB
2. Ensure the delivery of the agreed priorities that form the programme of work for the health economy including setting targets, looking at outcomes and monitoring performance including reporting to the Cumbria Local Safeguarding Children's Board
3. Ensure the effectiveness and resilience of the NHS Safeguarding system, through:
   - Monitoring training adherence
   - Ensuring that lessons from incidents and case reviews are learnt and implemented
   - Facilitating joint audit activities
   - Ensuring mutual support at times of stress (vacancies etc.)
   - Learning from all relevant audits including section 11
   - Identify key safeguarding issues for executive action relevant to the Health Safeguarding Executive Group and the LSCB
4. Lead on health aspects of inspection reviews; ensure inspection readiness (including self-assessment) across the health economy
5. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Safeguarding Hub Programme Board

The Safeguarding Hub Programme Board has the leading role in the development and performance of the Multi-agency Safeguarding Hub.

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

## 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.
3. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Child Sexual Exploitation (CSE)/Missing From Home (MFH)

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
7. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Neglect Task and Finish Group

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)
d. Identify creative ways to bring the Voice of the Child into the work of the sub-group and the wider Board

## Domestic Abuse Task and Finish Group

As Domestic abuse remains a key priority for the LSCB, in 2017 it was agreed that the task group become a sub group of the LSCB and was renamed the Children and Young People's Domestic Abuse Sub Group. The group will work with the CLSCB and the Safer Cumbria Partnership to set the strategic direction for Domestic Abuse, with specific attention to the needs of children and young people in Cumbria living with, witnessing, or being perpetrators of Domestic Abuse to ensure that they are safeguarded.

1. Maintain a strategic overview of performance issues across the county.
2. Provide analysis and challenge performance across the county.
3. Report highlights and exception to the LSCB business group and the Safer Cumbria DA Ops Group.
4. Monitor the effectiveness of multi-agency working, including monitoring practices of agencies to ensure procedures are followed.
5. 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.
6. Provide the LSCB with all the information necessary for them to provide an annual report on the work of the Domestic Abuse sub group including information on how the work of this group has directly impacted on children.

# 12. 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 table on the following pages is taken from the performance report that is presented to the PMQAG and shows the end of year performance for the range of indicators.

Alongside this the group receives a detailed update against each indicator which ensures agencies are held to account and the LSCB has assurances that poor performance is being addressed.

## LSCB performance Report (31 March 2017)

| Indicator | Description | Rate/Percentage | RAG (against target) | Trend over last year | Good performance is | Target 16/17 |
|---|---|---|---|---|---|---|
| CS1.0 | Referrals within 12 months of a previous referral | 17.7% | G | Improving | Low | 23.4% |
| CS1.1 | Assessments completed within 45 working days | 97.3% | G | Improving | High | 90.0% |
| CS2.0 | S47 Enquiries completed within 6 working days | 82.1% | G | Improving | High | 85% |
| CS2.1 | Initial Child Protection Conferences within 15 working days | 87.7% | G | Improving | High | 83.8% |
| CS2.2 | Social work reports for ICPC shared with family | 68.5% | A | Declining | High | 75% |
| CS2.3 | Number/rate of children subject of CP plan | 56.6 | R | Declining | Low | 40.0 |
| CS2.4 | CP Statutory visits | 98.3% | G | Improving | High | 96% |
| CS2.5 | Children subject of repeat CP plan within 2 years | 10.7% | A | Static | Low | 10% |
| CS2.7 | CP plans lasting over 2 years | 2.8% | G | Sustained | Low | 5%-7.5% |
| CS3.0 | Number/rate of looked after children | 68.0 | R | Improving | Low | 60.0 |
| CS3.1 | Number of children entering care | 14 | R | Improving | Low | 12 |
| CS3.2 | Number of children leaving care | 25 | G | Improving | High | 25 |
| CS3.4 | CLA Statutory Visits | 98.7% | G | Improving | High | 96% |
| CS3.5 | CLA with 3 or more placements in the year | 8.6% | A | Declining | Low | 8% |
| CS3.6 | CLA living in the same placement for 2+ years | 68.9% | G | Sustained | High | 70% |
| CS3.7 | CLA in purchased placements | 43.1% | R | Declining | Low | 30% |
| CS3.8 | CLA placed outside Cumbria | 28.8% | R | Declining | Low | 22% |
| CS3.10 | CLA with up to date PEP | 95.0% | G | Improving | High | 100% |
| CS3.12 | Initial health assessments for children entering care | 94.4% | G | Declining | High | 85% |
| CS3.13 | Review health assessments for children aged under 5 | 88.9% | G | Improving | High | 85% |
| CS3.14 | Review health assessments for children aged 5 and over | 96.4% | G | Sustained | High | 85% |
| CS3.15 | Health assessments for children looked after for 12 months or more | 95.4% | G | Improving | High | 85% |
| CS3.16 | Dental checks for children looked after for 12 months or more | 94.9% | G | Improving | High | 85% |
| CS3.17 | Immunisations for children looked after for 12 months or more | 96.9% | G | Sustained | High | 90% |
| CS3.19 | Children placed for adoption within 12 months of the decision | 60.2% | R | Improving | High | 78% |
| CS3.20 | Average time between entering care and placement with adoptive family | 653 | R | Declining | Low | 586 |
| CS3.21 | Average time between court authority and match with adoptive family | 369 | R | Declining | Low | 221 |
| CS3.22 | Proportion of families who wait more than 3 months from approval to match | 75.0% | R | Improving | Low | 46% |
| CS3.25 | Other authority CLA placed in Cumbria | 23.8% | n/a | Sustained | N/a | Not set |

| Indicator | Description | Rate/Percentage | RAG (against target) | Trend over last year | Good performance is | Target 16/17 |
|---|---|---|---|---|---|---|
| CS4.0 | Care leavers aged 19, 20 and 21 in suitable accommodation | 91.6% | G | Improving | High | 83% |
| CS4.1 | Care leavers aged 19, 20 and 21 in education, employment and training | 49.7% | G | Sustained | High | 49% |
| CS4.2 | Eligible CLA with up to date pathways plan | 91.4% | G | Improving | High | 95% |
| CS4.3 | Care leavers with up to date pathways review | 89.3% | A | Improving | High | 96% |
| CS4.4 | Care leaver visits | 76.7% | G | Improving | High | 75% |
| CS5.0 | Percentage of social work vacancies covered by agency staff | 12.2% | G | Declining | Low | 14% |
| CS5.3 | Young people in police custody | 0 | G | Improving | Low | 2 |
| CS5.5 | Return interviews within 72 hours | 50.8% | R | Improving | High | 80% |
| CS6.0 | CP Reviews - all reviews in last year held in timescale | 93.7% | G | Improving | High | 96.3% |
| CS6.1 | CP Reviews - latest review up to date | 99.4% | G | Sustained | High | 97% |
| CS6.2 | CLA Reviews - all reviews in last year held in timescale | 88.7% | G | Sustained | High | 90% |
| CS6.3 | CLA Reviews - latest review up to date | 99.5% | G | Improving | High | 90% |
| CS6.4 | CLA review participation for all reviews in year | 92.9% | G | Improving | High | 92% |
| CS6.5 | Participation in latest CLA review | 97.3% | G | Improving | High | 92% |
| CS7-0 | Early Help Assessments | 21.2 | G | Improving | High | 13.4 |
| CS7.2b | Percentage of EHAs closed by 'satisfactory outcome' | 57.7% | R | Declining | High | 75 |
| CS8-0 | Children educated at home | 404 | n/a | Declining | n/a | Not set |
| HE1 | CAMHS patients seen within 35 days of referral | 92% | G | Improving | High | 90% |
| HE2 | CAMHS patients assessed as urgent seen within 48 hours | 88% | A | Improving | High | 90% |

Below is more detailed information on those indicators that gave cause for concern in the 2016-17 Annual Report, and how the LSCB has worked to improve those areas.

## Early Help Assessments

Early Help remains a significant area of focus from the LSCB and the Early Help Team continues to work closely with all agencies, especially schools through the Early Help and the Education Subgroup of the LSCB.

The levels of initiation in schools are monitored both in the Safeguarding Hub and in the Districts and some schools are identified as needing to be encouraged to engage more effectively. A RAG rating approach is used to record schools who have engaged and therefore those who need to be targeted for support and training.

| Early Help Assessments (EHAs) initiated | March 2013 | March 2014 | March 2015 | March 2016 | March 2017 |
|---|---|---|---|---|---|
| Rate per 10,000 | 17.3 | 46.9 | 131.1 | 196.6 | 206.4 |
| **Number** | **178** | **443** | **1234** | **1828** | **2126** |

***Auditing of EHA***

Importantly it was identified that EHA were not being closed appropriately. The Early Help sub group commissioned a data cleansing exercise with partners to ensure that EHA were being closed and that reasons for closure were detailed. The reason for closure is key, an Ofsted monitoring visit identified that too many times a reason for closure was lack of engagement or non-consent from parents. This is not an acceptable reason for closure without further information as this could actually be a reason for escalation.

The development of the Early Help panels allows all agencies to more easily refer 'stuck' Early Help Assessments, work has been undertaken and all panels now have social care representation.

| | Early Help Assessments (EHAs) initiated | Early Help Assessments (EHAs) closed | Gap |
|---|---|---|---|
| **September 2016** | 180 | 61 | **119** |
| **March 2017** | 254 | 279 | **-25** |

In September 2016 the number of closures was low and only 45% were closed because of a satisfactory outcome being achieved; other reasons for closure included referral to children's services, moved out of county and lack of engagement with the process.

The increase in number of closures at March 2017 is reflective of the data cleansing exercise that has taken place to ensure that historic cases have been appropriately closed with adequate information regarding outcomes. 78% of closures in March were due to a "satisfactory outcome achieved" and only 1% because of "lack of engagement".

## Re-Referrals

The PMQAG identified the number and % of re-referrals as an area of concern in 2013-2014 following the significant increase in this indicator alongside the increase in the number and rate of the Children on a Child Protection Plan and commissioned an audit of re-referrals to ensure full understanding of the issues and if any areas of improvement could be identified.

| Re-referrals/Referrals * | March 2013 | March 2014 | March 2015 | March 2016 | March 2017 |
|---|---|---|---|---|---|
| **Number of referrals received** | **419** | **633** | **473** | **443** | **436** |
| Referrals where the same child had been recorded within the previous 12 months | 114 | 163 | 126 | 87 | 77 |
| **Percentage** | **27.2** | **25.8** | **26.6** | **20.1** | **17.7** |

The results of this audit, alongside the Child Protection Plan work 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. The LSCB has continued to keep a close watch on these and whilst there have been variances across the year – the average for the end of year (all referrals in the last 12 months) the rate remains within target (23.4%) at 22.1%. The LSCB is satisfied the current rate is appropriate and shows good performance.

The latest reports show that the number of actual referrals has declined and it is widely accepted that this is due to an increase in the number of Early Help Assessments and the implementation of the Safeguarding Hub.

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

## Child Sexual Exploitation and Missing from Home (MFH)

These indicators continue to enable the Child Sexual Exploitation (CSE) Subgroups to monitor prevalence and risks to young people. A new CSE/MFH scorecard has been in place since October 2016, this coupled with a revised CSE self-assessment provides improved oversight of CSE within Cumbria. Through the CSE Oversight Group there has been some successful work to identify 'hot spots', repeat perpetrators and appropriate action has been taken where necessary. It was recognised that there needed to be some dedicated work in relation to MFH (especially Return Home Interviews) so in response to this a Task and Finish group was established in late 2016 . In order to support the work of the group, a 12month fixed term MFH Coordinator post was recruited to in February 2017

| CSE and MFH (full year) | March 2015 | March 2016 | March 2017 |
|---|---|---|---|
| CSE reports to police* | 221 | 317 | 684 |
| MFH episodes | 532** | 685** | 1138 |
| % Return Home Interviews in 72 hour timescale | 19.1%¥ | 46.5% | 29.5% |
| *All Sexual offences and obscene publications offences with a victim under the age of 18<br>** The number of instances where children (under 16) MFH and required and return interview<br>¥ April 2015 monthly figure | | | |

## Child Protection

The number of children subject to child protection (CP) plans has risen from **325** to **525** in the 2 years April 2015 to March 2017. This is an increase of **200** children. The figures for statistical neighbours and nationally for 2015/16 (latest figures available) are 39/10,000 and 43.4/10,000 respectively. Cumbria's current rate is **56.6/10,000**.

| Number of Children on a Child Protection Plan | March 2013 | March 2014 | March 2015 | March 2016 | March 2017 |
|---|---|---|---|---|---|
| Rate per 10,000 | 36.1 | 62.5 | 34.6 | 44.6 | 56.6 |
| **Number** | **345** | **591** | **325** | **416** | **525** |

The Performance Management Quality Assurance sub group noted this rise in CP numbers and undertook a piece of work in partnership with Children's Services developing and testing out hypotheses via data analysis and a case file audit. The findings and recommendations from this have been developed into an action plan which is currently being delivered.

## Looked After Children

The number of looked after children is the lowest it has been in previous 5 years but remains high and significantly above national averages and our own Cumbrian target rate of 60.0.

| Children Looked After CLA) | March 2013 | March 2014 | March 2015 | March 2016 | March 2017 |
|---|---|---|---|---|---|
| Rate per 10,000 | 70.2 | 67 | 72.1 | 71.1 | 68.0 |
| **Number** | **663** | **640** | **678** | **663** | **631** |

This continues to be an area of scrutiny for the LSCB and it is recognised as a whole partnership issue – led by the Local Authority who have 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. This indicator remains the focus of continual weekly scrutiny within the Local Authority where they have in place a CLA Tracker and Permanence Panel.

It should be noted that these figures do not reflect the significant and successful work to move a cohort of children who, through previous poor permanence planning, remained in care and were not placed with adoptive parents in a timely way. Although much of this work has now taken place and children are placed with their forever families, they are yet to become subject to adoption orders and therefore remain children looked after.

This is reported regularly to the LSCB but it has not been possible to meet the target figure of 610 at the end of March 2017. The LSCB has been assured by the LA that the effect of this work will be reflected in the reducing numbers of CLA over the next 3-6 months. There are good signs that the actual numbers are now reducing in that the number of children looked after is 617 in the week at the end of April 2017.

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.

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# 13. Multi-Agency Quality Audits

The LSCB delivers a quality assurance programme via the Performance Management Quality Assurance Group (PMQAG) to assure itself that the quality of safeguarding practice in Cumbria is improving. The PMQAG, in conjunction with the Board, commission regular quality assurance audits around areas of particular interest or concern.

The PMQAG has three subgroups, one in each locality, to carry out quality assurance activity on behalf of the LSCB. These Quality Assurance Groups (QAGs) have multi-agency representation and are chaired by agencies from across the partnership:

- North & Eden: Police
- South: Children's Services
- West: NCUHT.

QAGs have a forward plan and their activity is directed by the PMQAG, based on intelligence from performance indicators, learning from serious case reviews, national agenda and the needs of other LSCB sub-groups.

In 2016/7 the QAGs undertook themed audits on MFH, Parental Substance Misuse and Children with Disabilities. These audits identified a number of areas of good practice and make recommendations for areas for improvement. Recommendations from audits are regularly monitored by the Board to ensure they are implemented and progressed.

### Key Themes from Audits

Missing from Home

- Stage 1 and 2 meetings were not consistently taking place
- effective multi-agency working with good information sharing between agencies resulting in an appropriate response to missing episodes
- Improved processes within the Hub had resulted in information being shared in a more timely way
- In a number of cases the 72 hour timeframe was not being met for return interviews, this was due in some instances to late notifications
- Some strong evidence of voice of the child but this wasn't consistent across all cases audited
- When children placed in Cumbria by other Local Authorities had gone missing the intelligence from the return home interviews was not being shared with the Police.

Parental Substance Misuse

- Drift was a factor in a number of cases
- There was good evidence of multi-agency working in a number of cases with improvements for the child seen
- There was some good evidence of voice of the child in the cases audited but it was not always clear how it had been used to inform planning for the child
- Some plans needed to be more SMART with defined outcomes and timescales.

Children with Disabilities

- Good examples of the voice of the child being assessed, recorded and acted upon for non-verbal children
- Good information sharing between agencies
- Early planning for transition to adult services and transition from school to school
- There wasn't always consistent attendance at core groups
- Assessments were not always up to date

# 14. Good Practice

The LSCB receives examples of good practice from its members. These include examples of interventions (single and multi-agency) which have made a positive outcome on a child or young person's situation and examples of changes made to agencies systems and processes following learning from serious case reviews.

Examples received by the LSCB are available via the LSCB website in the good practice catalogue. The catalogue has been developed to act as a 'learning system', by encouraging us all to reflect on our practice and then plan for improvement.

# 15. Neglect

Cumbria LSCB identified neglect as an area of priority in The Business Plan for 2014-2017, although neglect is not a priority in the 15 – 18 business plan it is a cross cutting theme across the work of the sub groups and features highly as a factor in both local and National Serious Case Reviews. The Neglect task group continues to provide oversight and implementation of the neglect strategy.

### STRENGTHS AND ACHIEVEMENTS

### Policy & Strategy

Developing a shared understanding across the partnership of neglect and its impact on children has been a priority for the group:

- The group has written a new strategy for 2016 -18.

- The group has developed procedures, guidance and tools for professionals. The Responding to Abuse and Neglect policy is the 6th most visited policy on TriX and has had two hundred and sixty six (266) visits. The Working with Uncooperative Families - Disguised Compliance policy is the 7th most visited and has had one hundred and eighty one (181) visits.

## Awareness raising and training

The neglect training offer continues to develop with oversight of the Learning and Improvement sub group.

ELearning Awareness of Child Abuse and Neglect Core course continues to be the most widely accessed:

- 1885 completed the Awareness of Child Abuse and Neglect - Core
- 614 completed the Awareness of Child Abuse and Neglect - Foundation Version
- 66 completed a young people version of Awareness of Child Abuse and Neglect
- 39 completed a Police Version awareness of Child Abuse and Neglect Core Level

In "The Child's Time" (2014) reported that the pervasive and long term cumulative impact of neglect on the wellbeing of all children of all ages was well documented. Evidence from inspections and research of what works includes early recognition of neglect and supporting the development of protective factors, along with good quality assessments using standardised approaches such as the Graded Care Profile.

Implementing and embedding the Graded care profile and the Risk and Resilience matrix continues to be a priority.

Working with the Communications, Engagement and Participation sub group to consult with the 'touchstones' findings informed the new neglect strategy.

A key achievement was working with the young people's shadow board and the young people's forum to consult with them on what neglect means to the children and young people of Cumbria and captured within the strategy.

The neglect task group continues to raise awareness of strategy and guidance through the Practitioner Forums and the newsletter. There is a specific area on the LSCB website for professionals to access policy, guidance and tools.

The group agreed to use the terminology across all agencies, to use 'Was Not Brought' instead of 'Did Not Attend'.

Neglect SCR conference took place in January 2017. Key note speech delivered by Dez Holmes, (Research in Practice) and input from Claire Hyde MBE, with just over 150 attendees. Feedback was very positive and comments included:

- Fabulous conference – held my interest all day'
- 'Was a really interesting and relevant event, I now get neglect'
- 19 people referenced that they will be using GCP within their practice
- Feedback on speakers was excellent: 'inspiring', 'speakers were excellent',' brilliant guest speakers' 'effects of neglect on brain and Dez form RiP was excellent', 'good to hear the views of young people (CiCC members)'

### PRIORITIES

Priorities for the year ahead continue to be:

- Ensuring practitioners and managers are able to recognise and respond to early indicators of neglect through the use of the graded care profile
- Supporting parents to enable change through partnership working in order to reduce the impact of neglect on the emotional and physical wellbeing of children

# 16. Domestic Abuse

Domestic Abuse and the impact on children continues to be a significant concern for the LSCB. When a domestic abuse incident is attended by the police they record whether there were children present. In 2016/17 there were 3244 DA contacts recorded.

As a result of the LSCB campaign to raise awareness of the impact of domestic abuse on children and young people it is positive to note that the trend is upwards in respect of DA referrals where a child is present or in the household. This suggests an increased awareness of the signs of Domestic Abuse as well as improved understanding of the effect on children.

### Governance

The Domestic Abuse sub group was established to undertake specific tasks which fell out of the 2015/16 Business Plan. The group completed its task to undertake a service mapping exercise; this provided a picture across the partnership and also identified gaps in current service provision along with informing the future commissioning of services.

In 2016 the sub group confirmed its strategic arrangements with the Community Safety Partnership and became an established sub group of the LSCB with a remit to 'Work with the Safer Cumbria Partnership to set the strategic direction for Domestic Abuse, with specific attention to the needs of children and young people in Cumbria living with, witnessing, or being perpetrators of Domestic Abuse to ensure that they are safeguarded'.

### Awareness raising and training

The information on the LSCB website has been updated and has dedicated areas with up to date information for professionals, along with sources of support for parents. Domestic Abuse training/learning events also have a specific part of the website to ensure it is easily accessible. The website has policy and research information along with links to sources of support. Key

messages continue to go out through the newsletter and a specific DA newsletter has been circulated.
A task group was established to pull together the 'DA training offer' and now has oversight from the L & I group. There are a range of multi-agency learning opportunities available for those staff that require specific learning around Domestic Abuse as part of their role and responsibility. Face to face training was well attended:

- 121 attendees at the Advanced Domestic and Sexual Abuse
- 77 attendees at the Domestic Abuse and Sexual Violence Awareness (Level 2)
- 15 attended the Multi-Agency MARAC Training

Comments included:

- Information packed
- Excellent passionate facilitators
- Very informative
- Good service information
- Powerful visual aids

## Performance & Audit

The group agreed its performance scorecard which allows members to provide a detailed analysis of Domestic Abuse specifically related to children and young people, and also includes numbers of contacts into the Hub that are DA related. In 2016/17 there were 15541 contacts to the Hub (recorded in EHM) 20.9% of this total were DA.

As children living with Domestic Abuse was the 'deep dive' theme for joint targeted area inspections and to test the effectiveness of multi-agency working, the group agreed to undertake a deep dive audit. A total of 5 cases were audited this included 1 child looked after, 2 children on a child protection and 2 children in need. The audits identified a number of areas of good practice and these included:

- Good multi – agency working in some of the cases
- Timely reporting of incidents and timely, effective response to Domestic Abuse from practitioners
- Good examples of using risk assessments. For example the SafeLives DASH Risk Assessment
- The identification of CSE was appropriate, and the response was good with agencies working together to lower the risk.

The report highlighted some areas that could have been done differently and these included;

- Opportunities for sharing information specifically with schools staff and school nurses were missed.

- In several of the cases the needs of the child, their non-abusive parent and the perpetrator could have been met at an early stage through timely access to effective help.
- In some of the cases practitioners could have identified and responded to Domestic Abuse sooner and a lack of consent at the early stages which then led to the growing risk at Early Help level.

One child talked positively about the help that was given to her by her SW. '*Emily talked through things with me and let me be really honest with her. She had some sheet which we worked with which allowed me to talk about the things I like, what would happen and how I could make myself safe in the future. What was really good was that I could just be really honest and someone (Emily) would listen to me'.*

**Policy and Procedure**

Domestic abuse can take many different forms and no two experiences are likely to present in the same way. It is crucial that practitioners who encounter the issue in their work are competent in current practice and have the essential knowledge base to identify the risks and respond appropriately. With this in mind the group have commissioned Barnardo's to deliver train the trainer training to a cohort of 12 professionals, this will equip them with the skills and knowledge to cascade briefing sessions on the Risk Identification Matrix.
The group updated the LSCB Domestic Abuse policy.

**PRIORITIES**

Priorities for the group continue to be centred around improving practice and response through training professionals leading to a reduction in the incidence of Domestic Abuse and the impact on children and young people. Key tasks include:

- To undertake another themed audit
- Review of the DA training packages
- Deliver the Barnardo's DV RIM training to practitioners
- Hold a DA summit
- Scrutinise the performance data in relation to the impact of DA on children and young people

# 17. The Shape of Safeguarding in Cumbria

### Latest Inspection

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

### What Ofsted said about the 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; (2014)
- 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 HWB;
- 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.

The LSCB Business Plan 2016-19 covered all of the recommendations in the Ofsted report and the table below shows what we have done to address each of these areas. In addition, the update included in this Annual Report in Section 25 shows that good progress has been made across all of our priority areas.

The table below offers an update against each of the recommendation for the LSCB from the 2015 Ofsted report:

<table>
<tr><th>Ofsted Rec No.</th><th>2016-17 Update</th></tr>
<tr><td rowspan="2">1</td><td>Ensure that clear governance arrangements are in place so that the LSCB can evaluate the effectiveness of services provided to children who live in households where domestic abuse occurs.</td></tr>
<tr><td>The LSCB has worked across the partnership to improve understanding and identification of Domestic Abuse that affects children. There are new tools in use, more relevant training available and commissioned services providing support to both victims and children. The LSCB utilised the learning from a service mapping exercise to inform/influence future commissioning. A Domestic abuse audit was undertaken in January 2017. The group audited a total of 4 cases and the overall grading's of the cases were as follows:<br>• Requires Improvement: 3 cases<br>• Good: 1 cases<br>Learning from the audit has been used to further inform practice.<br><br>Training has been improved with a number of specialist courses on offer and the numbers for 2016-17 are shown in the table below:
<table>
<tr><th>Learning event</th><th>Number attended</th></tr>
<tr><td>Advanced Domestic and Sexual Abuse</td><td>121</td></tr>
<tr><td>How to Write an Early Help Assessment</td><td>57</td></tr>
<tr><td>LSCB Domestic Abuse and Sexual Violence Awareness (Level 2)</td><td>77</td></tr>
<tr><td>Multi-Agency MARAC Training workshops LSCB</td><td>15</td></tr>
<tr><td>Total</td><td>270</td></tr>
</table>
The commissioning process has been undertaken to "Train professionals to aid a consistent understanding of how Domestic Abuse affects children and to give practitioners the confidence to work with domestic abuse". This was awarded to Barnardo's, roll out of the training is planned to commence in June 2017.<br><br>An advanced DA & SV course has been developed and dates are in place for 2017. A task group has been established to review the DA training offer and will link across to L & I group.</td></tr>
<tr><td rowspan="2">2</td><td>Deliver the Child Sexual Exploitation Action Plan as developed from the LSCB self-assessment of child sexual exploitation. Develop robust measures to improve the Board's oversight of children and young people who go missing and who are vulnerable to child sexual exploitation.</td></tr>
<tr><td>Development day held in July 2015 and review of TOR, data and self-assessment were all completed. Since the development day and in light of feedback the terms of reference and self-assessment have been updated and the performance indicators have been agreed. Data set is now reported to the CSE Strategic group on a quarterly basis.<br><br>Risk assessment tools and disruption statement developed by small task and finish group. Task and finish group also reviewed the LSCB Child Sexual Exploitation procedure – and the revised procedure went live on 29 February 2016. Ongoing review of the procedure aligned with Tri-X deadlines.<br><br>Online training now live. Six face to face sessions were delivered to 210 practitioners in November 2015 - March 2016. Online training must be completed by all delegates before they are able to attend face to face training. SARC became operational in December.<br><br>2016-17 has seen further developments in this area. Individual agency self-assessments were undertaken and these were reviewed as part of the 2016-17 CSE/MFH Development day. The CSE self-assessment has been rewritten. The March 2017 CSE Strategic Group discussed the process for an annual update from agencies and an Annual Report was presented to the LSCB.</td></tr>
</table>

| Ofsted Rec No. | 2016-17 Update |
|---|---|
| 3 | **Evaluate the outcomes for those children who receive early help services, including those who experience step-down arrangements when child protection or child in need plans end.** |
| | Completed an audit of step down cases and the actions to address themes were completed.<br><br>Maturity Matrix is complete. And the action plan was completed in October 2015 and was monitored through the Early Help subgroup, and was fully reviewed at the June 2016 Development Day.<br><br>The LSCB has now implemented Early Help Panels in each of the six districts. They have full attendance from across the partnership, including social care – to ensure step ups and step downs are managed appropriately. This is a forum for "stuck" cases and is increasing confidence with Early Help across all professionals and practitioners. |
| **4** | **Monitor the effectiveness of all partners in promoting the welfare of looked after children.** |
| | CLA strategy is in place and delivery is monitored through the strengthened Corporate Parenting Board is a standing item on the LSCB agenda. Full report on CLA presented to the LSCB in every 6 months including those children who are placed out of county.<br><br>Performance for CLA reviews and CLA Health Assessments has been monitored through the Performance Management and Quality Assurance Group and this has improved significantly over the last 12 months, with the Independent Reviewing Service becoming increasingly effective.<br><br>The LSCB has undertaken audits of CLA children with a specific focus on care leavers as parents as this was an issue that was highlighted in recent serious case reviews. |
| **5** | **Ensure that the annual report contains a rigorous and transparent assessment of the performance and effectiveness of local services, identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken.** |
| | Annual Report contained all of the requirements in the Ofsted report. This Annual report builds on that.<br><br>The 2014-15 and 2015-16 report s were presented to the LSCB Business Group and signed off by LSCB. They have been commended by the DfE Advisor and Chair of ChIB. They were also presented to PCC, HWB, County Council Chief Executive and the Leader in line with statutory requirements. Business Plan, SCR Action plans and self-assessments agreed. |

<table>
<tr><th>Ofsted Rec No.</th><th>2016-17 Update</th></tr>
<tr><td rowspan="2">6</td><td>Develop a range of training opportunities which reflect the Board's current priorities, including children who are missing and vulnerable to child sexual exploitation, domestic abuse and early help practice. Evaluate the effectiveness of this training, including through feedback and audit activity.</td></tr>
<tr><td>Training opportunities and the quality of face to face training have been a focus for the past 2 years for the LSCB. This Annual Report contains a comprehensive update of training, learning and evaluation. The figures for 2016-17 are impressive as can be seen in the table below:
<table>
<tr><th>Learning event</th><th>Number attended</th></tr>
<tr><td>Advanced Domestic and Sexual Abuse</td><td>121</td></tr>
<tr><td>Early Help Assessment Training (multi agency)</td><td>75</td></tr>
<tr><td>How to Write an Early Help Assessment</td><td>57</td></tr>
<tr><td>LSCB Domestic Abuse and Sexual Violence Awareness (Level 2)</td><td>77</td></tr>
<tr><td>Multi-Agency MARAC Training workshops LSCB</td><td>15</td></tr>
<tr><td>Safeguarding and Child Protection Working Together to Safeguard Children</td><td>398</td></tr>
<tr><td>Safeguarding Level 2 (early years practitioners)</td><td>92</td></tr>
<tr><td>Safeguarding Responsibilities, Threshold Guidance and Referral Process.</td><td>392</td></tr>
<tr><td>Substance Misuse and Parenting</td><td>65</td></tr>
<tr><td>Train the Trainer - Advanced Practitioners</td><td>9</td></tr>
<tr><td>Train the Trainer 2 Day LSCB</td><td>25</td></tr>
<tr><td>Better together roadshows</td><td>349</td></tr>
<tr><td>CSE awareness course half day</td><td>186</td></tr>
<tr><td>CSE full day workshop</td><td>188</td></tr>
<tr><td>P&P Practitioner forum workshops disguised compliance</td><td>116</td></tr>
<tr><td>P&P Practitioner forum workshop CSE</td><td>89</td></tr>
<tr><td>P&P Practitioner forum workshop under aged sexual activity</td><td>75</td></tr>
<tr><td>Neglect SCR conference</td><td>150</td></tr>
<tr><td>Achieving best evidence</td><td>16</td></tr>
<tr><td>Suicide and self-harm training</td><td>1500</td></tr>
<tr><td>Grand Total</td><td>3995</td></tr>
</table>
E-Learning is also available and is well-received in terms of raising awareness.<br><br>This year, the LSCB has developed an accreditation system for external training providers – this is ensuring that high-quality and relevant training courses that are delivered in a multi-agency setting – are on offer across the County. The first training courses are now available, with evaluation and quality assurance processes in place.</td></tr>
</table>

| Ofsted Rec No. | 2016-17 Update |
|---|---|
| 7 | **Monitor and evaluate the consistent use of local multi-agency procedures by all agencies, including the application of thresholds.** |
| | Procedure manual refreshed every six months by a multi-agency group. Tri-x – the provider of the software for the policies and procedures have been impressed with the Cumbria LSCB processes and engagement which is resulting in excellent buy-in from across the partnership.<br><br>Policies and procedures subgroup members have attended the Practitioner Forums twice this year (12 Practitioner Forums in total) to raise the profile of the policies and use a policy to help to raise awareness, this includes using a case study and applying a particular policy, this is also benefitting the usability of the policy and in some cases has resulted in further awareness raising or amendments to the policy based on feedback from the practitioners.<br><br>Google analytics available and being monitored by the Policy & Procedures Group for measuring/monitoring the use and impact of the Tri.x manual.<br><br>57% of respondents in the 2017 Practitioner Survey had accessed the Tri-x manual, this is an increase of 10% from 2016. The most popular were Reporting Concerns and Child Sexual Exploitation. Further analysis of these responses will be done through the Communications, Participation & Engagement Subgroup of the LSCB to identify any ways to increase the number of professionals accessing the manual. The newsletter will continue to be utilised to further raise awareness and the Policy & Procedures Sub Group attend the Practitioner Forums twice a year. Pleasingly, 94% of those who had accessed the manual found the manual useful and it supported their practice. The findings from this question, including additional comments, will be shared with the Policy & Procedures Sub Group.<br><br>69% of professionals have read and understood the revised multi-agency Thresholds Guidance. 78% of respondents from schools said that they had read and understood the guidance. 89% of respondents answered that they do know how to escalate concerns appropriately when they have intelligence that a child or young person is misusing substances, this would suggest people understand and apply the thresholds guidance. The Policy & Procedures Sub Group have written a procedure to support practitioners working with children and young people who misuse substances, this will be on the procedures manual from August 2017. |

## Children's Services

In March 2016 it was one year since we received the Ofsted inspection that found the delivery of children's services, specifically in relation to CLA, to be inadequate. Leadership, management and governance in the Council were also therefore judged to be inadequate. Children who need help and protection, experiences and progress of care leavers and adoption performance were judged to be requires improvement.

Of the five areas of work inspected three were judged to be requiring improvement and two inadequate as follows:

**Overall inadequate**

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

The latest inspection report published on 13 May 2015 concluded that despite significant improvements in many areas, particularly in safeguarding, services for Children Looked After were now inadequate. This was the third inspection that gave an overall inadequate judgement.

Monthly Ofsted monitoring visits started in July 2015, in addition to which Cumbria has benefited from the support of a DfE Advisor three days per month. The feedback offered to the local authority from both of these relationships affirms Cumbria's own view that we are progressing at sufficient pace, addressing key challenges and that service to children young people and families in Cumbria have improved further. The DfE Advisor chairs the Children's Improvement Board (ChIB) (previously the Safeguarding Improvement Board – this was changed to reflect the improvements in Safeguarding). The Chair of the LSCB is a member of the ChIB and is held to account for the performance of the partnership. This Board oversees the delivery of the Improvement Plan. Phases 1 and 2 have been successfully delivered and phase 3 is well-underway.

A number of external reviews have identified and evidenced common areas of improvement and further areas for development. External improvement validation has been received through:

- Monthly/quarterly Ofsted monitoring visits
- DfE Reviews
- Local Government Association, LGA Care Practice Diagnostic, January 2016

- DfE review of Step up/Step Down, November 2015
- RESPECT assessment 2015

The latest letter from the Minister of State for Children and Families has indicated that he is satisfied that Children's Services are taking reasonable steps to address the remaining weaknesses. He says that he is reassured that they are giving due attention to performance across the range of services. He welcomed the steps that have been taken to strengthen governance and accountability. The LSCB is assured that sufficient progress is being made.

**John Macilwraith – Corporate Director – Children's Services:**
"The state of safeguarding in Cumbria is increasingly improving with a genuine collective commitment to consistently delivering good outcomes for children".

**Deborah Evans – Assistant Director – Children and Families:**
"Understanding of safeguarding responsibilities and responses required is much improved since 2015 and staff across the partnership present more confidently, although there is some way to go in working with and managing challenges in the community".

## Health

Clinical Commissioning Groups (CCG) and Primary Care

NHS Cumbria Designated Doctor and Nurse for Safeguarding and the County Lead GP with the Named GPs have actively supported the work of the LSCB and reinforced a shared partnership approach supporting a more holistic view of families.

The CCG Director for Children and Families represented the CCG on the LSCB and the Childrens Improvement Board. The CCG children's commissioning team have lead and supported a number of health and partnership safeguarding developments including health input to the Safeguarding Hub and emotional health and wellbeing. The team have proactively engaged with the work of the LSCB through their sub group membership.

**Louise Mason Lodge (Designated Nurse for Safeguarding – Cumbria CCG):**
"Much work has been done at a strategic level and within Children Social Care in particular to respond to the issues arising from the Improvement Journey: the impact on frontline staff and practice is sometimes less tangible and impacted by the ongoing changes we see across statutory partners.

The direction however is good and positive – we shouldn't lose sight of the fact that impacting on multiagency frontline practice in a consistent way will a challenge and needs a sustained effort to achieve. The opportunities afforded by the wider health and social care focus should be ceased in order to build on integration".

## Police

Cumbria Constabulary is committed to safeguarding Children and acknowledges its responsibilities to the Multi Agency partnership under the governance of Cumbria's LSCB.

As a statutory partner the Police have been instrumental in the development of the Children's Safeguarding Hub, making resources available where necessary to support that function.

# 18. Safeguarding (Section 11) Audit

### INTRODUCTION

The LSCB Safeguarding Audit is an annual process carried out by partner organisations to ensure that they carry out their functions with due regard to the need to safeguard and promote the welfare of children.

The audit is made up of 9 elements. Each element focuses on a standard and outlines the requirements to be achieved as required in statutory duties (Section 11 of the Children Act 2004 and Working Together 2015).

Organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services
- Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed (Sir Robert Francis's Freedom to Speak Up review report can be found at https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf.)
- Arrangements which set out clearly the processes for sharing information, with other professionals and with the LSCB
- A designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals

should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively

- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check
- Appropriate supervision and support for staff, including undertaking safeguarding training.
- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children.
- When completing the audit agencies were asked to state if they fully, partially or did not meet each of the standards.

The 2016/17 audit ran from 8 December 2016 to 13 March 2017, with 469 responses submitted. Of these, 35 were partial or duplicate responses; this leaves a total of 433 valid responses completed by agencies.

The PMQAG met on 28th March 2017 to review the summary findings from the audit and to plan the next steps in the quality assurance process.

### Process for reviewing audit submissions

A total of 433 completed responses were received these included 205 submissions from schools and 47 from GPs.

Due to the large number of responses received from agencies the PMQAG focussed its discussion on the submissions received from statutory partners. These included: Local Authority, District Councils, Youth Offending Service, Police, Health and Probation.

## SUMMARY OF FINDINGS

### Statutory Partners

A total of 15 submissions were received from statutory agencies these included: Local Authority, District Councils, Police, Youth Offending Service, Probation and Health agencies. . Key points noted by the PMQAG were:

- *Full compliance* - 3/15 agencies (20%) said they 'fully met' all standards

- Only one agency said 'not met' for one of the standards– 'The commissioning process included a requirement upon your organisation to safeguard children'. All other standards were fully or partially met, or marked as N/A by all agencies
- *Commissioning* – 8 agencies 'fully met', 1 agency 'partially met' and 4 recorded N/A for having arrangements in place to ensure that organisations commissioned to provide

services on their behalf have regard to the requirements of section 11 of Children Act 2004

- *Voice of the child* – 4/15 agencies (27%) felt they only 'partially met' there being a culture of listening and engaging in dialogue with children and their families
- *Information sharing* – 14/15 agencies (93%) 'fully met' having effective guidance on sharing information about a child and their family and staff knowing how to access and use it. Again, 14/15 agencies (93%) 'fully met' staff being confident about how to obtain consent for information sharing and when information may be shared even though consent has not been obtained.

- *Safer recruitment* – only 12/15 agencies (80%) 'fully met' having robust procedures for regular review of staff checks and records. 11/15 agencies (73%) 'fully met' the standard that staff involved in recruitment are suitably trained

- *Supervision* – 14/15 agencies (93%) 'fully met' having access to further advice, support and supervisions for relevant staff who have contact with children and families

- *Allegations against staff* – All agencies 'fully met' having in place a clear policy and procedure for dealing with allegations against staff and volunteers.

It is positive to note that statutory agencies compliance with the audit standards has increased from last years. Points of particular note are having arrangements in place for sharing information with other professionals and the LSCB has risen from 58% fully meeting the standard in 2015/16 to 93% in 2016/17; a culture of listening and engaging in dialogue with children has gone up from 50% to 73%; and having clear policies in line with those from LSCB for dealing with allegations against people working with children has increased from 73% to full compliance.

### Overall Compliance 2015/16 v 2016/17

The number of responses received in 2015-16 was 471. A summary of findings was provided to the May 2016 LSCB, this included a breakdown of the 'fully met' scores against each standard, a comparison with this year's responses is provided in the table below:

| | **2015-16** | **2016-17** | **Year-on-Year Comparison** |
|---|---|---|---|
| Number of responses | **486 (inc. schools)** | 433 | **-53** |
| A clear line of accountability for provision and/or commissioning of services designed to safeguard and promote the welfare of | 98% | 97% | **-1%** |

| | 2015-16 | 2016-17 | Year-on-Year Comparison |
|---|---|---|---|
| children | | | |
| A named person responsible at a senior level | 97% | 98% | +1% |
| A culture of listening and engaging in dialogue with children | 96% | 97% | + 1% |
| Had a 'whistle-blowing' procedure for all staff/volunteers who have concerns about poor practice | 95% | 95% | - |
| Arrangements in place for sharing information with other professionals and the LSCB | 95% | 96% | + 1% |
| Had a designated professional lead | 95% | 93% | -2% |
| Had safe recruitment processes | 94% | 93% | - 1% |
| Appropriate supervision and support available for staff | 94% | 94% | - |
| Had clear policies in line with those from LSCB for dealing with allegations against people working with children | 96% | 97% | + 1% |

There is a triangulation with the results of the staff survey, in that:

- information sharing - 2% of staff survey respondents said they were not clear about the circumstances in which they can share information
- supervision - 18% of those responding to the staff survey said didn‘t have regular supervision
- know who designated lead is for safeguarding is - 90% knew who their DSL was in the staff survey
- Children and young people involved in Safeguarding decisions about them - 20% said children and young people weren’t involved in decisions
- Keeping up to date with learning form SCRs – 82.5% said they kept up to date with learning from SCRs in the staff survey.

## Quality Assurance Process

The PMQAG propose that there are two strands to the quality assurance of Section 11 responses:

1. A ‘Learning from Each Other’ event is held for statutory partners and the voluntary sector respondents in September 2017. Chief Executives and/or Safeguarding Leads of these agencies would be invited to a half day event the purpose of which would be for agencies to challenge each other’s services on how their organisation embed

safeguarding in their policies, procedures and structures and to share areas of good practice. Members of The Young Perspective Board will also input in to the event.

2. The second strand to the quality assurance process would be led by the Education Sub Group. It is proposed the sub group, with support from members of the PMQAG, undertake quality assurance visits to a sample of schools, these will follow the same format as the 2015/16 visits.

## Conclusions

The findings have been considered by the LSCB PMQAG at their meeting on the 28th March 2016. The audit shows that, on the whole, agencies are complying with Section 11.

Following feedback from the Health and Education Sub Groups, the Voluntary Sector Reference Group and the undertaking of the quality assurance event and visits the strategic themes will be reported to the Board with any specific actions and recommendations to help further improve the way agencies are working to safeguard children.

The results will be used by the subgroups, the LSCB and individual agencies to learn and develop targeted communications, training and learning opportunities or review and refresh policies and procedures as necessary.

# 19. Front Line Staff

## Staff Survey Findings

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 is tested in an annual staff survey of front-line staff.

The survey ran from 17 June to 22 July 2016, and was responded to by 368 members of staff from across the LSCB. This is a slight increase from the 316 staff who responded to the summer 2015 survey.

Some of the key findings are detailed below:

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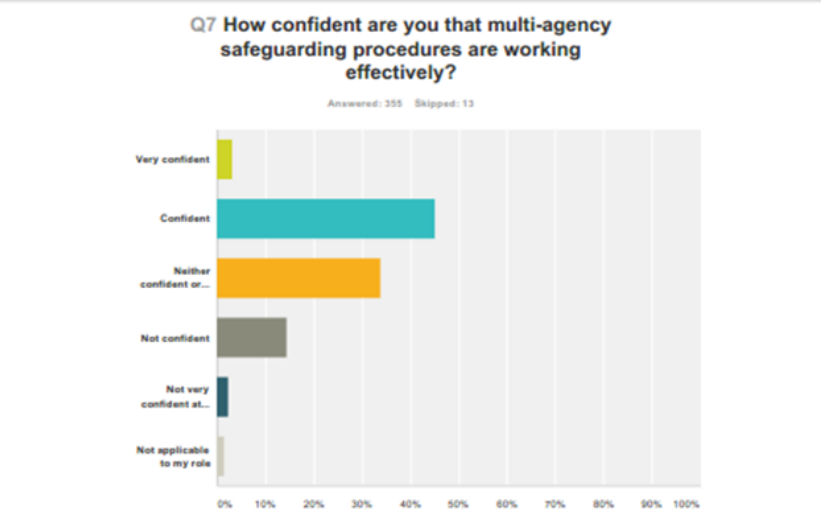
Confidence in the Multi-agency Safeguarding procedures:



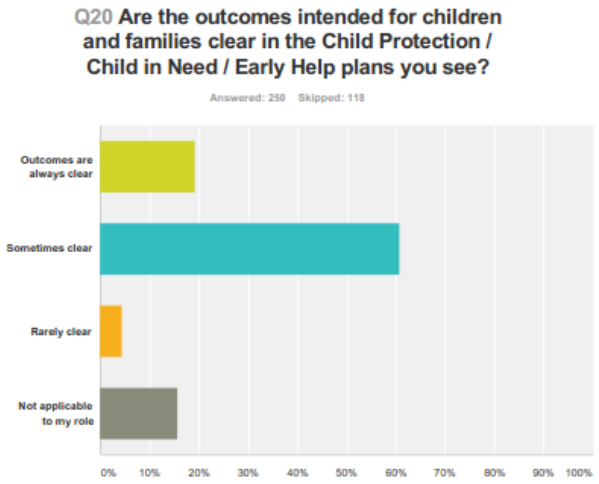

| Answer Choices | Responses | |
|---|---|---|
| Very confident | 3.10% | 11 |
| Confident | 45.07% | 160 |
| Neither confident or not confident | 33.80% | 120 |
| Not confident | 14.37% | 51 |
| Not very confident at all | 2.25% | 8 |
| Not applicable to my role | 1.41% | 5 |
| Total | | 355 |

This question has been reworded following feedback from last year's survey. This was a key question and only 16% of respondents said they were not confident, this a slight decrease from 2015 where 19% were not confident. Results are very similar to last year and demonstrates that year on year confidence is not increasing. Further analysis of these responses was undertaken through the Learning & Improvement and Communications & Engagement Subgroups of the LSCB. L & I continue to develop its safeguarding training programme to build the confidence in practitioners and managers to apply and work within safeguarding procedures effectively. Confidence was lowest with schools, 50% of those who were 'not confident at all' were schools

staff, and this will be addressed at the Education sub group to best identify how the LSCB can support this area and help to increase confidence.

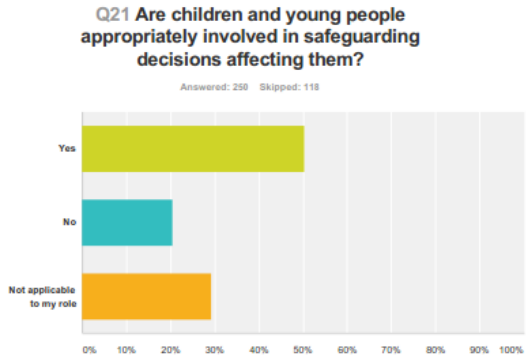
---

Outcome clarity in plans:




| Answer Choices | Responses | |
|---|---|---|
| Outcomes are always clear | 19.20% | 48 |
| Sometimes clear | 60.80% | 152 |
| Rarely clear | 4.40% | 11 |
| Not applicable to my role | 15.60% | 39 |
| Total | | 250 |

This concerned outcome clarity in plans. The majority (61%) felt that outcomes were only "sometimes" clear; this is a similar result to last year (60%). Only a small number of those who responded felt that felt they were "rarely" clear (4%). These results were shared with the Learning and Improvement sub group of the LSCB for further analysis. Individual agencies also received the results to ensure all can target improved recording and multi-agency involvement. Since this survey was undertaken SMART planning has been incorporated into the level 2 and level 3 training; sessions at the Practitioner Forums on SMART planning have been delivered; a guidance document on planning has been written; LSCB newsletter with information and evidence based practitioner guidance about SMART plans has been published; training on SMART planning will also be delivered as part of the LSCB 2017/18 Training programme.




| Answer Choices | Responses | |
|---|---|---|
| Yes | 50.40% | 126 |
| No | 20.40% | 51 |
| Not applicable to my role | 29.20% | 73 |
| Total | | 250 |

When asked about the voice of children and young people, 20.40% of respondents felt that CYP were not appropriately involved in decision making and this therefore remains a key area of focus across the LSCB. These results were shared with the IRO service and the Young Perspectives Board.

## Conclusion and Next Steps

The results have been used by the subgroups, the LSCB and individual agencies to learn and develop targeted communications, training and learning opportunities or review and refresh policies and procedures.

The findings, analysis and recommended actions in this report were considered by the LSCB Business Group at their meeting on the 18th August 2016. The actions were added to the Business Group Action Tracker – any residual actions will be transferred into the LSCB Business Plan 2016-19.

# 20. Learning and Improvement – including Multi-Agency Training

The priorities for the Learning and Improvement group 2016 – 17 have been:

- ✓ Performance Reporting on Delivery of training
- ✓ Quality monitoring of agency learning programmes
- ✓ Appropriate attendance at multi-agency training
- ✓ Efficient and Effective Systems
- ✓ Learning through SCR (conferences / learning events)

The focus continues to be on developing and supporting the pool of volunteer trainers through the systems that have been put in place to support them. Two trainer development events have been held and provided the trainers with up to date information on the work of the LSCB. The learning events have provided opportunities for the trainers to discuss practice issues, receive training on policies and SCRs. The events have been well received and the trainer's feedback concludes that they feel more supported and part of the LSCB.

Recruitment into the pool continues through delivery of the train the trainer 2 day courses and 1 day refresher courses. 25 people have been trained over the last year.

The LSCB has continued to commission the design, planning, organisation and implementation of the training/learning programme based on LSCB priorities, learning from SCRs and reviews of child deaths. A range of multi-agency learning opportunities were provided through the 2016 – 17 programme. These included a number of multi-agency workshops aimed at both practitioners and managers. Learning events and courses are organised into 3 key areas:

- Safeguarding Awareness which includes eLearning and safeguarding responsibilities workshops
- Safeguarding Intermediate which includes multi-agency face-to-face workshops designed to assist multi-agency working
- Safeguarding Enhanced/Specialist which includes multi-agency face-to-face workshops designed to assist specific staff groups

In response to each local SCR, Practice Learning Review and the findings from quality audits the LSCB has provided regular briefings on lessons learnt. SCR Learning activities have been delivered at practitioner forums and to the third sector reference group.

2015 saw the first SCR conference on Child Neglect with over 150 attendees from across Cumbria, the LSCB launched the new Neglect strategy.

349 professionals from across Cumbria attended six Better Together multi-agency roadshow events. The objective was to communicate key messages from the LSCB programme board. The Board wanted to increase practitioners understanding of the whole system and the interplay around the various elements; thresholds, referrals into the hub, the single contact form, the process at the Hub, and Early Help. The roadshows were also an opportunity to launch the refreshed Threshold Guidance document and were delivered with a Child Centred approach.

Co-ordination and administration of the face to face learning programme is now undertaken through the LSCB office, this has led to more effective and efficient systems. The LSCB website has also enabled practitioners to access the training programme, newsletter updates and new guidance information to enhance their learning/knowledge.

Specialist training has been delivered in line with the LSCB priorities and additional courses have been added to the programme, these include Substance Misuse and Parenting, Advanced Domestic and Sexual Abuse, MARAC training, along with suicide and self-harm training which was commissioned through the CTB.

Multi-agency face to face core safeguarding children courses were delivered at awareness (level 2) and intermediate (level 3);

- ✓ 398 - Safeguarding and Child Protection Working Together to Safeguard Children
- ✓ 92 - Safeguarding Level 2 (for early years practitioners)
- ✓ 392 - Safeguarding Responsibilities, Threshold Guidance and Referral Process.

A key achievement for the learning and Improvement sub group has been the 2016 /17 learning programme and the numbers of professionals that have attended and accessed the learning events.

- ✓ The total number of attendees in 15 / 16 was 1401
- ✓ The total number of attendees in 16 / 17 was 3995

### ELearning opportunities

Cumbria LSCB renewed its membership to the Virtual College on 29th March 2016 for 3 years, and includes unlimited access to the full list of safeguarding courses and the self-registration system.

With access to the full list of safeguarding courses for learners to choose from, the 'Awareness of Child Abuse and Neglect – Core' is still the most widely used, followed by 'An Introduction to Safeguarding Children' and then 'Safeguarding Children from Abuse by Sexual Exploitation'.

For the period from 1st April 2016 to 31st March 2017, 10,950 courses have been allocated and 8,839 passes, giving a completion rate of 81%. Last year, 31st March 2015 to 31st March 2016, the total number of course allocations was 6,753, with 5,533 completions, a completion rate of 82%.

For this membership year, the departments that have accessed the most training are; primary schools, secondary schools and Cumbria County Council.

### All completions and allocations by department

| Department | Passed | Total |
|---|---|---|
| A&E | 0 | 2 |
| All Other | 242 | 306 |
| Allerdale | 38 | 51 |
| Carer | 612 | 859 |
| Carlisle City Council | 3 | 3 |
| Child Minder | 97 | 122 |
| Children's Centres | 110 | 120 |
| CHOC | 4 | 5 |
| Colleges | 140 | 159 |
| CPFT - Adult mental health | 0 | 4 |
| CPFT - CAMHS | 2 | 5 |
| CPFT - Children's Community Nursing | 25 | 30 |
| CPFT - Family Nurse Partnership | 4 | 5 |
| CPFT - Physical Therapies | 84 | 109 |
| CPFT - School Nurse | 10 | 20 |
| Cumbria County Council | 1496 | 1757 |
| Education services | 218 | 266 |
| External Local Authority | 52 | 65 |
| Foster carer | 89 | 117 |
| GP | 6 | 11 |
| Health visitor | 21 | 26 |
| Housing | 57 | 74 |
| Inspira | 98 | 105 |
| LSCB Partners | 1 | 1 |
| Maternity | 1 | 2 |
| Nurseries | 833 | 1104 |
| Other hospital/health service | 38 | 52 |
| Paediatrics | 12 | 22 |
| Police | 20 | 28 |
| Primary Schools | 1761 | 2113 |
| Probation | 10 | 24 |
| Secondary Schools | 1539 | 1732 |
| South Lakes | 4 | 6 |
| Voluntary agency | 603 | 823 |
| Young Person (11-18 year old) | 614 | 818 |
| Youth Offending Service (YOS) | 2 | 2 |

## Learner Feedback

At the end of each e-learning course there is a questionnaire that learners must complete before they are able to print their course certificate. Both quantitative and qualitative data is collected comments received from some of Cumbria LSCB's learners include;

- 94% of learners found the system either 'Very Easy' or 'Easy' to access and navigate through.
- Only 13% of learners needed to contact the system's Help and Support services.
- Out of those who did need to contact the system's Help and Support Services 92% rated their experience as 'Excellent' or 'Good'.
- 98% of learners were either 'Very Satisfied' or 'Satisfied' that the course gave them all the information they needed to know; and
- 97% of learners would recommend the courses to other people.

# 21. Child Sexual Exploitation (CSE) and Missing from Home (MFH)

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.

### Governance and Structures

The LSCB has a strategic sub group devoted to CSE and Children Missing from Home (MFH). The subgroup is chaired by the Local Authority Lead Senior Manager for CSE and has membership from all agencies represented at the LSCB, demonstrating that this is a partnership response to the problem. Whilst the main strategic group retains a good overview of the CSE delivery plan and its implementation, there are two more operational groups that report through the Strategic Group: the Working Group that monitors the effectiveness of multi-agency working, including monitoring practices of agencies to ensure procedures are followed and an Oversight Group that provides Cumbria-wide multi agency tracking and oversight of individual young people and perpetrators where there are indicators of high going missing vulnerability and active CSE. The Oversight and Working Group are both chaired by a Detective Inspector from the Police Public Protection Unit. The groups are well established and well attended.

The Working 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 Working subgroup also monitors CSE intelligence, including CSE reports to police, numbers of children MFH, 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.

### CSE Strategy

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

A CSE self-assessment, the Strategy and associated action plan were reviewed in 2016, and a recently completed updated version of each signed off by the Strategic group. This review was informed by recent learning from the Ofsted Joint Targeted Area inspections, and lessons learnt in other areas.

## Awareness Raising and Training

There is a specific area on the LSCB website for CYP and professionals and newsletters from the LSCB include CSE key messages. Additionally, there have been two CSE webchats held in July 2016 and in March 2017, to coincide with CSE Awareness Day. Members of the CSE/MFH subgroups built on the success of last year's Facebook events and again held a live multi agency chat with representation from the Police, Children's Service, Sexual Health and NSPCC ahead of National CSE awareness day on 18th March. This was viewed by 2,901 people. Post Activity i.e. likes, shares, comments & views totalled 114,311 and a reach of just under half a million people

A Cumbria Police Snap Chat account was opened to coincide with a week of CSE awareness raising in March, The Snapchat was aimed directly at children to warn of the dangers of image sharing and its links to CSE.

Media Students at College took over the account and produced an impactive video which was released in segments throughout the week. The Snapchat account went from 0 to 650 followers within that week

The complete video was posted on the Police Facebook page, it has been viewed 211,000 times, has been shared 1620 times giving an overall reach of 1,141,262 Facebook users.

2016/17 training plans covered 3 key areas for improving CSE awareness and practice in the county. These were 3 half day awareness sessions, 5 full day learning events, and e-learning. The full day learning events had attendance from over 200 practitioners. The half day awareness raising sessions, which were new to the LSCB training programme, took place in October and November 2016 and were attended by 186 professionals from a range of organisations. All delegates rated the events as "excellent" or "good". The third "strand" of training has been the e-learning package. This has been completed by over 1000 staff (over 500 of which have been in the 2016). In order to learn from the feedback from 2016/17 events and ensure continued effectiveness of training for 2017/18 a small task and finish group has again been established to plan the coming year's events.

Awareness raising has been undertaken in schools via the delivery of Chelsea's Choice (funded via the PCC). Two rounds of Chelsea's Choice have been delivered across the County (2015 & 2016) with additional sessions for teachers and parents. In 2016 this was delivered to 6835 children. We have learnt lessons and developed our approach to Chelsea's Choice for example the availability of professionals to support YP following delivery and the timings and location of the sessions. Chelsea's Choice will be delivered again in 2017

## Missing from Home

In 2016/17 we saw 437 Cumbria Children who had one or more MFH episodes. The total number of missing episodes for this cohort was 1186. Of the 437 children, 207 (47.4%) were open to Children's Social Care

Of those 207 children:

- ✓ 36 (17.4%) were CLA, placed in CCC
- ✓ 28 (13.5%) were CLA placed out of CCC
- ✓ 143 (69.1%) were an "open" referral to CCC at the point of going missing (current assessment / CiN / CP).

In 2016 the CSE/MFH Strategy Sub group recognised that there needed to be some dedicated work in relation to Missing From Home. In response to this a dedicated Task and Finish group was established in late 2016, and has been focused on improvements around the RHI completion within timescales.

In order to support the work of the group, a 12month fixed term post has been funded. The Missing from Home Coordinator has been in post since February 2017.

### CSE/MFH Procedures and Tools

Alongside the strategy, the CSE/MFH Subgroup developed procedures for staff to follow, should they identify anyone they feel may be at risk. Following findings from CSE and MFH audits and feedback from practitioners the procedures for CSE and MFH have been recently updated (now available on the LSCB on-line manual). Included in the CSE procedures are detailed flow charts to define actions for different "cohorts" (e.g. children not on a plan, children on an Early Help plan, and Children on a Social Work plan [including those Looked After]); the MFH procedure now also includes a process overview.

### 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 works 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.

## Impacts 2016-17

Whilst all of the above demonstrates activity in relation to CSE and MFH, it is important to consider the impact of this. It is recognised that some of the work will take time to be "seen" in terms of impact however it is possible to identify some elements where we have seen changes which indicate a growing confidence around identification and response to tacking CSE:

- There has been a significant increase in CSE incident logs recorded by the Police (45 in Quarter 2 of 2015/16, and 387 in the same period 2016/17).
- We have seen a significant increase in Child Abduction Notices (rising from 4 in Q2 2015/16 to 17 in the same period 2016/17). This is a proxy indicator of CSE disruption activity.
- We have however seen a relatively steady number of children being managed under a CSE category (61 in June 2016, and 58 in December 2016 ), which indicates that awareness is high, but the screening and risk assessment process is thorough. It is important thought that this is routinely reviewed and triangulated with assurance work such as through case audit.
- It is notable though that although the overall number of children with a CSE category in Cumbria has remained relatively static for the last 6 months, the proportion being managed at a "preventative/early support" level i.e. Category 1 has increased from 60% 65% when comparing June 2016 to December 2016, indicating increased prevention of escalating CSE risks.

Through the strong partnership work of the CSE/MFH subgroup(s), the activity above demonstrates continued progress in Cumbria with;

- Increased clarity about the "picture" of CSE and MFH in the county
- A large number of staff better informed of the issue through online training
- Wider reach both in terms of young people being identified and supported, and, professionals trained and supported to understand and address CSE
- Dedicated resource and attention to improve the response to MFH

## Next Steps 2016-17

There is still a continued focus to improve our work in relation to CSE and MFH. The current position in more detail, and associated developments identified are captured in the Self-Assessment and the subgroup has developed an action plan in response to the findings in our own Self-Assessment. The plan for the coming year includes:

- Undertaking a review of the Oversight Group
- Implementation of a Memorandum of Understanding between Police and Independent Children's Homes and schools
- Further development of CSE training, including a new targeted 'advanced' level course
- Further work undertaken to harness the wider community via awareness raising
- Ensuring improved strategic response to the intelligence gathered from RHIs.

# 22. Local Authority Designated Officer (LADO) (16-17)

Cumbria has 2 full time dedicated workers who carry out the statutory duties of LADO. The LADO service currently has management oversight from the Senior Manager in the Safeguarding Hub.

The role of the LADO is defined in Working Together (2015) and places a responsibility on all LSCB's to have clear policies for dealing with allegations against adults who work or volunteer with children in both paid and 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

There are three strands which will be considered in response to an allegation;

- A police investigation of a possible criminal offence
- Enquiries and assessment by Children's Services to assess if a child is in need of protection or services.
- Disciplinary or management action to be undertaken by the person's employer.

The LADO is responsible for the oversight and scrutiny of individual allegations, 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. The LADO does not undertake investigations as this responsibility lies with the employer or the governing body of the organisation. However, the LADO will offer advice and support when necessary to ensure that the allegation is dealt with expediently and fairly.

### LADO Activity

The LADO service maintains a database which enables the service to track and record allegations and provides statistics to the LSCB in respect of:

- categories of allegation received
- employing organisation
- reporting organisation, the organisation referring to the LADO
- the names of adults named in any allegation
- details of the child/ren named in the referrals
- the resulting action/outcome and action plan

For the period 1st April 2016 to the 31st March 2017 a total of 296 allegations were recorded by the LADO. This is a reduction from the previous two years where the total numbers of allegations received were 381 in 2015/2016 and 507 in 2014/2015. Possible reasons for the decrease are due to a change in the national threshold criteria. This is discussed in greater detail in section 3.6

All allegations to LADO are recorded in a separate secure workspace on the ICS system. This can only be accessed by the LADOs and the manager. This means that records and documents can be easily stored and provides quality case records. It also means that highly sensitive information is protected. Currently the workspace does not have a report function however the data is gathered from ICS and collated in a robust data programme. This provides concise and precise records.

### Data relating to LADO referrals

**Breakdown of allegations by employee type and category of abuse.**

| Employer | Physical | Emotional | Sexual | Neglect | Conduct |
|---|---|---|---|---|---|
| Foster carer Local Authority | 9 | 5 | 1 | 1 | 1 |
| Foster carer Non-Local Authority | 9 | 0 | 0 | 1 | 0 |
| Residential worker Local Authority | 0 | 0 | 0 | 0 | 0 |
| Residential worker Non-Local Authority | 32 | 3 | 2 | 12 | 13 |
| Other social care staff | 3 | 0 | 2 | 0 | 11 |
| Health | 8 | 0 | 3 | 3 | 8 |
| School staff employed by LA | 28 | 2 | 7 | 12 | 7 |
| School staff not employed by LA | 13 | 4 | 5 | 10 | 5 |
| Early Years | 9 | 0 | 2 | 8 | 3 |
| Police | 3 | 1 | 2 | 1 | 0 |
| YOT | 0 | 0 | 0 | 0 | 0 |
| Probation | 0 | 0 | 0 | 0 | 0 |
| Secure Estate | 0 | 0 | 0 | 0 | 0 |
| Voluntary organisations | 3 | 0 | 6 | 2 | 7 |
| Faith Groups | 1 | 0 | 1 | 0 | 1 |
| Armed Forces | 0 | 0 | 4 | 0 | 0 |
| Immigration/Asylum Support services | 0 | 0 | 0 | 0 | 0 |
| Transport | 3 | 0 | 2 | 0 | 1 |
| Self employment | 0 | 0 | 1 | 1 | 1 |
| Connexion / services for young people | 0 | 0 | 0 | 0 | 0 |
| Other | 2 | 0 | 6 | 1 | 4 |
| **Total** | **123** | **15** | **44** | **52** | **62** |

As in previous years the highest numbers of allegations relates to concerns in respect of physical harm. Thirty percent of these referrals (37/123) are from independent schools and children's homes where children with behavioural difficulties are either educated or placed. Many of these children are children who are looked after by other local authorities. A young person is advised following any physical restraint that they can make a complaint. Any complaint from a child in these circumstances is reported to the LADO. Discussions with the child's social worker, the police and the setting will then take place and an assessment of the restraint and circumstances surrounding this will then take place. An action plan will be agreed and this will included a decision as to the suitability of the placement for the child.

Of the 123 allegations where *"physical"* abuse was the primary harm category, 29 (24%) allegations related to allegations of physical abuse following a member of staff undertaking a physical intervention or restraint. This is pro-rata decrease on the previous year when of

142 allegations, 41 (29%) related to allegations following a member of staff undertaking a physical intervention or restraint. Working Together 2015 amended the threshold criteria known previously as suitability –

> *"behaved towards a child or children in a way that indicates s/he is unsuitable to work with children"*

to

> *"behaved towards a child or children in a way that indicates they may pose a risk of harm to children"*

This amendment has effectively raised the threshold for referral and allegations which would previously have met the criteria and been recorded as conduct no longer meet the threshold. This has led to a reduction in the actual number of allegations recorded. However, there has been confusion within professional agencies about actions they should take in respect of employees conduct. LADO are often asked to provide advice and guidance on these matters. This can be time consuming and the fact that this is not recorded on the ICS record means that there is no record of this activity. Following discussions with LADO via the regional North West group it has been agreed that the "conduct" will be removed as a category of abuse. This fits with the threshold criteria from Working Together 2015. Allegations which relate to professional conduct and meet the threshold indicating they may pose a risk of harm are now recorded in the "neglect" category of abuse.

**Number of referrals by agency: 1st April 2016 to 31st March 2017**

| Agency | Number |
|---|---|
| Social Care | 130 |
| Health | 8 |
| Education | 63 |
| Early Years | 7 |
| Police | 58 |
| YOT | 0 |
| Probation | 0 |
| CAFCASS | 0 |
| Secure Estate | 0 |
| NSPCC | 2 |
| Voluntary Organisations | 6 |
| Faith Groups | 1 |
| Connexions | 0 |
| Armed Forces | 0 |
| Immigration/Asylum Support services | 0 |
| Ofsted | 10 |
| Other | 11 |
| **Total** | **296** |

Records of referrals to the LADO service highlight that as in previous years the highest referring agency is social care with 130 of the 296 coming from Social Care teams. 89% of all LADO referrals are made within one working day which is the expected timescale for referral. This timescale has been maintained from 2015/16.

**Outcome of referrals to the LADO**

| Final Result | Number |
|---|---|
| No further action after initial consideration | 85 |
| Training needs identified | 56 |
| Being unfounded | 31 |
| Being unsubstantiated | 102 |
| Being malicious | 17 |
| Substantiated | 82 |
| Suspension | 47 |
| Dismissal | 19 |
| Deregistration | 7 |
| Cessation of use | 12 |
| Resignation | 10 |
| Section 47 enquires/investigation | 30 |
| Criminal investigation | 63 |
| Disciplinary procedures | 39 |
| Criminal prosecution | 10 |
| Caution | 3 |
| Conviction | 11 |
| Acquittal | 0 |
| Referral to Barring Board('ISA') | 27 |
| Referral to regulatory body | 24 |

Of the 279 allegations, 85 were concluded with '*no further action*' after initial consideration/discussion. Although the number of allegations has decreased from those recorded in 2015/16 the allegations which result in no further action to LADO has increased. It is important to recognise that although after the initial discussion, this may not warrant further action by the LADO it may have required action by the employer. Given the increase in NFA outcomes in 2016-17, part of the development activity referred to in section 4 will address proposed actions to explore this further.

## Developments in the LADO Service

The key highlights in relation to the LADO service developments are:

**FISCH (Forum for Independent Schools and Children's Homes) –** this group has now resumed via the LSCB. This is chaired by a representative from the Independent School Children's Homes. LADO are active members of the group and attend the quarterly meetings.

**Service Profile:** The profile and contact details of the LADO is high in Cumbria amongst professionals. The mechanism of making a referral to the service is well known and embedded. The LADOs are known to professionals.

**Service User feedback:** A Service User feedback form continues to be sent to all agencies upon the closure of the case. This helps the service to analyse trends and amend practice in response to needs.

**Audits:** The LADO service undertakes quarterly audits with a random sampling of closed cases. A report is compiled for the outcome of the audit sessions and this is shared with the LSCB. However for a period in 2016/17 this was paused due to significant staffing capacity reductions.

**Duty system:** A duty LADO system continues and is reaping positive results in terms of cases being progressed and monitored to ensure that they are recorded and concluded in a timely manner.

**Regional profile:** The LADO service attends and shares practice, with colleagues from the North West Regional LADO Forum, and North West LADO Sub Group on a quarterly basis. The Cumbrian LADO Service regularly updates North West colleagues on their practice development and learning from cases, and the North West LADO Sub Group meets bi-monthly to discuss cases and develop practice across borders.

### Challenges for the LADO Service

Disclosure and Barring Service (DBS) requests are currently managed and compiled by LADO. The level at which confidential information should be shared and with whom is always a challenge - particularly if it concerns family circumstances. It is important that there is consistency about the information shared and that it complies with the Council Information and Governance guidelines. It is important that there is liaison with legal department on this matter.

As referred to earlier, staff absence, and secondment to another role, there has been significant reduction in service capacity for a short period, impacting on the ability to undertake audits. These will be restarted.

In line with regional developments it is recognised that recording activity which does not meet the threshold criteria but needs monitored is a challenge, the service is developing a secure system to ensure this can be effectively implemented.

### Key Priorities for 2017 – 18 for the LADO Service

Taking account of the wok undertaken in 2106/17 and analysing trends of LADO referrals and outcomes the service priorities for the coming year are:

- LADO training sessions to be delivered to managers and teams across agencies in respect of the process for referral and management of allegation.

- Aiming for the 'Allegations Management flowchart' to be displayed in all offices and be embedded within safeguarding procedures within agencies so all professionals are aware how to make a referral and in a timely manner.
- Exploring opportunities for a greater presence via LSCB communications such as a dedicated area of the website, or regular briefings
- Continue to implement learning from audits and evidence further development of good practice to the LSCB. This includes further enhancement to the focus of audits, learning form the aforementioned rise in NFA outcomes, for example auditing a sample of NFA outcomes drawn from the two final quarters of this period and, some from 2105/16 for comparison.
- Continue to send the LADO feedback form when an investigation is closed so that agencies can provide feedback on their experience of the LADO Service so that improvements can continue to be made

# 23. Privately Fostered Children (2016-17)

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 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."

## Performance

The Department of Education has removed the annual requirement that Private Fostering figures are sent to them. This means that we are no longer able to compare our statistics with the North West and all of England. The figures on statutory visits will be added as an addendum to this report when they become available.

There has been a decrease in the number of notifications – 6 - compared to 13 the previous year (2015-2016). It had been anticipated that the increased publicity may lead to an increase in the number of private fostering referrals from LSCB organisations. In 2016-17 it appears that none of the notifications came from LSCB organisations despite the raised awareness completed within them. The figures are monitored monthly by the Lead Officer who reports progress internally within Children's Services.

| Number of children reported as being under private fostering arrangements at 31 March | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** |
| **Cumbria** | 8 | 9 | 5 | 7 | 6 | 8 | 8 | 13 | 6 |
| **North West** | 160 | 170 | 180 | 170 | 150 | 160 | * | * | * |
| **England** | 1,530 | 1,590 | 1,650 | 1,560 | 1,500 | 1,610 | * | * | * |

*NB – data in SFR is not broken down by individual authorities, so statistical neighbours' data not available*
**- information no longer available*

The Private Fostering leaflets and posters are available to download for staff and service users from the Cumbria County Council website with links from the LSCB 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 the webpage. The Private Fostering policies and procedures are reviewed annually for the LSCB and Children's Services. The LSCB education sub-group has taken a particular interest in Private Fostering this year and promotion has been through all links into education settings.

**Summary**

Numbers of Private Fostering cases have remained steady across the County despite a spike last year. Case recording of Private Fostering cases has improved and all Privately Fostered children have been reviewed in June 2017.

There has continued to be a concerted push to publicise and embed Private Fostering via the LSCB. 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 remain low in Cumbria and are still predominately spotted and generated by Children's Services staff.

The full Private Fostering Annual Report is available on the LSCB Website

# 24. Learning from 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:

1. Serious Case Review (SCR)
2. Practice review
3. Internal management review
4. Child death overview review.

# 25. Serious Case Reviews

It is worth noting that Cumbria has a number of "legacy" SCR that means a larger than usual number of SCR were published in 2016-17. The full reports and LSCB responses for these SCR are on the LSCB Website http://www.cumbrialscb.com/professionals/learningscr.asp

In total Cumbria has completed 5 Serious Case Reviews

- Child N
- Child L
- Child O
- Child R
- Child AC

Child N was the most high profile SCR and the publication of this report had to be agreed with the Crown Prosecution Service, the Coroner and the Independent Police Complaints Commission as some processes were still outstanding. All agreed that the report could be published in June 2016 and this was therefore published first, given the increased media attention in this case. The inquest for Child N has been continually delayed and is currently planned for November and December 2017.

One further SCR (Child AD) was completed in 2016-17, but this was re-categorised to a Practice Review – the learning from this review has been implemented and the actions and recommendations managed through the LSCB Business Group.

### Child N (published 13 June 2016)

Cumbria LSCB commissioned a Serious Case Review (SCR) into the death of Child N in Cumbria in 2012 – the SCR focusses specifically on how agencies worked together and individually between March 2011 and December 2012 just prior to her death.

**Child N's story**

Child N died in December 2012 aged 13 months. The post mortem x-rays carried out 2 days after Child N's death revealed healing fractures to Child N's tibia and fibula. The post mortem also revealed other possible injuries to Child N. During Child N's short life the family were only known to 'universal' services: schools and a range of health services. Child N's mother had a

complex childhood and had been a looked after child herself because she was at risk of Child Sexual Exploitation.

**Lessons learned from Child N**

1. Professionals working with pregnant and new mothers need to consider the long term impact of unresolved childhood trauma and abuse on future parenting capacity.
2. Professionals should use family history, chronology and genealogy to identify patterns of risk.
3. When immobile infants are presented multiple times with what appear accidental injuries – professionals should consider further enquiries and/or a Child Protection Referral, and/or an Early Help Assessment (EHA). (It is worth noting that should an EHA be considered and parents/carers refuse to co-operate and any help and support offered that in itself may raise the level of concern).
4. Multi-agency assessments should include understanding of the whole family and regular visitors to the home, alongside observations of multi-agency professionals who are involved with the family. A full & detailed history on fathers, partners (male and female) & other significant adults (male and female) in the family should be sought when gathering information.
5. Complex profiles need to be discussed through supervision and reflective support. Use reflective techniques in supervision to ensure that complex and changing family dynamics are continually considered.

### Child L (published 17 June 2016)

Cumbria LSCB commissioned a Serious Case Review (SCR) into the death of Child L in Cumbria in 2011 – the SCR focusses specifically on how agencies worked together and individually from the birth of the parents' first child in October 2009, until the date of Child L's death in July 2011. Due to his short life the panel also agreed to focus on Child L's sibling as part of the review.

**Child L's story**

Child L was born prematurely at 31 weeks in May 2011 and was admitted to the Special Care Baby Unit Medical. Child L died at home in July 2011 only 43 days old. During his short life he had been examined several times and one examination identified a possible heart murmur. Experts concluded that he died from cardiac arrest which on balance of probabilities was secondary to some form of head injury. Child L's mother had a complex background had experienced neglect, and had been a looked after child.

**Lessons learned from Child L**

1. Professionals need to establish that the family's actions agreed in the Child protection/ Family in Need or Early Help plan have been completed by the family.
2. Initial and ongoing assessments must be thorough, timely, gather multi-agency information, inform decision-making and take account of historic context of the family. (single agency)
3. On completion of a single agency assessment professionals must consider who else needs to know this information, and whether or not there needs to be a multi-agency response (e.g. Early Help) (single agency)

4. Care leavers are a vulnerable group who may require more support in order to parent effectively.

## Child AC (Published 8 July 2016)

Cumbria LSCB has commissioned a Serious Case Review (SCR) into the death of Child AC in Cumbria in 2015 – the SCR focusses specifically on how agencies worked together and individually from the from mid-2014 through to the time of Child AC's death in June 2015.

**Child AC's Story**

Child AC was killed by 3 other youths in June 2015 aged 14 years. Child AC was permanently excluded from school in July 2014 and attended the Pupil Referral Unit (PRU) where his attendance was poor. Child AC had a history of offending, first coming to the attention of the Criminal Justice System in August 2011. He attended a secure centre in November 2014 where he served two months. Upon release he was made subject to a Detention and Training Order on a licence with supervision.

Following allegations against an elder sibling, Child AC and his siblings, were made subject to a Child Protection Plan in January 2015. In April 2015, the younger two siblings were stepped down to a Child in Need Plan and Child AC remained on a CP Plan. His behaviour further deteriorated and there remained problems with attendance at the PRU and he was engaging in low-level criminal behaviour with episodes of him going missing overnight and a refusal to engage with professionals. The perpetrators of his murder, were tried, found guilty and are currently serving their sentences.

**Lessons to be learned from Child AC**

1. Professionals who are involved with a child or young person who is detained in a secure unit, should ensure their continued participation in planning, especially as the child or young person approaches resettlement.
2. Professionals need to remain focussed on the needs of the children - when working with families who appear to engage with support, or engage well, but there is little evidence of progress and, with other agencies may need to consider an escalation in intervention.
3. Professionals, who work with children and young people, where there is suspicion of substance misuse, must use this information when considering risk.

**The report identified the following additional lessons:**

- Agencies with a responsibility for working with children who are placed in another area need to consider how they communicate and share information with organisations outside of their usual local partnerships or networks.
- Agencies that hold a rich mix of information on children should consider how they can store that information in a format that can be shared effectively when there is an appropriate requirement.
- Where a child is subject of more than one statutory plan, it is important that the managers of each plan ensure there is effective coordination between each other and that the identified risks are being managed effectively.

- Professionals working with children who display non-compliance or passive avoidance should consider what incentive measures they may need in place to secure more effective engagement.
- Where children are placed in residential or secure centres a large distance from their homes consideration should be given to using communication technology to maximise agency engagement at meetings.
- Agencies working with children who demonstrate risk-taking behaviour should challenge themselves to consider the possible longer term consequences in respect of the risk-taking behaviour that is being displayed and how that behaviour may be managed.
- Agencies engaging with families should give consideration to the local context in which the family is operating and the wider span of influences that may be impacting on the children.

### Child R (published 18 July 2016)

Cumbria LSCB commissioned an SCR into the death of Child R in Cumbria in October 2014 – the SCR focusses specifically on how agencies worked together and individually from the beginning of Child R's last year at his Primary School in September 2011 to October 2014.

**Child R's Story**

Child R was aged thirteen and died at home, whilst in the care of his father. The cause of his tragic and untimely death was morphine poisoning, after being given a morphine tablet by his father who mistakenly believed it to be a suitable painkiller for his son's headache. Child R's father pleaded guilty to the manslaughter of his son and received a four year custodial sentence. Child R's school reported that he could sometimes be anxious and timid but was also a humorous and popular student who had a supportive circle of friends. His parents separated after only a few months, following their son's birth in 2001. Child R stayed with his mother until the age of three when he went to live with his father who eventually obtained a residence order in 2009.

It is widely believed that Child R and his father could have benefitted from Early Help and the findings of this case are centred on that premise.

**Lessons to be learned from Child R**

1. Transition plans should:
    - Include well-defined success criteria
    - Include a defined timescale for completion and review
    - Record the voice of the child
2. Attendance plans should:
    - Be child focused
    - Be robustly followed through with parents in line with school policy and practice and local authority guidance
    - Reviews are held in line with agreed policy and practice
    - Drift is avoided

- Medical/health evidence of absence on health grounds is corroborated to inform attendance plans
- Parents/Carers and students should be actively involved in plans around transition and attendance and have a direct voice in these processes
- Consultation should take place with the local authority Inclusion Service in line with current policy and guidance

3. School staff should consider undertaking an Early Help Assessment as part of a wider package of support when a student's absence reaches or exceeds the Department of Education (DfE) threshold for 'Persistent Absence'.
4. Where an Early Help Assessment is undertaken because of persistent absence due to health needs the School Nurse must be involved.
5. When a parent or significant family member (regardless of their level of contact with the child) has mental health and/or substance misuse issues practitioners must always consider and take account of the impact of this on the emotional wellbeing of the child.

## Child O (published 23 August 2016)

Cumbria LSCB commissioned a Serious Case Review (SCR) into the death of Child O in 2011 – the SCR focusses specifically on services that were provided to Child O and his family and how agencies worked together and individually prior to his death.

### Child O's Story

Child O died tragically at 17 years old after hanging himself. The Coroner report concluded that he took his own life whilst suffering from mental health problems and after consuming a substantial amount of alcohol. Child O was a very vulnerable young person with complex and poorly understood needs and risk factors: he had an extremely complex history of contact with services in Cumbria and the North East. Child O was home educated from the age of ten; coupled with the parent's withdrawal of Child O and his identical twin from the community and their disengagement from services this left them very isolated in their remote home.

### Lessons to be Learned from Child O

1. Practitioners and supervisors should understand and respond to the needs of 'twin families' and to children and young people who are twins.
2. Practitioners should recognise, assess and respond appropriately to the possible safeguarding implications for children and young people who are isolated and/or home educated.
3. Practitioners who visit children when they are home educated should see and speak to children and young people regularly and this should be specified and agreed as part of a child or young person's plan.
4. Practitioners and supervisors need to recognise, understand and respond to neglect, disguised compliance and fabricated or induced illness.
5. Practitioners and supervisors should proactively seek to discuss cases, share information, and give and receive support to and from multi-agency colleagues in their work with families or individuals.
6. Practitioners must ensure that children and young people who do not neatly fit service criteria do not 'bounce' between services and/or geographical areas.

**Actions to improve practice**

The work to implement the recommendations from all of the SCR completed in 2016-17 as well as any practice reviews have become part of the long term work of the LSCB and member agencies. The implementation of these recommendations is managed through the Board's Business Group and the long-term implications will be tested through the Board's Performance Management and Quality Assurance Group to evidence the expected impacts. The latest versions of the Action Plans are included in Appendix A (completed Actions) and B (outstanding actions).

Following findings and recommendations of serious case reviews being finalised it was recommended that the Chair of the LSCB, contact member organisations and seek assurance regarding issues which had been highlighted. This was undertaken and the response rate to the letter was excellent. All core member organisations and many others responded giving assurances including detail on how they implemented policies and procedures and how they assured themselves of knowledge and awareness of their workforce on relevant issues.

**Dissemination of Learning**

The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published.

Sharing learning from serious case reviews in order to improve safeguarding practice is vital. We use the recommendations from case reviews to improve safeguarding of children & young people.

The LSCB published a "response document" and these are available on the LSCB website, alongside the full SCR Report.

Following the publication of each report and development of associated action plans the LSCB completes a series of tasks to ensure the learning is widely available:

- Training materials has been reviewed to ensure the lessons are included.
- Policies and procedures (P&P) have been reviewed to ensure the lessons are included
- The website has been updated to reflect the lessons from this review.
- A specific newsletter has been published to cover the lessons from all published SCR
- The LSCB has conducted a number of workshops and a conference to raise the profile of the lessons from the SCR.
- Assurance has been sought from all agencies that the lessons from this SCR are being utilised.

The reports can be found here:
http://www.cumbrialscb.com/LSCB/professionals/learningscr.asp

# 26. Practice Reviews

We have concluded a number of practice reviews where the Case Review Group concluded that the criteria for a Serious Case Review was not met, but there could be learning for the LSCB and agencies.

Four Practice Reviews have been completed in 2016-17

- Child AB
- Child AD
- Child MW
- Child SR

Combined learning from these reviews has been used in training, newsletters, policies and procedure updates and Practitioner Forums:

**Working with vulnerable parents whilst keeping the focus on the child**
Adults who have been abused and neglected may experience lasting emotional effects which can impact on their ability to parent and maintain effective relationships.

Although the focus of the work is often supporting parents, it is important to keep assessing whether this is leading to sufficient capacity of the parents to respond to their child's needs. Always consider background information in assessments and consider the effect on parenting capacity.

**Professional curiosity about 'family friends'**
Professionals sometimes rely too much on mothers to tell them about the men involved in their children's lives. If mothers are putting their own needs first they may not be honest about the risks the men pose to their children.

When working with families make active enquiries about the child's father, the mother's relationships and any adults in contact with the child. Identify and carry out checks on any new adults who have significant contact with vulnerable children.

**Need for increased awareness of neglect and the tools available to support professionals.**
There are risk assessment tools that practitioners can use to support them to give an objective measure of the care of children. The Graded Care Profile is the evidence based tool that was agreed as part of the LSCB Neglect strategy.

**Share information**
Ensure information is shared in a timely way, is of sufficient quality for the recipient to be able to respond or act upon. Remember to share or feedback any important information e.g. changes to plans, minutes of meetings, placement moves, and outcomes of inquiries.

**Professional challenge**
At no point should professional disagreement regarding risks detract from ensuring the child is safeguarded. Practitioners need to understand and be confident to use the escalation policy.

**Domestic abuse**
Domestic violence and abuse may have a long term psychological and emotional impact in a number of ways:

- Children may be greatly distressed by witnessing (seeing or hearing) the physical and emotional suffering of a parent, or witnessing the outcome of any assault;
- Children may be pressurised into concealing assaults, and experience the fear and anxiety of living in an environment where abuse occurs;
- The domestic violence and abuse may impact negatively on an adult victim's parenting capacity;
- Children may be drawn into the violence and themselves become victims of physical abuse. Practitioners need to be aware of the impact of DA on the child.

**Quality of assessments**
The importance of timely, good quality and robust assessments is well recognised, and this is particularly crucial in cases where there are concerns about CSE. Working Together, 2015, states that the aims of assessment are 'to use all the information to identify difficulties and risk factors as well as developing a picture of strengths and protective factors'. It further outlines that an 'assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child'.

**Vulnerable parents**
Parents with complex needs, toxic trio, and those who have been looked after or in receipt of services – may be more difficult to engage.

**Risk**
Risk factors were not identified or explored during the pregnancy.

**The Hub**
The multi-agency safeguarding hub did not collate all of the relevant information in the case, provide a satisfactory screening of risk or provide feedback to key professionals involved.

**Safeguarding Concerns**
There were shortcomings in the identification and management of possible safeguarding concerns at the district general hospital in relation to him being an immobile infant. When immobile infants are presented multiple times with what appear accidental injuries – professionals should consider further enquiries.

**Transfer of the care of children to another authority.**
Ensuring when children transfer to the care of other authorities that the safety plan and risks have been clearly communicated and understood to ensure that there is no loss of momentum in the care and safety planning for the child.

**Complexity of working with young people**
There is a need for professionals to listen to teenagers, but also be able to balance the young person's wishes with their best interests.

**Impact of change of key professionals when working with vulnerable young people**
Always allow for safe handover of complex cases when lead professional/case holder changes: be sure to engage with the child and young person in that transition process.

**Recognition of the complexity of child sexual exploitation.**
When dealing with troubled young people, practitioners need to see young people as vulnerable children in need of protection rather than focussing on their challenging behaviour.

Confusion around young people's rights and their capacity to consent to sexual activity means both young people and professionals often wrongly view exploitative relationships as consensual.

**Hearing the unspoken voice of the child**
Professionals need to ask 'what are they trying to tell us' when analysing children's behaviour, as well as being alert to the fact that the needs of the parents can mask the needs of the young person.

**Chronologies**
Background info, parents own childhood.

# 27. Learning from Child Deaths (2015-16) (always a year in arrears)

## Introduction

This is the annual report for the Child Death Overview Panel for the local authority area of Cumbria. A reporting year runs from 1st April in one year through to 31st March the following year. 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 still births and planned terminations of pregnancy which were carried out within the law. 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 modifiable factors that may have contributed to a child's death. The review process looks at whether these modifiable factors could be altered, by means of nationally or locally achievable interventions, to reduce future child deaths. The CDOP review of a child's death "is not an investigation into why a child has died and it is not a serious case review."

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

This report includes various child death parameters for Cumbria 2015/2016. For each of these parameters two comparisons have been made; firstly, with national English data for the same period, and secondly, with previous years' data for Cumbria. It should be noted, however, that in line with a recommendation made in the 2014/15 annual report, this report covers all deaths reviewed by CDOP in 2015/16, rather than all deaths that occurred in that year. This brings the local reporting in line with the national reporting arrangements and means that the report does not include partial data. However as this is a change in the previous arrangement, the data are not necessarily comparable with previous years and indeed covers a number of deaths – those that occurred in 2014/15 but were signed off in 2015/16 prior to the publication of the last annual report – that have already been included in the last annual report.

## 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 were reviewed from 1st April 2015 to 31st March 2016.

## Number of child deaths

Thirty four child deaths were reviewed during 2015/16.

## Gender

During 2015/16 boys accounted for nearly two thirds of child deaths. There has been a persistent trend in England for boys to account for over half of child deaths, and Cumbria is not significantly different in this regard.

**Table 1. Gender of all Cumbrian child deaths by year of review, and compared to England 2015/16**

| | Cumbria | | | | England |
|---|---|---|---|---|---|
| | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2015/16** |
| **Male** | 12 | 19 | 10 | 21 | |
| | 57% | 73% | 37% | 62% | 58% |
| **Female** | 9 | 7 | 17 | 13 | |
| | 43% | 27% | 63% | 38% | 42% |
| **Totals** | **21** | **26** | **27** | **34** | |

## Age of child at the time of death

In 2015/16 half of Cumbria child deaths (17 children, 50%) occurred in the neonatal period (deaths under 28 days old). Of these 17 neonatal deaths, 16 occurred in the early neonatal period (death under 7 days old), and 10 (29%) were related to prematurity (8 of these – 24% - to extreme prematurity, at under 24 weeks gestation). The second most frequent age of a child's death was aged 28 days – 364 days (9 children, 26%). Cumbrian data follows national English 2014/2015 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

**Table 2. Age at death for all Cumbrian child deaths by year of review, and compared to England 2015-2016**

| | Cumbria | | | | England |
|---|---|---|---|---|---|
| **Age** | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2015/16** |
| **0 - 27 days** | 5 | 8 | 15 | 17 | |
| | 24% | 31% | 56% | 50% | 43.1% |
| **28 - 364 days** | 8 | 4 | 4 | 9 | |
| | 38% | 15% | 15% | 26% | 21.4% |
| **1 year - 4 years** | 2 | 4 | 2 | 3 | |
| | 10% | 15% | 7% | 9% | 11.7% |
| **5 - 9 years** | 1 | 3 | 1 | 1 | |
| | 5% | 12% | 4% | 3% | 7.6% |
| **10 - 14 years** | 1 | 3 | 3 | 1 | |
| | 5% | 12% | 11% | 3% | 7.1% |
| **15 - 17 years** | 4 | 4 | 2 | 3 | |
| | 19% | 15% | 7% | 9% | 9.1% |
| **Totals** | **21** | **26** | **27** | **34** | |

## Ethnicity

All but one of the 34 cases reviewed by CDOP in 2015/16 were identified as White British.

## 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 CDOP. Table 3 sets out the numbers in each category of death for the deaths signed off by CDOP in 2015/16.

**Table 3. Number of child deaths by category of death for completed CDOP reviews for Cumbria 2014-2015 (23 child deaths) and comparison with England 2014-2015**

| | Cumbria | | | | England |
|---|---|---|---|---|---|
| **Category of child death (hierarchical category number)** | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2015/16** |
| 1 - Deliberately inflicted injury, abuse or neglect | 0<br>0% | 0<br>0% | 0<br>0% | 0<br>0% | 1.6% |
| 2 - Suicide or deliberate self-inflicted harm | 0<br>0% | 2<br>8% | 1<br>4% | 0<br>0% | 3.3% |
| 3 - Trauma and other external factors | 3<br>14% | 1<br>4% | 2<br>7% | 3<br>9% | 5.1% |
| 4 - Malignancy | 0<br>0% | 2<br>8% | 0<br>0% | 2<br>6% | 7.1% |
| 5 - Acute medical or surgical condition | 2<br>10% | 2<br>8% | 2<br>7% | 4<br>12% | 6.1% |
| 6 - Chronic medical condition | 0<br>0% | 5<br>19% | 1<br>4% | 4<br>12% | 4.9% |
| 7 - Chromosomal, genetic and congenital anomalies | 4<br>19% | 5<br>19% | 9<br>33% | 2<br>6% | 26.0% |
| 8 - Perinatal/neonatal event | 5<br>24% | 5<br>19% | 11<br>41% | 16<br>47% | 32.2% |
| 9 - Infection | 4<br>19% | 4<br>15% | 0<br>0% | 1<br>3% | 5.9% |
| 10 - Sudden unexpected, unexplained death | 3<br>14% | 0<br>0% | 1<br>4% | 2<br>6% | 7.6% |
| Category unknown/not reported | 0<br>0% | 0<br>0% | 0<br>0% | 0<br>0% | 0.3% |
| **Totals** | **21** | **26** | **27** | **34** | |

The most common category of death was for perinatal/neonatal events (16 child deaths, 47%). While this appears higher than in England as a whole, low numbers are likely to account for this anomaly; there is no indication from the detailed review of these cases that there is any underlying cause of this figure being high. Usually (and across England) chromosomal, genetic and congenital anomalies is the second most frequent category of death; 2015/16 was unusual in Cumbria with this not being the case. However again very low numbers are likely to account for this.

## Modifiable deaths

Ascertaining whether a child death was modifiable is a key part of the CDOP review process. Of the 34 deaths in Cumbria, 25 (74%) were felt to have no modifiable factors. This is comparable with England as a whole, where 76% of child deaths were felt to have no modifiable factors. Of the remaining nine, five related to parental smoking. In one case, incidents during health care provision were identified as having been a possible contributory factor.

## Qualitative review

An informal analysis of the qualitative parts of Forms Cs has been undertaken to ascertain whether there are any themes or issues that have not emerged from the quantitative analysis.
It has been recognised by the review process that some services are only available in parts of the county rather than effective for the whole population. For example work is underway to ensure that families and communities have access to the bereavement support they need.

In 2 cases there was a concern raised that for the welfare of the child, withdrawal of treatment should have occurred earlier than it in fact did.

The hazardous nature of the A66 between Crackenthorpe and Temple Sowerby has been highlighted. A reminder that fever for more than 5 days should always raise consideration of Kawasaki Disease was reinforced across the county and added to the sick child template used in the GP practices and out of hours.

There have been improvements in the process over the year:

- The panel led the development of a Cumbria specific leaflet explaining the Child Death Overview process to families. In this the panel was greatly assisted by the comments and amendments by families who had suffered a bereavement and also families from Barnardo's.
- Working together and understanding between police and health has improved significantly, partly as a result of consistently holding rapid response and end of case meetings following sudden unexpected deaths.
- An ongoing problem for families is the length of time it takes to receive post mortem reports. The coroner has now agreed to release these reports to the Designated Doctors, who will co-ordinate with the lead professional for the family.
- There is now more robust liaison and co-ordination in relation to children from Cumbria who do not die in Cumbria.

## Quality of CDOP Process: Time taken to review cases

Each child death review cannot take place until all the required information has been collated. It can take many months to amalgamate this data as some investigations cannot be completed quickly, particularly for more complex cases. In 2015/16 this has been particularly notable due to a high number of serious case reviews being carried out on historic cases. However for many years the length of time taken to sign off deaths in Cumbria has been too great. In 2015/16 the proportion of deaths taking more than 12 months to review dropped notably, but remains much higher than the national average. The other notable feature of Cumbria is the extremely low proportion of reviews carried out within 6 months: where cases are relatively straightforward, this is clearly something that could be further improved. Achieving improvements in the time taken to sign off cases will require all agencies concerned to take steps to improve up their own processes, notably ensuring that the single agency Form B is completed quickly and with sufficient detail.

**Table 4. Time taken by Cumbria CDOP to sign off cases compared to England, 2015/16**

| | Cumbria | | | | England |
|---|---|---|---|---|---|
| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2015/16 |
| Under 6 months | 5% | 23% | 0% | 3% | 29% |
| 6 - 7 months | 5% | 4% | 0% | 9% | 14% |
| 8 - 9 months | 14% | 8% | 15% | 15% | 12% |
| 10 – 11 months | 5% | 15% | 19% | 18% | 10% |
| 12 months | 14% | 8% | 7% | 12% | 5% |
| More than 12 months | 57% | 42% | 59% | 44% | 30% |

## Recommendations

The following table sets out the recommendations made in the 2014/15 Annual Report and the progress made in implementing these:

| Recommendation | Progress |
|---|---|
| Health visiting and social care services should carry out a brief review of the support that they offer to parents who misuse alcohol or drugs in order to determine whether this is an area that requires further development. | The Quality Assurance Group of the LSCB has reviewed such support and revised actions are in place. |
| Maternity services should work to improve their data collection relating to smoking at time of delivery (SATOD) and to support more mothers to quit while pregnant. | In 2015, a mother's smoking status at time of delivery was not known in only 2.7% of cases – better than the England figure of 3.1%, and a significant improvement on previous years. 12.3% of women were known to be smokers at the time of delivery. This is also an improving picture but remains higher than England (10.6%) |
| CDOP should consider changing the timing of Annual Reports so as to publish in the summer the findings from all deaths signed off in the previous year, rather than waiting nearly 12 months until deaths from that year have mostly been signed off. This would bring the statistics in line with England and prevent annual reports including partial data from deaths that were not able to be signed off prior to the report being written. | Implemented in full in this year's annual report. |
| CDOP should continue to work to improve the timeliness of its review process and agree a plan to improve performance against those recommendations from last year that are still partly outstanding. | Timeliness is improving but more remains to be done to improve further, particularly with regard to rapid responses to more straightforward cases. Two actions from the previous year had been achieved in part:<br>• Add more social determinants to the case summary and document a mother's obstetric and antenatal history for premature births<br>• Ensure all practitioners completing documentation understand definitions used and have access to the guidelines which explain terms in detail. |

Recommendations arising from this year's report are as follows:

- All agencies should take action to improve the quality and timeliness of the completion of Form B's in order to speed up the CDOP review process.
- In support of this, CDOP should monitor and report on the quality and timeliness of the completion of Form B's on a regular basis.

- CDOP should consider adopting a rapid sign-off process using email for simple cases where full case discussions have taken place and there is a clear recommendation from the relevant Paediatrician for Child Death.
- CDOP should take steps to ensure further dissemination of the learning arising from each case considered.

## References

Department for Education (2012) Guidance Notes for the completion of the Local Safeguarding Children Board Child Death DATA Collection. Available online: https://www.gov.uk/government/publications/child-death-data-collection-2013-to-2014-lscb1-guide

Department for Education (2016) Statistical First Release on Child Death Reviews – Year ending March 2016. Available online: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016

CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

# 28. 2016-17 Business Plan Update

**Update on delivery of Actions in the 2016-17 Business Plan (anything not complete is to be carried forward into the 2017-2020 Business Plan)**

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| 1. Leadership and Governance | 1.1 | Implement a programme to review the learning and development needs of LSCB members and systematically address these through annual appraisal | Chair | Jul-17 | **Members of the Board are clear about their roles** | No update required | |
| | 1.2 | Conduct a programme of one to one discussions between members of the LSCB and the Chair to ensure they are supported and are taking appropriate actions in their role on the LSCB | Chair | Mar-17 | | 1:1 meetings booked in for April/May 2017 | **G** |
| | 1.3 | Review all of the Terms of Reference for all of the subgroups – based on this plan and the day-today operational requirements of the LSCB – include roles and responsibilities for the Subgroup Chair | LSCB Senior Manager | Nov-16 | | Complete | **C** |
| | 1.4 | Refresh the LSCB Members Handbook – and develop a contract for LSCB Members to sign up to. | LSCB Senior Manager | Jan-17 | | This has been completed - and will be presented to the LSCB in May 2017 - for sign off. | **G** |
| | 1.5 | All LSCB Members to sign up to the LSCB Members Handbook | LSCB Chair and all LSCB Members | Mar-17 | | This has been completed - and will be presented to the LSCB in May - for sign off. | **G** |
| | 1.6 | 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 | Jul-17 | **The Board is effective at challenging and scrutinising to protect and promote the welfare of Children** | No update required | |
| | 1.7 | Review all of the work plans for all of the subgroups – based on this plan and the day-to-day operational requirements of the LSCB | LSCB Senior Manager | Nov-16 | | Complete | **C** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 1.8 | Hold at least one development day for each LSCB Subgroup to review their work plan, TOR and national policy. | LSCB Senior Manager | Jul-17 | **The LSCB is well-placed to continually improve and the work of the subgroups is suitably aligned** | Development days are planned in for some subgroups - other will be scheduled in the coming months | **G** |
| | 1.9 | The LSCB will continue doing all the things it is doing well at the moment: in particular the effective partnership work and strong strategic planning (from LSCB Peer Review Report).<br>• Final updates of Business Plan actions, SCR action Plans and self-assessments (LSCB and CSE) to be agreed by LSCB Business Group<br>• Annual Report to be presented to the LSCB Business Group 17 August September 2016 with final sign-off by the LSCB in September. | LSCB Senior Manager | Sep-16 | **The LSCB is able to demonstrate a rigorous and transparent assessment of the performance and effectiveness of local services to safeguarding and promote the welfare of children** | Complete | **C** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 1.10 | The LSCB will conduct a thematic review of the CLA cohort of girls with a specific focus on:<br>a) preventing teenage pregnancy and<br>b) where girls do become pregnant developing and adapting new ways of working which would include consideration of therapeutic interventions, family fostering arrangements, and highly personalised gender specific and tailored support packages for mothers who have been looked after and/or experienced neglect, trauma and abuse.<br><br>The results of the review will show how need, risk and parenting capacity is assessed and responded to appropriately for this most vulnerable group - so that service gaps can be identified and support tailored more specifically to "themes of need" | Learning and Improvement Subgroup | Jan-17 | **Children Looked After are appropriately safeguarded** | Review underway and will be presented to the LSCB in due course. | **G** |
| | 1.11 | The LSCB will complete an audit of 3 families with a similar profile to Child N's family to see how parenting capacity is being assessed and responded to. The LSCB will ensure that single agency activity continues to be implemented. | Performance Management and Quality Assurance Group | Oct-16 | | 3 families with similar profile to Child N's have been identified and audit has been undertaken with the report presented to the March PMQAG (timeframe slipped due to other auditing priorities). Report and recommendations included in May's Business Group Report to the Boards | **G** |
| | 1.12 | Monitor the quality of work delivered in relation to children with disabilities by ensuring all multi-agency audit activity includes audit of cases of children with disabilities regardless of the theme of the audit, as appropriate, and undertaking a multi-agency themed children with disabilities audit | Performance Management and Quality Assurance Group | Apr-17 | **Children with a disability are appropriately safeguarded** | This audit has been completed, and the final report was presented to the PMQAG in March 2017 and reported to Business Group April 2017. | **C** |
| | 1.13 | Develop a new LSCB Communication, Engagement and Participation plan and deliver throughout the | Communications and Engagement | Jul-17 | **Improved LSCB visibility and** | Plan has been developed. Implementation is ongoing | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | | year – LSCB Business Group to monitor | Subgroup | | **influence** | | |
| | 1.14 | Use established audit tool to undertake an annual internal review of the Board or have a peer review | LSCB Senior Manager | Jul-17 | **The Board is assured of its own effectiveness** | No update required | |
| | 1.15 | Once the government's review is complete and guidance is being made available The Board should consider holding an away day with an external facilitator to reflect on the next stage of development (**from LSCB Peer Review**) | LSCB Business Group | Jul-17 | | No update required | |
| | 1.16 | Implement the revised LSCB Neglect Strategy to ensure a shared understanding and consistent application of thresholds for neglect across the partnership. Monitor the effectiveness of the work undertaken | Neglect task group | Nov 2016 ongoing | **Timely and effective interventions to tackle neglect** | Neglect Strategy was launched at the SCR conference in January 2017. Monitoring will be ongoing through the Business Group. | **C** |
| | 1.17 | The LSCB to continue to monitor the delivery of improvements for Social Care, Health and Police services for children and young people in Cumbria through robust and timely reporting to the Board of progress by Children's Services, Cumbria Partnership Foundation Trust, and the Police in response to their relevant inspections (Ofsted, CQC and HMIC) | LSCB Business Group | Quarterly updates to the Business Group - ongoing | **Assurances that improvements in services for children and young people are being delivered, appropriately managed and outcomes for CYP improve** | Updates received and monitoring continues through the Health Subgroup | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 1.18 | Cumbria Children's Services has agreed to move to the "Signs of Safety" model for Social Care. Cumbria LSCB has agreed to support this move and ensure that it's policies and procedures, training and other learning is appropriately changed to reflect this change in Practice. | LSCB Business Group | Jul-17 | **Signs of Safety methodology is reflected in all practice across services for children** | Meeting held in November 2016 with partners to develop the strategic plan. Project Board to be established. | **G** |
| | 1.19 | The LSCB will continue to develop mechanisms to assure itself that the most vulnerable groups in Cumbria are supported and Safeguarded. Mechanisms do not currently exist for children who are Asylum Seekers; suffered from Female Genital Mutilation or have been trafficked – the LSCB will discuss these areas at their 1st Development Day and ensure these are covered in the future. | LSCB | Mar-17 | **All vulnerable groups are considered by the Board and these children are appropriately supported.** | Development day was held and was discussed, forward plan for LSCB has been updated | **C** |
| | 1.20 | The LSCB will respond to the Alan Wood Review into the effectiveness of LSCBs and ensure that the LSCB continues to develop in line with Government requirements, and the needs of local children. | LSCB Business Group | Sep-17 | **The LSCB is fit for purpose and continues to be an effective mechanism to improve safeguarding practice in Cumbria** | No update required | |
| | 1.21 | The LSCB will continue to monitor the changing landscape for health commissioning and delivery to ensure that children in Cumbria are not disadvantaged by shifts in strategic responsibility and that services remain focused on the most vulnerable. | LSCB | Sep-17 | | No update required | |
| | | | | | | | |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| 2. Quality Assurance and Performance Management | 2.1 | Review the Multi-Agency Performance Management and Quality Assurance Framework to ensure fitness for purpose and to reflect recent changes to the Children's Services Framework - specifically focussed on the management of risk | Performance Management and Quality Assurance Subgroup | Oct-16 | **Children are safe, that risk is managed appropriately and outcomes for CYP improve** | A refreshed PMQAF was presented to the PMQAG in March - this will be signed off virtually and presented to the LSCB in May. (timescale slipped awaiting the CCC PMQAF review) | **G** |
| | 2.2 | Agree and deliver a refreshed and prioritised Quality Assurance 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 | Jul-17 | **Improved Safeguarding Practice based on Quality Audit information** | Review of audit process to be undertaken by PMQAG following Ofsted inspection | **G** |
| | 2.3 | Conduct the programme of S11 audits for 2016-17. The findings are to be scrutinised by the LSCB and feedback to agencies and wider LSCB about themes, actions and issues | Performance Management and Quality Assurance Subgroup | Mar-17 | **The Board is assured of the compliance of all agencies with their duties in relation to Section 11 of the Children Act 2004** | Section 11 audit complete and report will be presented to the LSCB in May. | **G** |
| | 2.4 | Refresh the LSCB Self-assessment and evidence catalogue to ensure the LSCB is always ready for inspection. | LSCB Senior Manager | November 2016 (then ongoing) | **The LSCB is ready for inspection** | this is underway and will be further updated following the sign off of the CS Self-Assessment | **A** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 2.5 | The LSCB Young People's Perspective Group to be engaged in the next round of Audits to provide their perspective. | Performance Management and Quality Assurance Subgroup | Mar-17 | **The views of CYP are reflected in the audits, improving the perspective** | We include the voice of the child in our audits via interviews undertaken by the Targeted Youth Support Service with those children whose cases we audit (who wish to speak with us). Work is ongoing to tie the themes the YP's Perspective look at with those of the audit programme. | **G** |
| | | | | | | | |
| **3. Early Help** | 3.1 | Early Help Team and Education Subgroup will work together to review attendance statistics for schools and correlation with Early Help Assessment to identify any schools with high levels of absence and low take up of Early Help. | Education Subgroup | Dec-16 | **Take up of Early Help in schools with high absence will increase and outcomes for children will improve.** | The education sub group has requested input from the inclusion officer who will be attending their next meeting in January. Currently work is ongoing to promote the use of early help in relation to attendance and early help officers are engaging schools appropriately. | **A** |
| | 3.2 | The Early Help Team and the Education Subgroup will work together to identify good examples of good Early Help and Attendance Plans - where there has been consideration of parents' issues and where there has been good consideration of the impact on the child and the child's voice is evident – these will be developed into a learning resource for schools through the Learning and Improvement Subgroup of the LSCB. | Education Subgroup | Dec-16 | **Attendance and Early Help Plans, where there are parents or significant adults with mental health and/or substance misuse, will show good assessment and planning in terms of the child's emotional wellbeing** | | |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 3.2 | Section 11 and Staff survey to include questions about Thresholds and confidence in being lead coordinator. | Performance Management and Quality Assurance Subgroup | Jul-17 | **Staff will report increased confidence in thresholds and being the lead coordinator for early help.** | This question was included in the 2016 staff survey and the 2016/17 Section 11 Safeguarding Audit. The 2017 audit is now underway and the questions will be repeated - hopefully we will see some improvements. | **C** |
| | 3.3 | Continue to develop the Early Help Panels | Early Help Subgroup | | **The numbers of EHAs recorded as closed, with an associated outcome, will increase** | Early Help Panel development day held, facilitated by Claire Burgess. Work continues to develop the Panels | **G** |
| | 3.4 | Working with learning and improvement and communications, engagement and participation sub groups deliver 6 roadshow events across the County to provide staff with clear messages about thresholds, screening and risk management and early help. | LSCB Hub Programme Board | Sep-16 | **Multi-Agency Safeguarding Hub is operating effectively resulting the identification of children who would benefit from early help** | Complete no update required | **C** |
| | 3.5 | Early help and Education groups work together to launch and promote the new thresholds document to improve schools staff confidence in applying thresholds | Early Help Subgroup and Education Subgroup | November 2016 and ongoing | **Early Help processes and systems are working for those who are working with children every day** | Thresholds revised and live on LSCB website. Early Help Team working with the education sector to increase confidence. Feedback at the education sub group from a college setting gave very high praise for the direct work the early help team were doing with them. | **C** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | | | | | | | |
| 4. Developing the workforce | 4.1 | 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 | Nov-17 | **Improved practice based on good practice exemplars** | A catalogue of good practice case studies is on the website, local and national research is also available. Continue to develop repository on LSCB website to include further case studies and local practice learning. | **C** |
| | 4.2 | Refresh the Safeguarding Responsibilities, Threshold Guidance and Referral Process Safeguarding and Child Protection Working Together to Safeguard Children (formerly level 3) training packages and support the training pool to deliver them.<br><br>Develop a new 'neglect' training package and support the training pool to deliver it.<br><br>Develop a new training package on "Hidden" Children & Young People: Working with Invisible Families (Private Fostered, Home Educated, Traveller Families, Migrant Families, Modern Slavery) | Learning and Improvement Subgroup | January 2017 and ongoing | **Children and young people in Cumbria are in the right place in the system to meet their needs Staff will be more confident to support children and appropriately manage risk** | The neglect package is still under development and will be signed off by L & I group.<br>The hidden child package is also under development with commitment from CCC school inclusion team to deliver sessions.<br>Both courses will be in the 2017 / 18 training programme. | **C** |
| | 4.3 | Continue to provide support to the training pool through the offer of 3 trainer development days a year.<br><br>Implement the volunteer trainer agreement. | Learning and Improvement Subgroup | October 2016 and ongoing | **All trainers will be confident to provide the training and evaluation will show increased satisfaction with training** | Trainer development sessions are now planned for the second year. Feedback from the trainers on the sessions is very positive.<br>The Volunteer trainer agreement has been implemented and the trainers are returning them. | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | 4.4 | The Learning and Improvement Subgroup will ensure that "how to work with resistant families" is covered in training materials especially when working with assessments and the need to share relevant information. To be included in the Safeguarding L2 and L3 workshops. (with the expectation that all partner agencies also include it in their L2 and L3 training) | Learning and Improvement Subgroup | Jan-16 | | Complete no update required | C |
| | 4.5 | The LSCB will conduct at least three workshops/conference to raise the profile of the lessons in the SCR that have been published since April 2015. These will also pick up learning points from the Practitioner Survey, the Section 11 Audits and the Multi-agency Audits.One to cover families (including young people themselves) not fully engage and deteriorating in behaviour with young people and their families with agencies. The event will focus on strategic as well as front-line learning.Another conference will be a "Learning from Practice" conference in autumn 2016 – with a focus on Neglect and will take this opportunity to further disseminate thresholds for all abuse including neglect and emotional abuse as specific case studies. | Learning and Improvement Subgroup (linked to 5.5) | Jul-17 | **Training is responsive to the SCR learning** | The first SCR conference in January 2017 was well attended and included learning from SCRs. L & I agreed the two SCR learning events to be incorporated into their 17 / 18 programme1)Families who are difficult to engage including teens … this will pull out the SCR learning on; care experienced young people who become parents; complex family history, disguised compliance.2) Learning from practice – to cover thresholds, managing risk, outcome focussed plans, information sharing | G |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | 4.6 | The LSCB will continue to support multi-agency opportunities for Health Visitors, social workers and midwives to meet and discuss thematic and case issues through Practitioner Forums and Early Help Panels ensuring that they have access to extended/enhanced supervision and multi-agency group support.<br><br>In particular Practitioner Forums and Early Help Panels will use the learning from the Child N serious case review to provide opportunities for frontline practitioners and their supervisors to further their understanding of need and risk in women with MCN's profile such as mothers who are care leavers, own child removed, a large number of subsequent children. | Communications, Engagement and Participation Subgroup and Early Help Subgroup | Aug-17 | **Practitioners will feel supported and have opportunities to meet and discuss thematic and case issues** | Multi-agency opportunities are in place through the practitioner forums, dates are set for the year and a work programme is in place. | **G** |
| | 4.7 | Develop and implement a shared training evaluation methodology to assess the impact of training on practice and quality assure LSCB training delivery reporting to the LSCB.<br><br>Cumbria LSCB is developing the impact and evaluation of the training delivered. This includes a dip sample survey of how learning points have been incorporated into our practice and have made a difference for children. This dip sample will have a question about recognising sexual abuse. | Learning and Improvement Subgroup | Jul-17 | **Training is appropriate, well-constructed and continually improves** | Learning & Improvement framework and training strategy, which includes methodology to assess impact is in place. L & I have received several impact reports from agencies. The partnership is starting to demonstrate the impact of the training. Impact of training evaluations to be published on the website. | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | 4.8 | External trainer's agreement to be developed based on quality markers (to be established). These trainers will be able to say that their training is "compliant" with Cumbria LSCB quality markers. First trainers to be endorsed by December 2016 – with subsequent trainers online by end of July 2016. | Learning and Improvement Subgroup | Dec-16 | **Cumbria LSCB is assured that there is sufficient good quality training for agencies to purchase that is compliant with the requirements of the LSCB** | The endorsement self-assessment tool has been completed by one agency and L & I agreed recommendation to endorse | **G** |
| | 4.9 | 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. Proportionate to the action and the outcomes. | Learning and Improvement Subgroup | Jan-17 | **All practitioners have access to good quality training that improves their practice** | L & I have received several impact reports from agencies. The partnership is starting to demonstrate the impact of the training. | **G** |
| | 4.10 | Procedures manual to be refreshed in August 2016 and February 2017. Consideration to be given to the need for a policy for children and young people who are placed in secure settings. | Policies and Procedures sub group | Feb-17 | **All Practitioners have access to multi-agency procedures which reflect local and national serious case reviews, changes in legislation and statutory guidance and/or national and local learning.** | The manual has been refreshed. A decision was made by the P&P subgroup that another procedure was not required as the YOS already have P&P's in place which cover children and young people placed in secure settings. | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | | | | | | | |
| **5. Learning from Case Reviews** | 5.1 | Develop an Action Plan for the period when the current burden of SCR preparation and dissemination is completed in order to take the next steps towards excellence (From the LSCB Peer Review Report):<br><br>• Develop a joint SCR Action Plan for all of the published SCR and Practice Reviews.<br>• Deliver the actions from the SCR Action Plan<br>• Report progress to the LSCB and Business Group | LSCB Business Group | As per actions in the Plan – latest September 2017 | **Case reviews result in changes in practice and they are conducted in line with statutory requirements and the actions that are generated as a result are implemented in a timely way.** | Plan developed and monitored through the LSBCB Business Group | **G** |
| | 5.2 | Improve the links with the Adult Case Reviews, in particular to pick up learning from Domestic Homicide Reviews (DHR) where learning for services for children are a feature. | Case Review Subgroup | Jan-17 | **Improvement in services for children – as a result of DHR – are identified and acted upon** | LSCB Senior manager has met with the Adult lead and have developed links between her and the Case Review Subgroup - this will include receiving appropriate information at both boards | **G** |
| | 5.3 | Ensure that the lessons from SCRs are communicated to front-line managers and practitioners, through effective dissemination and on-going re-enforcement | LSCB Business Group | Ongoing – following a review | **Lessons are learned and practice improves** | All lessons were communicated following the summer SCR publications. Lessons from Children P SCR are being collated and will be presented to the Board in May 2017 | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| | 5.4 | The Board should consider holding high profile, LCSB 'badged' one day events on key issues in order to raise awareness of the Board and improve feedback loops with the frontline (From LSCB Peer Review).<br><br>The LSCB will conduct at least three workshops/conference to raise the profile of the lessons in the SCR that have been published since April 2015. These will also pick up learning points from the Practitioner Survey, the Section 11 Audits and the Multi-agency Audits. | Learning and Improvement Subgroup (linked to 4.5) | Jul-17 | | The first of three SCR events took place in Jan. Two SCR learning events planned for the 17/18 programme are:<br>1) Families who are difficult to engage including teens … this will pull out the SCR learning on; care experienced young people who become parents; complex family history, disguised compliance.<br>2) Learning from practice – to cover thresholds, managing risk, outcome focussed plans, information sharing | **G** |
| | | | | | | | |
| **6. Learning from Child Deaths** | 6.1 | The LSCB Child Death Overview Panel (CDOP)will respond to the Alan Wood Review into the effectiveness of LSCBs and CDOPs and ensure that the LSCB continues to develop in line with Government requirements, and the needs of local children. | Child Death Overview Panel | Sep-17 | **The LSCB CDOP is fit for purpose and continues to be an effective mechanism to improve safeguarding practice in Cumbria** | no update required | |
| | 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 | LSCB Business Group | Following each Annual Report | **Themes from all child deaths in Cumbria area identified and acted upon** | no update required | |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 6.3 | Complete the CDOP annual report for children who died in 2015-16 including identifying patterns or trends in local data and report this to the LSCB | Child Death Overview Panel | Mar-17 | **Themes from all child deaths in Cumbria area identified and acted upon** | CDOP annual report has been completed and has been published on the LSCB website | **C** |
| | | | | | | | |
| **7. Child Sexual Exploitation and Missing from Home** | 7.1 | Further develop CSE training programme Plan to have the right balance of online training and face to face opportunities to include a series of district based learning workshops. | CSE/MFH Subgroup | Apr-17 | **Increased awareness of CSE across the workforce and Staff survey will show increased knowledge and confidence in dealing with CSE** | 2016/17 training programme has been delivered, this included three half day events and 6 full day. E-learning is also available. Planning for the 2017/18 training is complete, a new targeted full day learning event will be included in the new programme | **G** |
| | 7.2 | Collation of the findings from individual agency self-assessment templates - the responses. Agencies have also been asked to provide an annual report with information around activity and impact in relation to CSE and where appropriate MFH to help update the self-assessment. | CSE/MFH Subgroup | Dec-16 | **The LSCB is assured of the work to protect children at risk of going missing and of sexual exploitation** | Individual agency self-assessments were undertaken and these were reviewed as part of the CSE/MFH Development day. The CSE self-assessment has been rewritten. The March CSE Strategic Group will discuss the process for an annual update from agencies | **G** |
| | | Develop an action plan based on the findings of the CSE Self-Assessment for the CSE Subgroups to deliver. | | Jul-17 | | There is a strategic action plan in place. This will be refreshed for 2017/18 | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| | 7.3 | New projects led by the LSCB CSE Subgroup and part funded via Brathay and Office of the PCC (to complement existing provision e.g. from NSPCC) will see provision of:<br>• Targeted prevention work for young people most at risk<br>• Group work for those waiting to receive one to one crisis intervention to ensure they don't drop off the radar whilst waiting<br>• Group support for those receiving one to one crisis intervention to reduce re-referral and sustain change towards positive trajectories<br>• Peer leadership training to ensure people with experience of sexual exploitation are involved in designing and developing services<br>• Additional provision has been commissioned via the Office of the PCC in relation to Chelsea's Choice which is being rolled out in 2016-17. | CSE/MFH Subgroup | Jul-17 | **Children and YP who are victims of CSE have a range of suitable Services and support to help them** | Work is ongoing. Brathay are attended the December 2016 CSE/MFH Working Group to present ideas for developing the 'Be SAVY' project, which involved their peer leaders deliver CSE awareness raising in schools. Jon Owen from Brathay attended the March CSE Strategic Group to provide an update on the Brathay project. Chelsea's Choice to be shown in schools and other settings w/b 24/4/17 | **G** |
| | 7.4 | Re run the CSE audit activity to show progress against the plan, as part of the Missing from Home MA QAG audit and some dip sampling as part of the ongoing CSE Subgroup work | CSE/MFH Subgroup and<br>Performance Management and Quality Assurance Subgroup | Jul-17 | **The LSCB is assured of the work to Protect children at risk of going missing and of sexual exploitation** | The CSE/MFH Sub Group have undertaken an audit deep dive, this was reported to the Board in March. A 5 minute briefing will be published to share learning. The CSE Working Group will undertake a themed audit in June 2017 and findings will be reported to the July PMQAG. | **G** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
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| 8. Emotional Health and Wellbeing of Children | 8.1 | CYP forum to consider a future session on impact of parental mental health and/or substance misuse. | Communications, Engagement and Participation Subgroup | May-17 | **The LSCB will develop a good understanding of the impact of parental mental health/substance misuse of a CYP Emotional well-being** | Complete no update required | **C** |
| | 8.2 | Through improved links with the Children's Trust Board (CTB), increase the LSCB oversight of CAMHS and the "whole system" approach to Emotional Wellbeing, specifically with regard to emotional resilience for CYP – 1/4ly reporting to be established | LSCB Business Group and CTB | Jun-17 | **The LSCB is assured of the work to improve the emotional resilience of CYP** | CTB received update from EWMH Partnership. Cumbria Transformation Plan developed and available online. The LSCB will receive a further update in the May meeting. | **G** |
| | 8.3 | Review best practice regarding professionals keeping up to date with the changing environment that teenagers' operate within and publicise the results across the partnership and deliver a conference for schools to raise awareness | Education Subgroup | Jul-17 | **Improved knowledge base of partners regarding the environment teenagers operate within** | Conference being developed. On agenda for next sub group meeting. On track for delivery by Jul 17 | **G** |
| | 8.4 | Evaluate the arrangements for safeguarding children and young people within drug and alcohol treatment services in Cumbria as part of the QAG Audit forward plan | Performance Management and Quality Assurance Group | Jul-16 | **LSCB is assured that services for CYP is appropriate** | Substance Misuse Audit was undertaken in October 2016, this had slipped from June 2016 due to more pressing priorities. The findings were reported to the Nov 2016 PMQAG and the March Board | **C** |

| Theme | Ref. | Action | Who | When | What we are trying to achieve | April 2017 updates | RAG |
|---|---|---|---|---|---|---|---|
| 9. Domestic Abuse | 9.1 | Utilise the learning from the service mapping exercise to inform/influence future commissioning | Domestic Abuse Task and Finish Group | Sep-16 and ongoing | **Children who live in households where domestic abuse is a factor will be well supported through appropriate service provision** | Complete no update required | **C** |
| | 9.2 | Undertake a domestic abuse case audit | Domestic Abuse Task and Finish Group | Jan-17 | **Practitioners will understand the response expected for children where Domestic Abuse is a factor** | Domestic abuse audit undertaken 9th January 2017. The Findings will be reported at Feb Business Group and a final report to the PMQAG in March 2017 | **G** |
| | 9.3 | Embed the use of the Barnardo's Risk Assessment tool through a 'train the trainer' programme for practitioners. | Domestic Abuse Task and Finish Group | November 2016 and ongoing | | The commissioning process has been undertaken and awarded to Barnardo's, roll out of the training is planned to commence June 2017. | **G** |
| | 9.4 | Train professionals to aid a consistent understanding of how Domestic Abuse affects children and to give practitioners the confidence to work with domestic abuse.<br><br>Update and further develop training on domestic abuse and sexual assault/ abuse for professionals within the LSCB | Domestic Abuse Task and Finish Group | August 2016 and ongoing | | An advanced DA & SV course has been developed and dates are in place for 2017. A task group has been established to review the DA training offer and will link across to L & I group | **G** |

# 29. Conclusion

The Annual Report 2016-17 demonstrates that the LSCB has further matured and is able to evidence significant improvement across Safeguarding in Cumbria.

The previous Annual Report (2015-16) was praised by the DfE Advisor and the Peer Review in 2016 suggested that the report was fit for purpose and showed good progress.

Highlights this year have included the development of the Children and Young People's Perspectives Board resulting in improvement in the impact of CYP views on the work of the LSCB; advances in learning opportunities with improvements in the training pool; training and take up of the LSCB courses; the accreditation of external trainers.

Further, the LSCB has completed another staff survey and a Safeguarding Audit, both of which show good progress as well as some areas of learning.

The delivery of the LSCB Business Plan 2016-19 has been very successful as can be seen through the update above.

# 30. LSCB Priorities 2017-20

The LSCB will review priorities for 2017-20 and these will be reflected in the new Business Plan.

# 31. Glossary

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|---|---|
| **ABE** | Achieving Best Evidence |
| **CAMHS** | Children & Adolescent Mental Health Service |
| **CCG** | Clinical Commissioning Group |
| **CDOP** | Child Death Overview Panel |
| **ChIB** | Children's Improvement Board |
| **CHOC** | Cumbria Health on Call |
| **CiCC** | Children in Care Council |
| **CLA** | Children Looked After |
| **CP** | Child Protection |
| **CSAB** | Cumbria Safeguarding Adults Board |
| **CSE** | Child Sexual Exploitation |
| **CTB** | Cumbria Children's Trust Board |
| **CQC** | Care Quality Commission |
| **CYP** | Children and Young People |
| **DA** | Domestic Abuse |
| **DBS** | Disclosure and Barring Service |
| **DfE** | Department for Education |
| **EHA** | Early Help Assessment (Common Assessment Framework – CAF) |
| **FGM** | Female Genital Mutilation |
| **HWB** | Health and Well-being Board |
| **ICS** | Integrated Children's System |
| **JSNA** | Joint Strategic Needs Analysis |
| **LA** | Local Authority |
| **LADO** | Local Authority Designated Officer |
| **L&I** | Learning and Improvement |
| **LSCB** | Cumbria Local Safeguarding Children Board |
| **MARAC** | Multi Agency Risk Assessment Conference |
| **MFH** | Missing from Home |
| **NHSE** | National Health Service England |
| **PCC** | Police & Crime Commissioner |
| **PMQAG** | Performance Management & Quality Assurance Group |
| **PMQAF** | Performance Management & Quality Assurance Framework |
| **PPU** | Public Protection Unit |
| **PVP** | Protecting Vulnerable People |
| **QAG** | Quality Assurance Group |
| **RHI** | Return Home Interview |
| **SA** | Cumbria Strategic Assessment |
| **SARC** | Sexual Assault Referral Centre |
| **SCP** | Safer Cumbria Partnership |
| **SCR** | Serious Case Review |
| **ToR** | Terms of Reference |
| **WT** | Working Together 2015 |
| **YOT** | Youth Offending Team |

# 32. LSCB ANNUAL REPORT ON A PAGE

CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

## Annual Report 2016-17

### Achievements

**Business Plan 2016-19** successfully delivered

An increased range of **Quality Audits** with improved practice noted across the county

**Staff Survey** – increased responses and improved awareness of Whistleblowing, Child Sexual Exploitation, Domestic Abuse and Neglect

Well-functioning and engaged **Young People's Group** – actively contributing to the work of the LSCB

Published 5 **Serious Case Reviews** and delivered related action plans – making a real difference to practice in Cumbria

**Inspections** of related services (Police, Heath and Local Authority Ofsted Monitoring visits) show that improvements are becoming embedded

433 responses to the **Safeguarding Audit** (Section 11) utilised in Annual Report – and Learning from Each Other event planned

**Neglect** Conference held with over 180 attendees which launched the LSCB Neglect Strategy in response to a number of Serious Case Reviews

A catalogue of **good practice** case studies has been developed and is on the website

Implementation of **Early Help Panels**

### Performance and Data

Improved **performance** across the whole range of safeguarding indicators for example (2015-16 to 2016-17):

- ✓ Rate of Early Help Assessments – from 196.6 to 206.6
- ✓ Rate of re-referrals – from 20.1 to 17.7 (less is better)

Almost 4000 **multi-agency training sessions** attended (increase from 1400 the previous year)

Over 1,200 followers on **Twitter**

**Newsletters** and **briefings** received by 3,834 practitioners who have signed up for updates

94% of those who had accessed the **Policies and Procedures Manual** found the manual useful and it supported their practice

Multi-agency Facebook chat regarding **Child Sexual Exploitation** - likes, shares, comments & views totalled 114,311 and a reach of just under half a million people

Chelsea's Choice (**CSE awareness** raising for school-age children) attended by over 6,835 children in Cumbria

Widened range of **E-Learning** available with 5,533 completed courses in 2016-17

### View from LSCB Members

Voice of children and young people is more evident in the work of the LSCB

Partnership working has improved significantly and is genuine with good constructive challenge in the system

Collective ownership and cohesive, with good ownership of the partnership working to ensure multi-agency focus on safeguarding children

Strong and determined partnership to develop with significant improvements in the last 3 years

LSCB website is easy to navigate and communication continues to improve

Development of sub groups and the co-ordination of audit is bringing real benefits

Learning from SCR's becoming embedded

Competency of the LSCB team with significant improvements in the administration in the last few years

Continued development of organisational leads in supporting and enabling the work of the LSCB alongside the promotion of multi-agency understanding of the roles of each agency

Continued engagement with the education sector

Feels like a 'one team' approach