CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

# ANNUAL REPORT 2012/13
# AND
# BUSINESS PLAN 2013/14

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# INTRODUCTION FROM THE INDEPENDENT CHAIR

As a result of government policy, there are radical changes in local health and education services. Public Health is now part of the Local Authority, offering huge opportunities across the economy. The Health and Well Being Board is now established and work plan are being developed. Additionally we are awaiting the publication of Working Together 2013 which will further strengthen the role of the LSCB.

These changes provide opportunities for us to improve the way in which we work together to safeguard, and promote the welfare, of children in Cumbria. The LSCB will be involving partners in Education, Health and Police services in developing early help to children. We will be working with the Health and Wellbeing Board to improve the health and wellbeing of children in our local communities.

Whilst these developments will affect safeguarding services throughout the country, here in Cumbria we face the additional challenge of the outcome of the inspections by Ofsted and the Care Quality Commission in 2012. An Improvement Plan for our safeguarding services has been put into action, under the oversight of an Improvement Board. The LSCB and its partners are members of this Board.

In this report we outline how we will work together to respond to these challenges and opportunities. We will do this by creating a culture in Cumbria in which everyone in the organisations with a responsibility for safeguarding children, and in our local communities, understands, and acts on, the basic principle that:

***Safeguarding is everyone's business***

**Allan Buckley**
**Independent Chair**

# INTRODUCTION FROM THE CORPORATE DIRECTOR, CHILDREN'S SERVICES

In Cumbria we have high aspirations for all of our children and young people. We want the best for every child, young person and family. We want Cumbria to be a great place for a child to live and grow up in, a place where young people are able to live happy and productive lives and a place where young people will want to live and work in the future. We recognise that no single agency alone can achieve this vision and we continue to build our partnership arrangements.

The Local Safeguarding Board's role is to provide leadership, support and challenge to partners across the county to ensure that a focus on safeguarding permeates the work of all agencies and has a positive impact on the lives of children. The Ofsted inspection report into Safeguarding arrangements in 2012 are clear that though we have strong representation at the Board, we need to focus on working more effectively as a partnership and strengthening our scrutiny and challenge role. I am confident that there is robust commitment from partners to take this forward. We have made good progress over the last year and the priorities we have identified for the coming year will enable us to move closer to our vision. By working together and listening to children and young people, we will make Cumbria not just a great place, but more importantly, a safe place to be a child and grow up.

**Julia Morrison**
**Corporate Director, Children's Services**

# MEMBERSHIP OF THE LSCB

| INDEPENDENT CHAIRPERSON |
|---|
| Allan Buckley, Independent Chair |

| MEMBERS | | |
|---|---|---|
| **AGENCY** | **ROLE** | **NAME** |
| CAFCASS, Cumbria | Service Manager | Ian Gopsill |
| Children's Services, CCC | Assistant Director – Schools and Learning | Caroline Sutton |
| Children's Services, CCC | Corporate Director | Julia Morrison |
| Children's Services, CCC | Interim Assistant Director – Children and Families | Lyn Burns |
| Churches Together in Cumbria | Roman Catholic Minister | Reverend Chris Barwise |
| Cumbria Constabulary | Detective Chief Inspector | Mike Forrester |
| Cumbria District /Borough Councils | Corporate Director (Monitoring Officer) | Debbie Storr |
| Cumbria partnership Foundation Trust | Director of Operations and Executive Nurse | Andy Roach |
| Cumbria Probation Service | Divisional Manager | Mike Craven |
| Higher Education | Vice Principal | Elaine Price |
| Independent Schools | Headteacher | Gillian Ridgway |
| Inspira | Chief Executive | Mark Bowman |
| NHS Cumbria | Executive Director Lead for LSCB | Professor John Ashton (or Neela Shabde) |
| North Cumbria Acute Hospitals | Acting Director of Nursing Quality and Governance | Chris Platton |
| North Cumbria Acute Hospitals | Designated Doctor Safeguarding | TBC |
| NSPCC | Regional Head North East and Cumbria | Liz Benson |
| Primary Care | General Practitioner | Amanda Boardman |
| Primary Headteachers Association | Headteacher | Claire Render |
| Representing Public Health function | Associate Director | Nigel Calvert |
| Safer and Stronger Communities, CCC | Corporate Director | Dominic Harrison |
| Secondary Headteachers Association | CASH Executive Officer | Terry Hobson |
| University Hospitals Foundation Trust | Executive Nurse | Jackie Holt |
| Voluntary Sector representative | East Cumbria Family Support – Chief Officer | Pam Hutton |
| Voluntary Sector Representative | Barnardos | Richard Simpson (Vice Chair) |
| Youth Offending Service | Acting County Manager | Amrik Panasar |

| OBSERVERS | | |
|---|---|---|
| Elected Member - CCC | Portfolio holder for Children's Social Care | Anne Burns (Chair of CTB) |
| Safeguarding Adults Partnership | Safeguarding Adults Co-ordinator | Linda Mason |
| Cumbria LSCB | Cumbria LSCB Manager | Lynda Maudlin |
| NHS Cumbria | Designated Nurse Child Protection | Louise Mason Lodge |

# CUMBRIA'S CHILDREN AND YOUNG PEOPLE

There are over 108,454 children and young people aged 0 to 19 years living in Cumbria. The number of young people aged 0-15 in mid 2011 was 83,000, the number is forecast to fall by 6.4% by 2035. Of all county councils, Cumbria is projected to have the largest decline in population in people aged 0-15 by 2035.

## Health and social care challenges for children and young people

The rising tide of obesity is one of the greatest threats to health in the UK as we now have amongst the highest proportion of children who are overweight or obese in Europe. Childhood obesity is increasing in Cumbria which can result in children having low esteem and being bullied. In Cumbria a survey of more than 600 Year 6 pupils (aged 10 and 11) reported 21% being bullied because of their size or weight. In recognition of the importance of healthy food choices, the skills of the early years workforce are being developed to enable them to support parents of young children.

## Risk Taking Behaviour

Adolescence is the time when young people start to make decisions about how they live. Opportunities arise to engage in what is known as "risky behaviour" such ass smoking, drinking alcohol, engaging in sexual activity and experimenting with drugs. Cumbria Health Related Behaviour Survey has provided data on young people's behaviour for more than 20 years.

## Smoking

Nearly a third (30%) of 16 to 24 year olds in Cumbria smoke which is similar to the national picture. There is a considerable variation between districts with the highest rates in Copeland (40%) and lowest rates in South Lakeland (14%)

## Alcohol

Boys are generally more likely to drink alcohol up until age 15 when rates become equal in boys and girls. Amongst 15 to 16 year olds in Cumbria 12% of boys and 7% of girls said that they had drunk 21 or more units of alcohol in the week before the Cumbria Survey. Hospital admission rates amongst under 18 year olds for alcohol related conditions in Cumbria are the 4$^{th}$ highest in the 11 primary trust areas most similar in England.

## Substance misuse

Cumbria surveys show that 2% of primary pupils and 18% of secondary pupils have been offered cannabis. 13.4% of 10 to 15 year olds reported substance misuse compared to 12.9% in the North West region and 10.6% in England. Among those aged 15-24 years Cumbria's hospital admission rate for substance misuse is significantly worse than the national average with 119.3 admissions per 100,000 compared to the rate of 63.5 for England.

## Sexual health and teenage pregnancy

A strategic review of sexual health needs and services undertaking in Cumbria in 2010 showed that 89% of 12-20 year olds felt confident they would know where to go if they were worried about their sexual health 59% would like to have access to more information about sexual health, particularly through educational talks. 80% of young people identified a link between alcohol and sexual health. During 2008-2010 per 1000 women aged 15-17 the conception rate was 374. This is below the rate for both England the North West at 38.1 and 37.4 respectively.

## Exposure to unintentional injury

Accidental injury is one of the biggest single cause of death for children aged 1-15 years and is closely linked to deprivation. There is significant concern in relation to the numbers of young drivers who are killed and seriously injured in road traffic accidents. Between 1st January 2010 and 31st December 2011 data from Cumbria Police shows that eight young people were killed and 120 were seriously injured, however, the number of people killed and seriously injured on Cumbria's roads reduced by 15.6% between 2008 and 2010.

## Domestic violence

There were over 6500 incidents of domestic violence reported to the police in Cumbria in 2011, a 15 5 increase on the previous year, 41% of incidents had repeat perpetrators and it is predicted that around 60%remain unreported.

## Emotional and Mental Wellbeing

Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three quarters before their mid 20s. Around 19,000 children and young people in Cumbria are at risk of poor mental health due to life events such as bullying, bereavement, divorce or serious illness. Some children are at greater risk of developing problems with rurality identified as one of the contributors to poor mental health and well being. 28% of Cumbria's young people live in rural communities. Cumbria has a higher rate of suicide and self harm amongst the 1-17 year age range than nationally, with 1-2 suicides per year and 220 Accident and Emergency attendances for self harm. The number of referrals to the Child and Adolescent Mental Health Services (CAMHS) continues to rise which presents a challenge to accessing intervention programmes.

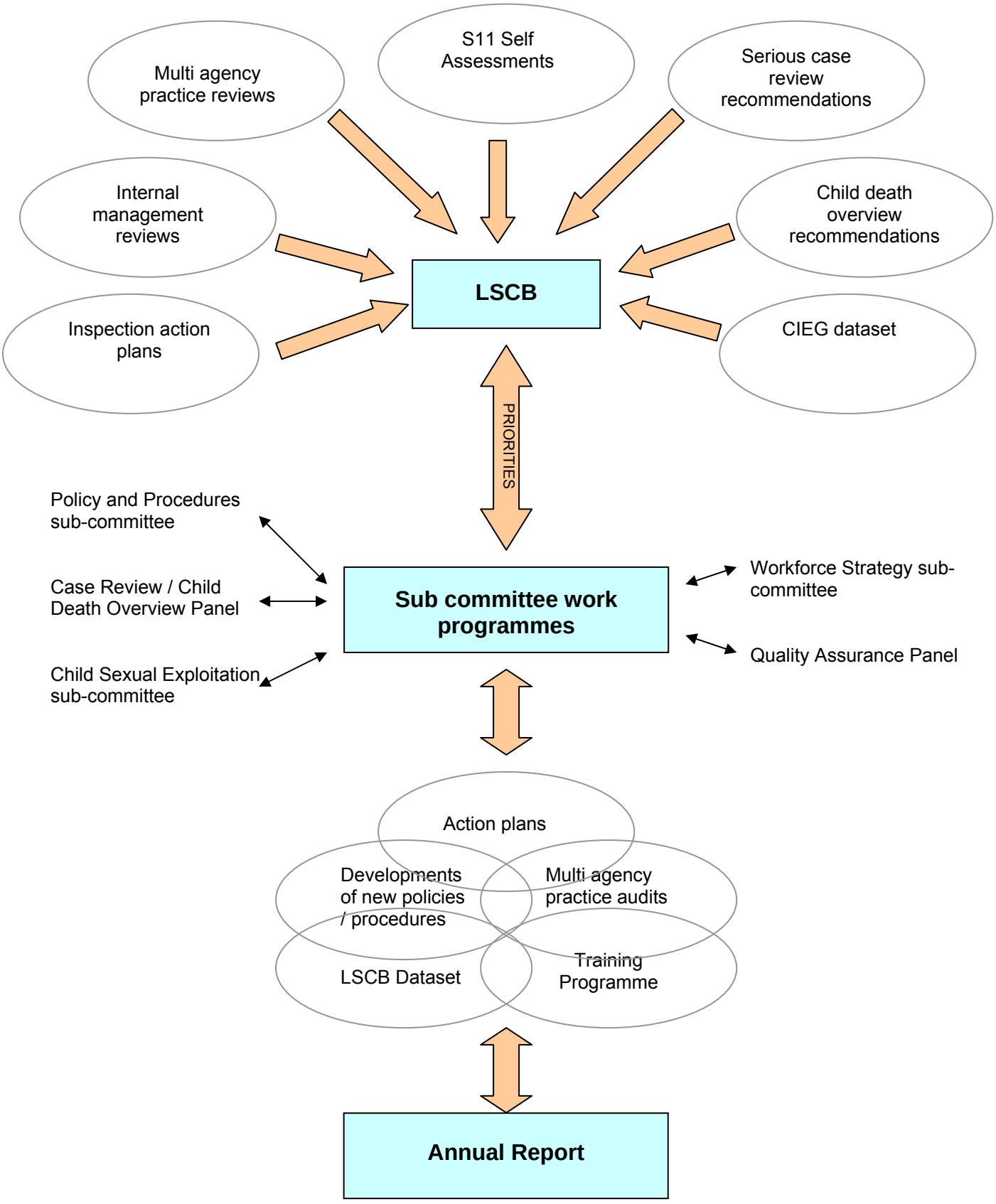
## Views of service users

By using a "parent participation" model parents and professionals are working together to design, develop and improve services for children, young people and their families.

Feedback from children, young people and families pertinent to the LSCB shows:

- Alcohol education and the reduction of extreme risk taking behaviour was a priority for young people;
- There is a need to reduce teenage pregnancy;
- There is a need for services that raise self esteem, confidence and aspirations.
- Parents and carers of children and young people with disabilities have long expressed the view that needs are not responded to in a timely way and that there needs to be significant improvement in the level of integration between health and other services.

# CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD



# THE ROLE OF THE LSCB

The Local Safeguarding Children Board (LSCB) is an independent body. It cannot be absorbed by any of the organisations which are represented on it. Nor can it instruct them about what they should do.

However, the LSCB should properly monitor and challenge the safeguarding arrangements of agencies. Its key roles are:

- Co-ordinating the work of organisations which are responsible for safeguarding, and promoting the welfare of children.

- Overseeing and challenging them in carrying out their safeguarding responsibilities, to make sure that they are doing that work effectively.

- The way in which safeguarding work is carried out is changing significantly. In 2010 the Government asked Professor Eileen Munro to review safeguarding arrangements for children. She produced a wide ranging review of safeguarding services, and the key changes which she proposed can be summarised as:

    - Focussing child protection on the needs and experiences of children and young people.
    - Enabling staff to develop, and use, their skills and judgement, instead of being dependent on procedures.

# HOW THE LSCB WORKS

## THE GOVERNANCE OF THE LSCB

Each local authority is required by the government to have a local safeguarding children board (LSCB).

Whilst the LSCB is an independent body, the Director of Children's Services (DCS) is accountable for its effective performance. The DCS reports to the Chief Executive of the County Council, who is responsible for making sure that the DCS is fulfilling her responsibilities for safeguarding and promoting the welfare of children.

The DCS also works closely with the County Councillor who is the Lead Member for Children's Services. This Councillor is also a member of the LSCB, as a "participating observer".

The DCS and the Lead Member for Children's Services also attend the Children's Trust Board and the Health and Wellbeing Board, whose work is outlined below.

A wide range of organisations –both statutory and voluntary-are represented on the LSCB. They are accountable for:

- Regular and active membership of meetings of the LSCB.

- Making sure that there is effective communication between their organisation and the LSCB.

- Accounting for the arrangements within the organisation, or group of organisations, which they represent for safeguarding, and promoting, the welfare of children.

- Membership of the LSCB also includes two lay members, who:

    - Support stronger public engagement in safeguarding, and a better public understanding of the LSCB's work in local communities.

    - Challenging the LSCB on accessibility by the public, and children and young people, to its work.

    - Helping to make links between the LSCB and local community groups.

Cumbria have a lay member, with a lead on the specific engagement of children and young people and are in the process of recruiting to another member with a focus on public engagement,

Working Together 2013 is now published and has made a number of changes to the roles and responsibilities of the LSCB and its partner agencies including:

- Setting out the expectation that all children and their families should have access to early help services provided by local agencies that will use early assessment models such as CAF and the principle of the of the Lead Professional, underpinned by the three domains of the assessment triangle. Each LSCB needs to have a published threshold document which outlines the types of early help on offer and the criteria for referral to Children's Social Care for statutory services and assessments.

- Defining the safeguarding responsibilities of LSCB partners, including NHS Commissioning Board, Clinical Commissioning Groups and Police and Crime Commissioners.

- Promoting the involvement of children and young people in the work of the LSCBs with a reminder that the local authority must take reasonable steps to ensure that the LSCB includes lay members representing the local community.

- Including the British Transport Police, (Educational) Academy Trusts and independent schools

- The annual report should provide rigorous and transparent assessment of performance and effectiveness of local services. It should identify weak areas, causes, remedial action; lessons learned from reviews; and income and expenditure.

- Setting out a less prescriptive process for conducting SCRs and allows LSCBs the flexibility to select a learning approach which suits the circumstances of the case being reviewed. This will enable LSCBs to use the 'systems methodology' recommended by Professor Munro. The guidance no longer specifies that Individual Management Reviews should be commissioned from all agencies involved with the child; or that there should be a full chronology of the case and a genogram; and there is no longer a standard format for SCR documents. There will be a new Panel of Experts who will assist LSCBs in dealing with the

criteria for Serious Case Reviews and the appointment and review of those undertaking SCRs.

## LINKS BETWEEN THE LSCB, CHILDREN'S TRUST BOARD AND THE HEALTH AND WELLBEING BOARD

The **Children's Trust Board** co-ordinates the planning and development of services for children and young people. It is chaired by the Lead Member for Children's Services. Both the Director of Children's Services and the Chair of the LSCB are members of the Children's Trust Board.
The priorities of the Children's Trust Board are:

- No avoidable child deaths
- No children living in poverty
- All children are ready for school by the age of 5
- Young people are pro-active and productive citizens by age 16
- Children and young people respect and value themselves and each other.

The LSCB has agreed with the Children's Trust Board that performance in implementing these strategic priorities will be a joint responsibility of both boards.

The **Health and Wellbeing Board** is responsible for developing the Health and Wellbeing Strategy and Joint Strategic Needs Assessment for Cumbria (JNSA). The JNSA is the description of the health and wellbeing of the people of Cumbria, and the strategic plans to meet these needs.

The Lead Member for Children's Services and the Director of Children's Services are members of the Health and Wellbeing Board.

Whilst the Chair of the LSCB is not a member of the board, the revised version of "Working Together" requires that the LSCB should link effectively with the Health and wellbeing Board, and the Director of Public Health. Specifically, it should both inform, and draw on the Joint Strategic Needs Assessment, and should present its annual report to the Health and Wellbeing Board.

The Health and Wellbeing Board, Children's Trust Board, and the LSCB have clear remits for safeguarding and promoting the welfare of children, which each relate to the levels of preventing harm to children outlined in the Munro report:

**Universal/Primary Prevention: The Health and Wellbeing Board.**
The remit of the **Health and Wellbeing Board** is to improve the health and wellbeing of the people of Cumbria as a whole, including children and young people.

**Selective/Secondary Prevention: The Children's Trust Board.**
The remit of the **Children's Trust Board** is to co-ordinate the development of services specifically for children and young people.

**Tertiary Help/Prevention: The LSCB**
The remit of the LSCB is to co-ordinate and scrutinise the safeguarding and early help work of local organisations with responsibility for safeguarding and promoting the welfare of children.

**Figure 1** in the Business Plan shows the links between the three boards, and the plan to connect and co-ordinate their future work.

# LSCB SUB-COMMITTEES

| **Name of Sub-Committee:** |
|---|
| **Child death overview panel and Case review Group**. |
| **Terms of Reference:** |
| **Terms of Reference: CASE REVIEW GROUP**<br>• To consider, and where appropriate, recommend to the LSCB with regard to the criteria being me to hold a Serious Case Review.<br>• To consider the need to carry out a practice review<br>• To monitor the implementation of LSCB actions following a Serious Case Review.<br>• To provide direction to the DDG and QAG with regard to implementation and Quality Assurance of LSCB actions from Serious Case Reviews.<br>• To collate single agency responses to the actions following serious case Reviews.<br><br>**Terms of Reference: CDOP**<br>• Reviewing all deaths up to the age of 18, excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law<br>• Collecting and collating information on each child and seeking relevant information from professionals and family members<br>• Discussing each child's case, and agreeing who will provide feedback to the family, in an appropriate and timely manner<br>• Determining whether the death was deemed preventable and decide what, if any, actions could be taken to prevent future such deaths<br>• Making recommendation to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible<br>• Identifying patterns or trends in local data and reporting these to the LSCB, and<br>• Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required. |
| **SERIOUS CASE REVIEWS:** |
| SCRs regarding Child G (Completed) and Child J (Ongoing) |
| **IMPACT AND OUTCOME:** |
| The practice review model will be reviewed in light of the learning from experience and feedback from practitioners involved.<br><br>Involving front line practitioners across the agencies will improve Safeguarding practice and working together which will support keeping children safe in Cumbria.<br><br>Reviewing child deaths will identify patterns of concern and inform the need for service improvement and focused public health campaigns |
| **FUTURE PRIORITIES:** |
| Ensure timely submissions of chronologies and IMR's by agencies |

Ensure attendance at SCR meetings and practice reviews by relevant staff.

The subcommittee will to continue to update and monitor the SCR Thematic action plan to ensure all learning from reviews is captured and addressed by relevant partners and staff.

To use shared funding to provide IMR training for key agencies.

SCR into the death of HH (Child J)

Conduct practice reviews into cases : EE RE JG

**Name of Sub-Committee:**

**Quality Assurance Panel**

**Terms of Reference:**

1. To develop and maintain a system to identify key themes taken from serious case reviews, locally and nationally.
2. To develop an audit tool to gather evidence to measure whether lessons learned from case reviews are being embedded in practice and make a difference in terms of outcomes for children.
3. To contribute to the development of those parts of Cumbria's Improvement Plan relating to:
   - Ensuring that the child's voice informs individual plans and the work of the LSCB (SG 13);
   - Developing and implementing robust quality assurance systems (SG 5)
   - Ensuring that learning from serious case reviews is embedded(SG 12);
4. To establish quality measures of safeguarding practice based on:
   - The experiences of children and young people.
   - Key themes taken from serious case reviews, locally and nationally.
   - The findings of the Ofsted Report of April 2012/June 2013.
5. To establish and maintain communication and co-ordination with the Children's Trust Board's Impact and Evaluation systems.
6. To report on the outcome of quality audits to the LSCB, and make recommendations for action arising from the audits.
7. To advise the Board on how to hold partner agencies to account, singly and on a multi-agency basis, for the quality of their safeguarding practice, specifically focusing practice on the needs and experiences of children and young people.

**ACTIVITY COMPLETED BY THE GROUP:**

1. The district Quality Assurance Groups (QAGs) have undertaken three multi-agency audits since the formation of the groups, to a programme agreed by the QAP. These were informed by issues from Serious Case Reviews (SCRs), from papers presented to the LSCB and performance information.

2. The QAP has supported the delivery of more consistent processes across the QAGs. For example:
   - delivered SMART action plans after each audit;
   - expanded the core membership of the local QAGs to include more consistent

representation from schools (primary), Police, Health, VCS sector and Children's Centres;
- ensured robust follow-up on specific actions arising from each audit, at both a QAG and county level; and the reporting of audit findings, action plans and impact reports to the LSCB and SIB;

3. The focus of the first QAG audits was on ***Children Subject to Pre-Birth Assessments***, drawing out good practice as well as common themes for QAP/LSCB action and others requiring action at a District Delivery Group or single agency level;

4. Each QAG developed an action plan clearly identifying those areas where further development and improvement in practice was required, as evidenced by the audits. Examples include:
   - ***Effectiveness of the case conference process*** *There should be multi-agency training around conference, core groups and standardisation of reports and plans to make sure that the processes are robust enough to make care planning meaningful.*
   - ***Adult focus*** *The Assessments sometimes focused too much on physical risks to the adults of Domestic Violence but lacked a child focus and an understanding of emotional abuse.*
   - ***Information sharing*** *There were some gaps in information sharing due to some gaps in attendance at multi agency meetings. Needs to review invitation to strategy meetings as some key agencies not invited and this was felt to be a missed opportunity.*
   - ***Conflict resolution*** *There should be an agreed escalation procedure owned by the LSCB in order to have a clear process for managing conflict.*
   - ***Thresholds*** *There should be robust links between Child Protection Teams and universal services to move into CAF to ensure continuity of support.*

5. A report summarising the findings and learning from the first QAG audits was produced for reporting and action to the QAP, LSCB and CIB;

6. The second QAG audit focussed on the effectiveness of intervention with ***young people engaging in risk taking behaviour*** in recognition that this group continues to be a challenge for services.

   - This audit identified some positive improvement in using the CAF as a tool (half of the cases in the Allerdale and Copeland sample) and some evidence of sound supervision and recording practice.
   - However, conversations with young people as part of this audit showed that there continue to be some challenges around engaging this age group.
   - There was also close link with this group of young people and the risk of self harm and suicide. The message from the young people was that wanted practical support not so much discussion, the purpose of which they didn't always understand.

7. Linked to the audit above, a more consistent approach to engagement of young people in the audits has been developed and rolled out, supported by the CYP Engagement Officers. Using their stories to improve practice quality and providing evidence of robust challenge on behalf of CYP, and reflecting this in local audit reports

8. A multi-agency audit tool and protocols have been developed and refined to capture learning from the QAP commissioned audits;

9. Audit 3 focussed on the quality of assessment work with children and young people who are ***known to self- harm and to be at risk of suicide***. This was recognised as an area of concern across Cumbria and is a priority in the LSCB business plan for 2013/4.

    - These audits have shown that when engagement with services occurred there was a positive outcome for the young person, however, non-engagement was a common theme.
    - PAC (Positive Alternative to Custody), Inspira and sexual health services engaged well with young people by using alternative methods of communicating such as texting. It is also important to have appointments at flexible times that suit young people.
    - A number of the cases had been referred and open to CAHMS but subsequently closed due to lack of engagement.
    - Findings from the audit included the need for all staff working with teenagers to be trained in dealing with self-harm and suicide and a clear pathway for risk escalation and information sharing to be implemented within Cumbria Partnership Foundation Trust and shared with Children Services.
    - The participation strategy will also seek to identify and develop more creative ways of engaging with young people.

10. The QAGs have recently reviewed their methodology and process which has been used to measure impact for children and young people and to develop proposals for priority audit themes and further develop the framework for this through to March 2014. The outcomes of this will be reported to the August 2013 LSCB Board meeting.

11. The QAP/QAGs have also contributed to:
    - the Peer Challenge on Performance and Quality undertaken by the Durham team;
    - the recent LSCB Development Day; and
    - recent Ofsted Inspection of arrangements for safeguarding children

**IMPACT AND OUTCOME:**

1. A recent review of the QAGs following the first three multi-agency audits found that the Audits had changed practice through specific identified actions but not yet clear whether or how this has had an impact on individual children/young people and families.

2. To maximise the impact of audits, the QAGs have asked for more specific guidance withint he specification for each audit as to how to  How do we measure impact – some things are measureable

3. An agreed framework for holding conversations with children and young people has been developed, as a feature of this audit process to make sure the Board listens to the voice of the child. This has now been used for subsequent audits.

4. A conflict resolution protocol which is now operational.  The LSCB will audit the effectiveness of this protocol via the Policy and Procedures sub-committee and will report this back to the LSCB;

5. A draft pre-birth risk assessment tool that has been sent out for consultation in order to be adopted across the partnerships;

6. A participation event has been planned for July 2013 bringing together members of the QAGs, Audit and Practice Development team and participation leads across the agencies in order to develop a joined up participation strategy to address the issues young people have raised across the audits.

7. The LSCB have endorsed the threshold document and supported the development of the central triage team recognising that there needs to be a common understanding of help and intervention. Future audit activity will be used to clarify whether that the application of thresholds is effective and whether the development of the central triage team has improved the quality and consistency of response

8. A task and finish group of the LSCB has met regarding child sexual exploitation. This group has recommended to the LSCB that there is a standing sub-committee to focus on this group of vulnerable children, making the link also with children going missing and children at risk of trafficking. The group will work to a common data set, develop a communication and training strategy and will contribute to the auditing activity of the QAGs.

9. Four of the young people in the Carlisle and Eden sample were identified as young carers, looking after parents with either mental health issues or alcohol dependency. The QAG have arranged to talk to a group of Young Carers about what extra support they require.

10. There was a clear link between children missing from home and a concern around the lack of return to home interviews in order to understand why the young person had gone missing. The protocol agreed by the LSCB regarding Children going Missing now includes a template and an expectation on all staff to record the interviews. The quality of these interviews will be a feature of the sub-committee focusing on children at risk of going missing, sexual exploitation and trafficking.

**FUTURE PRIORITIES:**

1. Future planned multi-agency audits (one each quarter) include:
    - Domestic Violence – in particular children in need plans where there is repeat domestic violence
    - Re-referrals – to find out the story behind the higher rate
    - Missing from home and school – focus on learning from SCRs and sexual exploitation

2. Terms of reference for the QAP and QAGs to be extended to include themes arising from performance data and other quality assurance activity and not solely those from SCRs.

3. Specifications for future audits to include a section on the intended outcomes and impact of the audit work.

4. Timescales for audits to include a better balance between time to conduct multi-agency audits and time to take forward the local actions from earlier audits, to ensure that that changes in practice are embedded to secure the best possible outcomes for children.

5. The need to ensure that the links between the QAGs and DDGs and district managers in the key agencies, work effectively in relation to taking forward the local actions arising from audits.

| **Name of Sub-Committee:** |
|---|
| Policy and Procedures |
| **Terms of Reference:** |
| • To commission and recommend for approval by the LSCB, Policies and Procedures that result in effective multi-agency working together to safeguard and protect the children and young people of Cumbria<br>• To ensure the robust review of existing Policies and Procedures in the light of local and national serious case reviews, changes in legislation and statutory guidance to ensure compliance<br>• To ensure efficient and effective consultation regarding draft Policies and Procedures<br>• To have responsibility for the accuracy and updating of the Cumbria LSCB website<br>• To recommend actions for other sub-groups to ensure effective communication, understanding, implantation of Policies and Procedures and the monitoring of Practice<br>• To ensure consistency of other agencies' Child Protection Policies and Procedures through a Section 11 process |
| **ACTIVITY COMPLETED BY THE GROUP:** |
| In the past year, we have:<br>a. Undertaken ongoing reviews of existing Policies and commenced the task of responding to the revised Working Together in terms of these policies<br>b. Commissioned a fundamental review and rewrite of the Domestic Abuse Policy<br>c. Received a fundamental review and rewrite of the Runaways Policy and SUDI Protocol<br>d. Undertaken a short questionnaire and analysed the results regarding views on the current LSCB website<br>e. Given thought as to how we could assess the impact of the introduction of a new Policy such as the Runaways Policy<br>f. Undertaken a Section 11 Audit and explored alternative ways to undertake the Audit next year<br>g. Commissioned and introduced a Conflict Resolution/Escalation Policy |
| **IMPACT AND OUTCOME:** |
| A number of the Tasks above have been intended to have significant Impact and Outcome. The survey regarding the website demonstrated that, in the main, the website has a positive impact on those who use it. Our approach to the introduction of the new Runaways Policy will help us understand how and if new policy impacts on practice, etc. The Section 11 |

Audit helps us to know whether agencies are compliant around Child Protection and Safeguarding. We expect that the Conflict Resolution/Escalation Policy will have a very great impact in helping to deal with some of the tensions and problems we know are around thresholds, etc.

**FUTURE PRIORITIES:**

Our Priorities for the coming year will include:

a. Continuing the task of ensuring the current suite of policies are in line with the new Working Together and adding to the suite if required
b. Analysing the results of our attempt to assess the impact of the introduction of the new Runaways Policy
c. Explore ways to improve and enhance the Section 11 Audit process
d. Analyse the impact of the first year of operation of the Conflict Resolution/Escalation Policy

## Single and Multi agency training provision

Description of provision, evidence for and evaluation of effectiveness
Changes made as a result of previous learning , priorities and new developments
Fit with and contribution to the LSCB priorities

## Section 11 audit

The section 11 self assessment was overseen by the Policy and Procedures sub-committee of the LSCB. School returns constitute a return of 24% of LA maintained schools and academies in Cumbria. (The audit was sent to all independent schools, but no returns have been received.) The school responses in the assessment returns did not evidence a shortfall in Section 11 compliance. Zero no responses were recorded. 17 (2%) partly responses were recorded out of the total 780 fields completed. These indicated that some schools need to take up basic training for staff and governors, and inter-agency training for designated staff. The key themes from the comments section were that some governors needed to access training and some schools' needed to review their child protection policies.

The Agency responses in the assessment returns did not evidence a shortfall in compliance. The vast majority of fields were completed as compliant. Where agencies said that action was completed this did not constitute an overall pattern but a single issue for the agency concerned. Copeland Borough Council was the only agency that reported that they were not compliant. They were though following the assessment in the process of agreeing an action plan to resolve the matter.

Twenty Eight (25 on the agreed form) returns is a small sample of the total agencies in Cumbria who have contact with children. However the key agencies in Cumbria did complete the self assessment.

Quantitatively it does appear that the virtually all agencies that responded are Section 11 compliant. However there are individual issue for agencies, are detailed in their action plans. These individual issues do not form a pattern across the County.

Themes that appeared on more than one occasion across agency action plans were;

- access to and training of staff;
- safely commissioning services; and
- the recruitment and induction of staff.

The LSCB have agreed that:

- That Copeland Borough Council is supported in the completion of their action plan.
- That the LSCB adopt the Virtual College, Safeguarding Children e-academy Online Section 11 /CQC audit toolkit to enable more effective support and scrutiny of Section 11 compliance than a paper based exercise. It may also lead to more agencies completing a Section 11 self assessment than the current sample.
- Examples of excellent policies e.g. Barnardos, NSPCC and the Police are stored with our agencies so reference can be made to them when updating policies in the future.
- That completion of each individual agency action plan is checked by the LSCB at six monthly intervals until completion.

**Description of approach and framework used and impact on learning and priorities.**

## Case Review and audit Function

The LSCB have combined the case review and child death overview functions in order to develop a culture of continuous learning from these processes. There are four types of review agreed and implemented by this group:

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

The LSCB have adopted the scie review process in order to review the death of a young person known as Child J The findings from this review will be available to the Board in November 2013.

A Practice review was completed and reported to the LSCB in May 2013, by the independent author (Child G), and produced the following learning with the involvement of the front line practitioners who had worked directly with the family:

*Single agency cultures did not promote multi agency working*

- *Lack of* sufficient multi agency assessment

*There was a limited* focus on the need for change
*Child G was not kept at the heart of multi agency decision making*
*A failure to implement Looked After Children regulations*
*A lack of understanding of the fact that Adolescents and Older Children need to be assessed for services based on vulnerability and risk*

The LSCB will hold member agencies to account for taking forward the agreed actions from this review and will share the learning within the "learning from review "workshops.

Four more practice reviews have been commissioned with an identified lead from the Case Review/CDOP sub-committee. The learning from these reviews will be shared with the relevant sub-committees of the LSCB and presented at the quarterly learning from review workshops focusing on first line managers across the agencies.

## CDOP

## Detail from annual report

# OUR PRIORITIES 2012/3

## PROGRESS AND ACHIEVEMENT

### Priority 1 – Developing and maintaining an effective partnership

| *Sub-objective* | *What the LSCB achieved* | *What needs to be done* |
|---|---|---|
| The LSCB will have an effective strategic overview of arrangements across all agencies to safeguard children and promote their welfare. | The Section 11 self assessment has been completed by 30 agencies and reported to the Policy and Procedure sub-committee indicating that agencies are complying with their responsibilities under Section 11. Only 1 agency return showed urgent actions required to address lack of compliance. The return from schools was only 25%. Children's Services staff have now visited 304 of 324 schools to follow this up.<br><br>The LADO Service has received and managed a rising number of referrals. Awareness of LADO is now much greater. 110 referrals to 145 over the year 12-13.<br><br>The LSCB held a development session on the 1st February 2013 allowing LSCB members to work together to focus on the impact and effectiveness of the LSCB and agree ongoing actions. | LSCB to monitor completion of agency Action Plans and ensure that good practice examples are shared.<br><br>Children's Services to follow up requests for support from schools.<br><br>Review the adoption of an electronic audit tool to increase the returns of the section 11 audit.<br><br>LSCB members will work together in 6 monthly development sessions to scrutinise safeguarding arrangement for the authority and to identify priorities for LSCB business. |
| The LSCB will produce clear understanding amongst all member agencies of their roles and responsibilities in relation to the LSCB. | An LSCB member's induction package has been developed which includes clear roles and responsibilities.<br><br>Conflict resolution protocol has been developed and is live across the partnership<br><br>360 review and appraisal of LSCB Chair have been conducted by DCS. | An annual review will take place with every member of the LSCB to identify the extent to which they have been able to fulfil their role as a Board member.<br><br>Each member of the Board will be expected to have completed multi agency training and to evidence ongoing professional development in relation to safeguarding children.<br><br>Analysis of Conflict Resolution protocol will take place. |
| The LSCB will | The sub-committee structure has | The structure will be further |

| *Sub-objective* | *What the LSCB achieved* | *What needs to be done* |
|---|---|---|
| develop an effective sub-committee structure with members able and committed to delivering on the business plan of the board. | been reviewed in order to cover all of the key objectives of the LSCB,<br><br>Each sub-committee has terms of reference and is chaired by an LSCB member who produces a progress report evidencing impact against their priority actions. | strengthened by the development of a sub-committee focusing on missing children, child sexual exploitation and trafficked children. |

**Priority 2 - Strategic objective: To ensure that the child's' voice, their experience and needs are clearly recorded and used to inform their individual plans and the work of the LSCB – this will be evidenced in all of the business of the LSCB**

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What remains to be done*** |
|---|---|---|
| The Safeguarding Board will identify a group of young people who will be in a position to inform the work of the LSCB | The LSCB has developed a link with the Cumbria Children in Care Council who have helped the LSCB to understand what children feel is meant by risk taking behaviours and how children could be kept safe. 18 young representatives of the three districts CiCC's worked with the LSCB Chair, Lead Member and LSCB Business Manager to identify issues and solutions. The Chair of the LSCB thanked and fed back to the young people in writing. | The LSCB will further develop the participation agenda building on the feedback from the Cumbria CiCC. The Board will hold a participation workshop including the Quality Assurance Groups, Agency leads for participation and Independent Reviewing Officers to develop a partnership participation strategy alongside maintaining the relationship with the Children in Care Council. This strategy will be 'youth proofed' by the CiCC prior to implementation. |
| The LSCB website will be an effective safeguarding information hub for practitioners, children and young people, parents and carers and the general public. | The LSCB website has continued to function as the information hub for policy, procedures and new safeguarding developments. The LSCB Online Code of Conduct for Staff is embedded across in-house and commissioned youth services provision including the CiCC. There have been discussions with companies regarding the redesign of the site. | The LSCB website to be developed into an interactive site with resources available for both practitioners and the public with a particular focus on information for children and young people. |
| The LSCB will ensure that all the child's voice is always present in the assessment and planning process | The Quality Assurance Groups have carried out three thematic audits and have built into the process conversations with young people placed in and out of county in order to measure the effectiveness and perception of the services provided. The key message from young people is the need to be listened to as 'young people' as well as focusing on their care, health and education plans. The draft tool to gather the views of children and young people is out for consultation. | Auditing activity will continue to involve children and young people with regular reviews built into the process to ensure the voice of children and young people is being considered and addressed in service planning and policy development. This will be further enhanced by a method of going back to young people to tell them what impact their involvement has had. Feedback from young people will influence the LSCB participation agenda and strategy. |

| | | |
|---|---|---|
| The LSCB will recruit a lay member with a remit for Children and Young People | The LSCB has recruited a lay member with a focus on engaging children and young people the other on communities. LSCB members have developed the job description and profile and will provide “buddies” for the lay members. | The lay members will have a full induction programme which will include multi agency training and being involved in at least one of the sub-committees of the LSCB. |

**Priority 3 – Strategic objective: To ensure that the arrangements for privately fostered children are robust and that effective scrutiny of these arrangements by the LSCB is in place.**

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What remains to be done*** |
|---|---|---|
| The LSCB will be confident that partner agencies; third sector organisations and commissioned services are aware of private fostering and the notification system. | The private fostering coordinator has provided a communication strategy to the LSCB which includes resources for partners to raise awareness within their own organisations. The recent survey of impact of this strategy shows that 84.6% of respondents have displayed the materials in their workplace and have briefed staff this has resulted in a 15.4% increase in notifications of Private Fostering arrangements. | Conduct a High profile National Fostering Week campaign in June 2013.<br>Revisit the impact of the initial publicity and follow up survey requests for further support. |
| The LSCB will be confident that relevant training practices are developed and followed up at a multi agency level | Multi agency briefings have been made available in order to raise awareness of private fostering. The LSCB website has been updated to include definitions and guidance. | The Private Fostering E-Learning package will to be publicised within CCC and become part of staff induction. |
| The LSCB will receive an annual private fostering report submitted by the local authority. | The LSCB has received the annual report and a 6 monthly update on progress which has included data and the outcome of auditing activity. This shows that over the last year the timeliness of action taken within 7 days of notification has improved from 19% in 2011 to 40% in 2013. 90% of initial visits to Privately Fostered children take place within 12 weeks. This is an improving picture. | Improve the timeliness of Action undertaken within 7 days to be at least at National averages. (from 40% to 77%)<br>Meet 6 week Reg8 visit expectation to be at least in line with national – improvement required from 46% – 65%<br>LSCB to monitor these indicators quarterly and hold partners to account. |
| The voice of the child will be heard within Private Fostering arrangements**.** | Practice guidance is clear on the involvement and engagement of children and young people. Auditing activity includes conversations with young people on their experiences in order to improve practice in this area. | The audit will to be completed and the annual report compiled. The audit will check to see if the Voice of the Child has been recorded and will highlight this in the annual report. |
| Cumbria Safeguarding Children Board members are to evidence how they | LSCB members have identified a lead within their own organisations and have advised | LSCB members will be asked via a questionnaire to describe how they have publicised Private Fostering |

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What remains to be done*** |
|---|---|---|
| have promoted private fostering within their own organisations. | the private fostering co-ordinator how they have raised awareness. | in their organisations. |

**Priority 4 –Strategic objective: To ensure that learning from serious case reviews is embedded in policies and practice and that the impact of training is fully evaluated.**

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What is still to be done*** |
|---|---|---|
| The LSCB will be confident that agencies have implemented the actions from serious case reviews. | The outstanding actions from serious case reviews were combined into a thematic action plan. Members provided evidence on implementation of the actions and the themes were used by the Quality Assurance Groups for multi agency audits and by the Policy and Procedures sub-committee to update their work plan.<br><br>Posters succinctly detailing the key learning from SCRs have been produced and widely disseminated across agencies.<br><br>The Case Review/Child Death Overview Group reviewed the overarching LSCB actions both in respect of the Board and the relevant agencies | The LSCB have adopted the (SCIE) systems approach for the current serious case review. The Case Review Group has developed a practice review model in order to establish a culture of continuous learning. The learning points from the reviews will be translated into SMART action plans and a communication strategy.<br><br>Child G will report to the May 2013 LSCB meeting<br><br>Child H will report to the September 2013 LSCB meeting. |
| The LSCB will know that policies and procedures have been reviewed in light of serious case reviews, that staff are aware of and have access to the procedures and that they are implemented | The Policy and Procedures sub-committee revised their work plan in view of the learning from serious case reviews and within the Section 11 self assessment clarified that staff have access to procedures. | Policy and Procedures will be updated in light of Working Together 2013<br><br>The Policy and Procedures sub-committee will undertake an audit to establish whether frontline practitioners have access to procedures within their workplace. The Quality Assurance Groups will audit compliance with procedures within their thematic audits. |
| The LSCB will be confident that the learning from serious case reviews is communicated in single and multi agency training. | Multi agency training has included the themes from serious case reviews. The workforce development sub-committee is developing the training strategy for 2013-14 which included the learning from serous case reviews. In the year 2012-13: 2019 staff from across agencies completed core training in Awareness of Child Abuse and | The action plans from practice and serious case reviews will be used to updating the training strategy with specific events focusing on themes from learning. |

| *Sub-objective* | *What the LSCB achieved* | *What is still to be done* |
|---|---|---|
| | Neglect. 558 completed Foundation Level training in Child Abuse and Neglect. | |
| The LSCB will be assured that the training provided is fully evaluated and has an impact on practice. | Childrens Workforce strategy group is incorporating an impact evaluation tool within the training plan/strategy. | The Childrens' Workforce sub-committee will provide the LSCB with Impact evaluation of training on a six monthly basis in order to measure the effectiveness of training. |

**Priority 5 – Strategic objective: To expand local arrangements for child death**

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What is still to be done*** |
|---|---|---|
| The protocol will be in line with government requirements and to provide appropriate guidance for all of the agencies | The Review/Child Death Overview sub-committee have developed a draft protocol in light of learning from serious case reviews and review of child death arrangements. | The draft protocol will be revisited in order to comply with Working Together 2013. |
| The LSCB will review and update terms of reference and procedures, and reconfigure processes as necessary in line with available resources and government requirements | Terms of reference and procedures have been reviewed. The designated doctor and nurse have planned a series of work shops to implement the procedure. | Agencies will be invited to attend district based workshops following the "signing off" of the protocol by the LSCB. |
| Ensure findings from child death overview are reported and disseminated through local, regional and national forums, and lessons learnt locally | The annual report relating to child death is being drafted. The LSCB have linked with both the North West and North East LSCBs to capture regional data and learning. | The annual report will be presented to the LSCB meeting in July 2013. |
| Continue to improve work with all relevant agencies and parents to inform and involve them with the work of the panel, and improve the learning from reviews | Relevant agencies are represented on the panel and involved in the review process. Parents/carers are invited to participate in the review by letter and follow up conversation. The learning from these conversations is included in the annual report. | The learning from reviews will be shared in the annual report and actions taken forward by the relevant sub-committees. |

## STRATEGIC PRIORITIES TO IMPROVE THE HEALTH AND WELLBEING AND SAFETY OF CHILDREN AND YOUNG PEOPLE IN CUMBRIA

### 1. Improving the Mental Health and Wellbeing of Children and Young People

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What is still to be done*** |
|---|---|---|
| The Lead member for Children's services, the Director of Children's Services and the chair will ensure that appropriate attention is given to this priority by the Health and Wellbeing Board. | *The H&WB Strategy now reflects the safeguarding priorities of the LSCB.*<br><br>*Children are represented as a specific priority within the strategy.*<br><br>*The Suicide Prevention Strategy has been endorsed by the Health and Wellbeing Board* | *The LSCB will establish effective governance arrangements with the Health and Wellbeing Board.* |
| There is effective linkage between the LSCB, the Health and Wellbeing Board<br>and the Children's Trust Board. | A guide to partnership working in Cumbria has been devised and disseminated.<br><br>A Tri-Board development Day saw the launch of the Multi Agency PMQAF and agreed joint priorities for action.<br><br>Robust challenge has been provided to the Partnership Trust CAMHS Review and Plan, this has resulted in a more appropriate service specification. | |

### 2. Addressing Suicide and Self Harm by Children and Young People

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What is still to be done*** |
|---|---|---|
| The LSCB will actively engage with the Cumbria Suicide Prevention Strategy. | *Rates of admission to hospitals for self harm has reduced from the high point in 2010/11 from 19.9 to 15 per 10,000.* | *This will continue to be a priority area for LSCB business with an expectation that agencies will increase their awareness of the issue and have clear pathways for support for both the child and family.* |
| There will be an expectation on partner agencies to demonstrate involvement in the strategy, notably in the | *The QAP has undertaken an Audit – Children at risk of self harm and suicide. Key triggers and priority actions have been identified on an area and* | *Review progress on action plans.* |

| | | |
|---|---|---|
| areas of training and awareness, and pathway development. | *individual agency basis.*<br><br>*The QAP has undertaken an Audit of 10 cases – Teenage risk taking behaviours. As a result a framework for holding conversations with children and young people has been developed.*<br><br>*Multi agency training has been delivered on suicide and self harm.* | |

## 3. Sexual Exploitation of Children and Young People

| ***Sub-objective*** | ***What the LSCB achieved*** | ***What is still to be done*** |
|---|---|---|
| Cumbria LSCB and Adult Safeguarding Board will monitor the progress of the Safer Cumbria Action Plan on Sexual Exploitation. | A task and finish group of the LSCB has been established regarding child sexual exploitation.<br><br>A risk assessment tool regarding sexual exploitation and trafficked children is being developed for front line practitioners to inform their assessment processes.<br><br>A Tackling Sexual Exploitation in Cumbria conference took place on the 21st February 2013, which was well attended with delegates taking forward individual agency actions which will be followed up in order to evaluate the impact of the event.<br><br>An example of good practice has been Operation Meadow in Carlisle. There was significant engagement and one child even said they stopped running away because of the visit. Another was readmitted to school. | We will "map" how we can measure the impact of the Children and Young People who go Missing or Runaway from Home or Care. |

# LSCB BUDGET

In 2012-3 partners made the following contributions to the LSCB

| **Agency** | |
|---|---|
| Children's Services (staffing/board support) | £93,790 |
| Health | £61,079 |
| Probation | £10,180 |
| Police | £10,180 |
| CAFCASS | £500 |
| SCIE Contribution | £10,300 |
| **TOTAL** | **£185,529** |

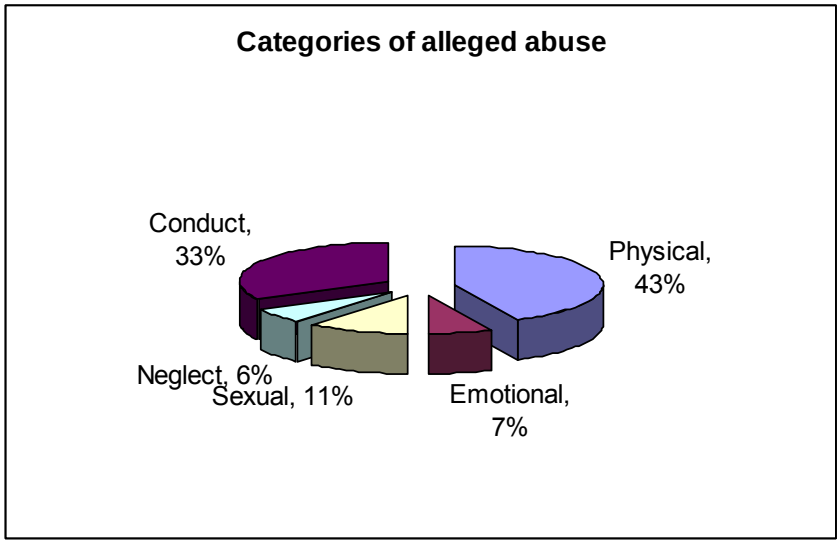
# LOCAL AUTHORITY DESIGNATED OFFICER

**An overview of LADO activity for 2012-3**

## Allegations against professionals

The Local authority designated officer (LADO) service is currently provided by two full time LADO's. The business year saw a significant increase in the level of allegations against individuals working with children across Cumbria which has seen LADO activity rise steeply. The LADO service has received and managed 616 referrals between April 2012 and March 2013. This is a hefty increase on the previous year when 296 cases were reported. Figure 1 provides a breakdown of the nature of the allegations received. A number of underlying reasons are attributable to this increase in allegations which are outlined below.

**Figure 1. Categories of alleged abuse 2012 - 13 :**




- Raising awareness supported by bespoke training sessions with key safeguarding partner agencies in the districts to enhance understanding.

- Review of the Minor Injuries Protocol (MIP) and the establishment of the County triage arrangements.

the recent publicity regarding high profile cases such as Jimmy Saville and Stuart Hall, has created an increase in the number of professionals contacting LADO for advice and reporting incidents which they are worried about. Some of these historical concern cases have led to professionals are or have been in a position of trust with children being prosecuted and receiving high tariff custodial sentence

# PRIVATELY FOSTERED CHILDREN

**an overview of private fostering activity for 2012-3**

**Private fostering**

Following the 2012 Ofsted Inspection findings the LSCB have ensured that arrangements for Privately Fostered children are robust and have effectively scrutinised the arrangements. There have been a number of areas that have been actioned on the basis of the Safeguarding Improvement Plan. Even with increased publicity this year, however, there has not been an increase in notifications. The figures are monitored monthly by the Lead Officer who reports progress internally and to the Children's Service Improvement Board. The Lead officer has carried out an audit of private fostering cases and has identified a need to improve on compliance with visiting within timescales and the quality of recording. The actions for improvement have been reported to the LSCB who will monitor compliance with the agreed actions. All private fostering notifications with be directed through the County Triage Team.

## Introduction

This Business Plan for 2012/13 is designed to support Cumbria Local Safeguarding Children Board in achieving its aims in the forthcoming year

## Statement of Intent

Cumbria Local Safeguarding Children Board will provide strong and effective leadership in order to:

- coordinate and ensure the effectiveness of the work done by agencies for the purpose of
- safeguarding and promoting the welfare of children and young people.

The Board aim to ensure that Children and young people in Cumbria are safe from:

- Maltreatment, neglect, violence, exploitation and sexual abuse.
- Accidental injury and death.
- discrimination and bullying
- crime and anti-social behaviour

And that they grow up in environments where they have security, stability and care.

Cumbria Local Safeguarding Children Board believes that everyone is responsible for safeguarding and promoting the welfare of children.

The members of the LSCB will lead on:

- Working with agencies to improve safeguarding practice
- Monitoring and where necessary challenging the performance of agencies in relation to Safeguarding
- Developing and implementing effective policies, guidance and procedures.
- Carrying out effective Serious Case Reviews and effectively learning from all child deaths.
- Co-ordinating high quality multi□agency training to the children's workforce.
- Promoting awareness of safeguarding within agencies and in the wider community.

## Strategic Objectives

The LSCB has agreed the following priorities as strategic objectives from 2013-4

- Developing and maintaining an effective partnership;
- Making sure that the child's voice, their experience and needs are clearly recorded and used to inform their individual plans and the work of the LSCB;

- Ensuring that the arrangements for privately fostered children are robust and effectively scrutinised by the LSCB;
- Making sure that learning from serious/case reviews is embedded in policy and practice;
- Fully evaluating the impact of training;
- expanding local arrangements for managing child deaths.
- To ensure that services for children who self harm and are at risk of suicide effectively safeguarding;
- Be confident that agencies are working together in their responses to children who go missing; children who are sexually exploited and are trafficked and that this response is safeguarding their welfare.

**The Role of the LSCB sub-committees**

Cumbria Safeguarding Children Board has five sub-committees that co-ordinate or implement the work that the Safeguarding Children Board has chosen to undertake and three district groups undertaking quality audits.

The sub-committees are as follows:

- Quality Assurance Panel – and three district Quality assurance groups;
- Policy and Procedures Sub-Committee
- Children's Workforces strategy Sub-Committee
- Case review and child death overview panel.
- Children going missing; child sexual exploitation and trafficked children.

Each is chaired by an LSCB member and formally reports to the LSCB at every meeting.

**Governance**

The LSCB will receive reports from each sub-committee at every LSCB meeting, detailing progress in relation to those aspects of the Business Plan that are owned by each sub-committee. This will enable the LSCB to monitor Implementation of the plans for the year and to assess its performance

The Business Plan will be published on the LSCB website, shared with all LSCB agencies and also shared with the Health and Well being board

**Financial Arrangements**

The Safeguarding Children Board is funded by contributions from its statutory members. These contributions enable the Safeguarding Children Board to employ an Independent Chair and a small team of staff Business Manager, Training Officer and administrative support.

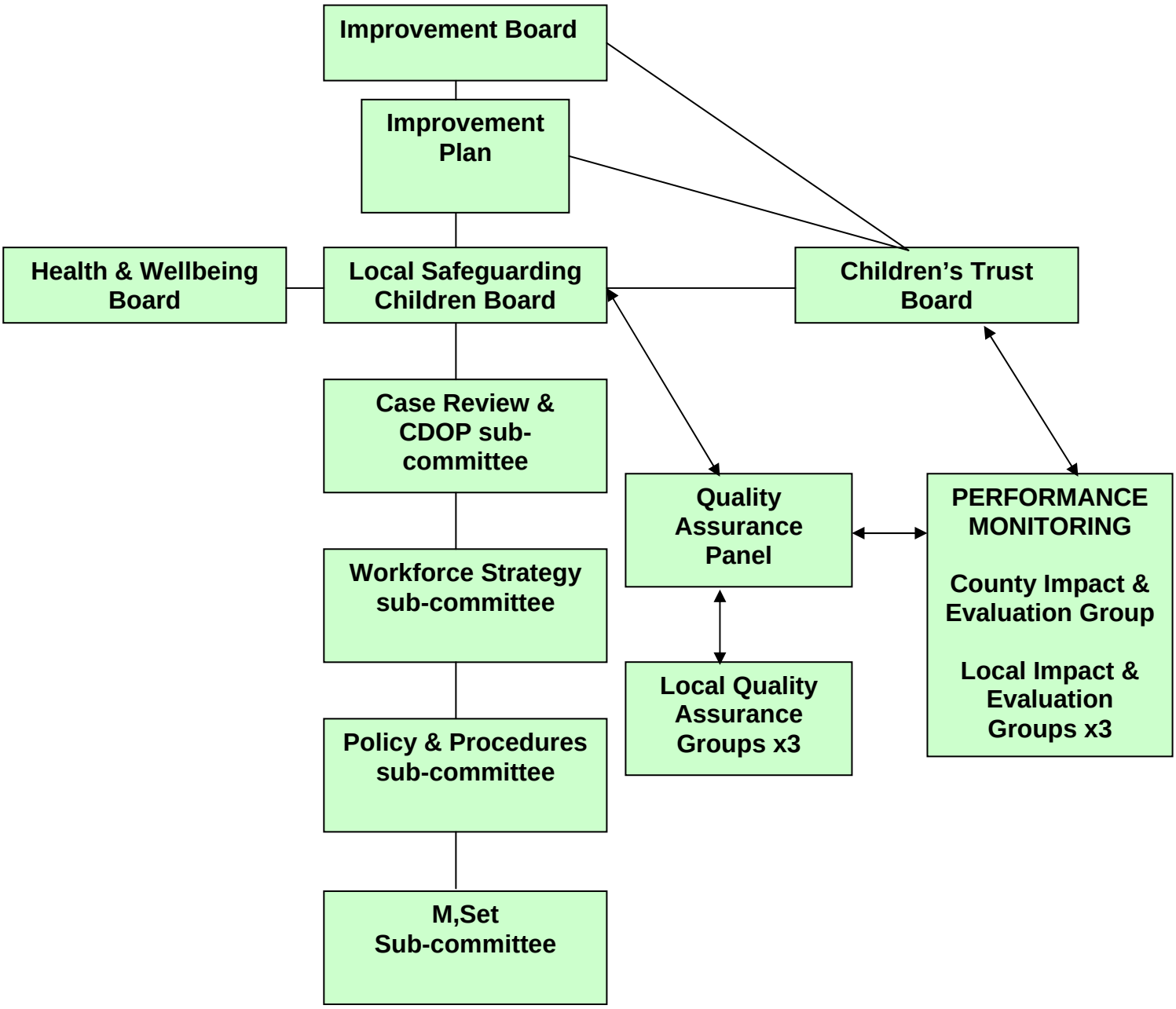
Contributions for 2013-4 have been committed as follows:

| **Agency** | |
|---|---|
| Children's Services | £84,830 |
| Health CCG | £61,079 |
| North Cumbria University hospitals | £7800 |
| Partnership Trust | £7800 |
| University Hospitals Morecambe Bay | £3000 |
| Probation | £10,180 |
| Police | £13,811 |
| CAFCASS | £500 |
| | **£189000** |

The budget will be allocated as follows:

| | |
|---|---|
| **Independent chair** | **12000** |
| **Business support – one business manager and two administrators** | **97000** |
| **Multi agency training with 0.5 administrative support** | **45000** |
| **Supplies and services including serious case review, practice review and stationary costs** | **35000** |
| | £189000 |

**Cumbria LSCB: Structure and Strategic links**



**Priority 1 – Strategic Objective: Developing and maintaining an effective partnership**

| Sub-objectives | Action required | Lead | Timescale | Impact for children |
|---|---|---|---|---|
| The LSCB will have an effective strategic overview of arrangements across all agencies to safeguard children and promote their welfare. (Section 11) | Audit of front line practitioners within agencies to ensure that they are aware of how their organisations are fulfilling the requirements of Section 11.<br><br>The Board holds 6 monthly development sessions in order to ensure that members are working together to scrutinise and challenge local arrangements for safeguarding children. | Policy and procedures sub-committee<br><br>Independent chair and safeguarding service manager | September 2013<br><br>October 2013<br><br>March 2014 | Children will be more effectively safeguarded as practitioners will be safely recruited, supported and trained in child protection processes and procedures.<br><br>LSCB members will be fully involved and working together to identify priorities relating to safeguarding children in the authority. |
| The LSCB will produce clear understanding amongst all member agencies of their roles and responsibilities in relation to the LSCB. | To ensure an effective induction programme is in place for all new LSCB members<br><br>To develop job descriptions, contracts, and confidentiality agreements for all LSCB members and sub-committees so that expectations are transparent and understood.<br><br>To review the learning and development needs of existing LSCB members and systematically address these through an annual appraisal. | LSCB business support | | Members of the LSCB will be in a position to speak for their organisations, commit their agencies on policy and practice and hold their organisations to account on behalf of children within the authority. |
| The LSCB will agree with the local authority and partners the levels for different types of assessments and services to be commissioned and | The LSCB will receive the local protocol for assessment from the local authority that sets out clear arrangements of how cases will be managed. | Quality Assurance Panel and Groups | October 2014 | Assessments will be coordinated, timely and proportionate to the needs of individual children and their families.<br><br>The LSCB will be in a |

| Sub-objectives | Action required | Lead | Timescale | Impact for children |
|---|---|---|---|---|
| delivered and make sure that agencies comply with the threshold document. | The LSCB will carry out auditing activity on the application of the threshold document to ensure that this is effectively safeguarding children. | | | position to monitor and evaluate the effectiveness of the response of agencies to both early help and safeguarding interventions. |
| The LSCB website will be an effective safeguarding hub for practitioners, children and young people, parents/carer(s) and the general public. | Policies and procedures will be updated in light of Working Together 2013<br><br>The website will be redesigned to be more accessible and interactive<br><br>Children and young people will be identified to help to develop safeguarding information that is accessible and understandable to them. | Independent chair | Reporting to each LSCB board meeting | The LSCB website will be accessible to practitioners, children and their families and the community and will provide up to date policies, procedures and guidance in relation to safeguarding. |
| The LSCB will develop a relationship with the Local Family Justice Board and Health and Wellbeing board in order to scrutinise local arrangements to safeguarding and promote the welfare of children in the area and to identify where improvement is needed. | Governance arrangements to be agreed between the boards with clearly defined reporting structures.<br><br>The LSCB to identify improvements and to hold partners to account for delivery. | | | The LSCB will be in a position to identify the effectiveness of partners working together to safeguard children and to identify where improvements are needed and then to hold partners to account for delivery. |

**Priority 2 – Strategic objective: To ensure that the child's' voice, their experience and needs are clearly recorded and used to inform their individual plans and the work of the LSCB – this will be evidenced in all of the business of the LSCB**

| Sub-objective | Action required | Lead | Timescale | Impact |
|---|---|---|---|---|
| The Safeguarding Board will develop a partnership participation strategy to ensure that young people are able to inform the work of the LSCB | The LSCB to continue to meet with the Children in Care Council on a six monthly basis.<br><br>The LSCB to hold a participation workshop which will include Quality Assurance Groups, participation leads from agencies and independent reviewing officers in order to produce a partnership participation strategy. | Quality Assurance Panel | | Children will be in a position to inform and influence the ways in which agencies/organisations are coordinating their safeguarding activity. |
| The LSCB will ensure that every assessment is child centred and informed by the views of the child as well as the family. | All auditing activity will include a section on the child's voice including feedback from the child/young person and a report back to the child/young person on their impact on the Board business. | Quality assurance panel and quality assurance groups. | Bi-monthly reporting to LSCB | Children will be at the centre of each assessment. |
| The LSCB will recruit two lay members one with a remit for Children and Young People | The lay members will operate as full members of the Board, participating as appropriate on the Board itself and on sub-committees with identified "buddies". | Independent Chair | May 2013 | Lay members will be able to help the LSCB make the link with community groups, support stronger public engagement and improve public understanding of the LSCB's child protection work. |

**Priority 3 – Strategic objective: To ensure that the arrangements for early help are effective in preventing children needing acute interventions.**

| Sub-objective | Action required | Lead | Timescale | Impact for children |
|---|---|---|---|---|
| That the threshold guidance makes sure that children's needs | That all agencies comply with the thresholds agreed in the document. | LSCB members | | Support for children will be identified at an early stage which will prevent them from needing acute |

| Sub-objective | Action required | Lead | Timescale | Impact for children |
|---|---|---|---|---|
| are identified at early stage and that they receive an appropriate services | That each audit carried out by the QAGs should include a section | | | services. |
| That Caf is embedded as a way of working across all relevant agencies | Lead Agencies are to provide evidence to the LSCB that there have arrangements in place to make sure that staff are equipped to take on the lead professional role in Caf. This will include arrangements for training and support.<br><br>The LSCB will receive performance data that will indicate that numbers of Cafs are increasing.<br><br>The Quality Assurance Panel will audit the quality of Cafs within each thematic audit. | LSCB members | Sept 2013 | Children will be safeguarded more effectively at an early stage. The lead professional will be clearly identified to them and all agencies will be working with the child to address their needs based on what children are saying. |

**Priority 4 – Strategic objective: To ensure that the arrangements for privately fostered children are robust and that effective scrutiny of these arrangements by the LSCB are in place**

| Sub-objective | Action required | Lead | Timescale | Impact |
|---|---|---|---|---|
| The LSCB will be confident that partner agencies; third sector organisations and commissioned services are aware of private fostering and the notification system. | LSCB members will be asked via a questionnaire to describe how they have publicised private fostering in their organisations. CCC Communications team have developed a plan for publicising Private Fostering. This includes how Cumbria will be involved in the National Private Fostering week in June. | Private Fostering Lead | September 2013 | The numbers of children privately fostered will increase to be in line with statistical neighbours. |
| The LSCB will be confident that relevant training practices are developed and followed up at a multi agency level | The Private Fostering E-Learning package will to be publicised within CCC and become part of staff induction. | Private Fostering Lead and Childrens Workforce Strategy Group. | September 2013 | Member agencies will be aware of the regulations and |
| The LSCB will receive an annual private fostering report submitted by the local authority and six monthly updates | The audit will to be completed and the annual report compiled. | Private Fostering Lead | July 2013 | The LSCB will be able to scrutinise private fostering arrangements on an ongoing basis and challenge where they feel children are not being safeguarded in their arrangements. |
| The voice of the child will be heard within Private Fostering arrangements. | The audit will to be completed and the annual report compiled. The audit will check to see if the Voice of the Child has been recorded and will highlight this in the annual report. | Private Fostering Lead | Annual report | |
| Cumbria Safeguarding Children Board | LSCB members will be asked via a questionnaire to | LSCB members | September 2013 | |

| Sub-objective | Action required | Lead | Timescale | Impact |
|---|---|---|---|---|
| members are to evidence how they have promoted private fostering within their agency/organisation. | describe how they have publicised Private Fostering in their organisations. | | | |

**Priority 5 – Strategic objective: To ensure that learning from serious case reviews is embedded in policies and practice.**

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| The LSCB will develop a framework in which reviews are conducted regularly not only on cases which meet statutory criteria but also on cases that provide the Board with valuable learning. | The framework will include the following types of reviews:<br><br>Serious Case reviews: for every case where abuse is known or suspected and either a child dies; or is serious harmed and there are concerns about how organisations or professionals worked together<br><br>Child death review (See priority 6)<br><br>Review of a child protection incident which falls below the threshold for an SCR; and<br><br>Review or audit of practice on one or more agencies. | Case Review/CDOP group | July 2013 | The LSCB will be in a position to identify improvement that is required and to consolidate good practice. |
| The LSCB will use a learning model to carry out serious case reviews that is consistent with the principles in Working Together 2013. | Case Review/Serious Case review on Child G and H to be completed using a systems framework.<br><br>The model will include participation from front-line practitioners. | Review panels | Child G May 2013<br><br>Child H – September 2013 | This will contribute to the culture of continuous learning and improvement and will identify opportunities to draw on what works and promote good practice. |

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| | The review will include input from family members.<br><br>Learning from serious case review will be made public. | | | Practitioners and family members will be able to contribute to the review from their perspective. |
| The LSCB will oversee the process and make sure that there are action plans that result in lasting improvements to services. | SMART action plans to be produced from practice, case and serious case reviews.<br><br>Implementation of action plans to be monitored by Case Review group<br><br>Learning to be shared with LSCB members who will development communication strategies within their own organisations. | Case Review/CDOP | | There will be sustainable improvements in safeguarding practice that will result in preventing serious injury or harm to children. |

**Priority 6 – Strategic objective: To ensure that the impact of training is fully evaluated**

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| The LSCB will set the standard expected of multi agency safeguarding training. This will include agreeing the levels of training expected from tiers of staff. | A learning and development strategy document will be developed and available as a reference point for all agencies. | Children's Workforce strategy sub-committee. | | The learning and development provided within agencies will equip professionals to safeguard children. |
| The LSCB will be confident that the learning from practice/serious case reviews is communicated in single and multi agency training. | The Workforce strategy group will ensure the learning from serious case reviews informs the training strategy. | Children's Workforce strategy sub-committee. | Training strategy available on the LSCB website. Annual programme. | There will be a continuous learning cycle informed by reviews. |
| The LSCB will be assured that the | The impact of training will be evaluated and | | Progress report to | The LSCB will be confident that the |

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| training provided is fully evaluated and has an impact on practice. | reported to the LSCB | | each LSCB | learning opportunities provided in agencies have an impact on direct practice with children. |

**Priority 7 – Strategic objective: To expand local arrangements for managing child deaths.**

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| The unexpected death protocol will be in line with government requirements and to provide appropriate guidance for all of the agencies | The protocol needs to be reviewed and to clearly state the responsibilities of each organisation. | Designated Doctor | November 2012 | That every agencies is clear of their responsibilities in relation to managing child deaths. |
| Ensure findings from child death overview are reported and disseminated through local, regional and national forums, and lessons learnt locally | Annual data and annual report to be provided to the LSCB including an analysis of themes.<br><br>The Childrens Workforce strategy sub-committee to use the information to inform the training plan | Safeguarding Service Manager<br><br>Childrens; Workforce strategy group. | September 2012 | That the learning from child death influences and informs practice. |
| Continue to improve work with all relevant agencies and parents to inform and involve them with the work of the panel, and improve the learning from reviews | There needs to be a clear communication strategy around the revised protocol.<br><br>Parents need to continue to be given the opportunity to advise the panel on their experiences. | Case review/cdop | November 2012-<br><br>Ongoing | That the learning from child death influences and informs practice. |

**Priority 8** – To ensure that services for children who self harm and are at risk of suicide are effective

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| The LSCB will actively engage with the Health and Wellbeing Board and Cumbria Suicide Prevention strategy in order to ensure that the responses to children at risk of suicide and self harm are effectively safeguarding them. | The LSCB will require regular reports on the progress made by these groups in this area. | | July 2013 | The children who are at risk of self harm and suicide reduce. |
| Partners will ensure that their practitioners are aware of the vulnerabilities of these children and young people and understand the pathways of responses. | The LSCB will expect agencies to confirm that their staff recognise when children are vulnerable and are able to identify appropriate support. | | | Staff are able to identify and respond to children who are at risk and to make sure they get the right support. |

**Priority 9 – the LSCB will be confident that agencies are working together in their responses to children who go missing; children who are sexually exploited and are trafficked and that this response is effectively safeguarding their welfare.**

| Sub objective | Action | Lead | Timescale | Impact |
|---|---|---|---|---|
| The LSCB have a sub-committee with a focus on children who go missing, child sexual exploitation and trafficked children. | • The LSCB will develop a data set reporting bi-monthly<br>• Policies and procedures will be updated in these areas<br>• Childrens Workforce will develop a training strategy<br>• There will be a communications strategy in order to raise understanding and awareness. | Chair of Sub-committee | July 2013 | The LSCB will be aware of the numbers of children vulnerable in these areas and will be confident that agencies are responding appropriately. |

The LSCB and sub-committees have the following membership and terms of reference:

**POLICY AND PROCEDURES SUB-COMMITTEE**

| | | |
|---|---|---|
| **1. Name of Group** | Policy and Procedures Sub Committee | |
| **2. Chair** | Richard Simpson, Barnardos | |
| **3. Vice Chair** | Lyn Burns, Children's Services | |
| **4. Members of Group** | Police Representative | Barry Carruthers |
| | Health Representative | Doreen Bertram/Heather McFarlane |
| | Children's Services | Ros Dean |
| | Children's Services (Education) | Sandy Cameron |
| | Connexions | Sue Lamb |
| | Voluntary Sector | covered by Chair |
| **5. Terms of Reference** | | |
| • To commission and recommend for approval by the LSCB, Policies and Procedures that result in effective multi-agency working together to safeguard and protect the children and young people of Cumbria<br>• To ensure the robust review of existing Policies and Procedures in the light of local and national serious case reviews, changes in legislation and statutory guidance to ensure compliance<br>• To ensure efficient and effective consultation regarding draft Policies and Procedures<br>• To have responsibility for the accuracy and updating of the Cumbria LSCB website<br>• To recommend actions for other sub-groups to ensure effective communication, understanding, implantation of Policies and Procedures and the monitoring of Practice<br>• To ensure consistency of other agencies' Child Protection Policies and Procedures through a Section 11 process | | |
| **6. Quorum** | At least half the group | |
| **7. Review date for ToR** | Annually | |
| **8. Frequency of Meetings** | Bi-monthly | |

**CASE REVIEW SUB COMMITTEE**

| | | |
|---|---|---|
| 1. Name of Group | Case Review Sub Committee | |
| 2. Chair | Mike Forrester, Cumbria Police | |
| 3. Vice Chair | Louise Mason-Lodge, Cumbria PCT | |
| 4. Members of Group | Cumbria LSCB | Lynda Maudlin |
| | Health Representative | Nicola Cleghorn |
| | Cumbria PCT | Nigel Calvert |
| | Children's Services | Catherine Witt |
| | North West Ambulance Service | Vivienne Forster |
| | Business Manager – Safeguarding Hub | Anne Cooke |
| | Lead GP for Children's Safeguarding | Amanda Boardman |
| **5. Terms of Reference** | | |
| • To consider, and where appropriate, recommend to the LSCB with regard to the criteria being me to hold a Serious Case Review. | | |

| | |
|---|---|
| • To consider the need to carry out a practice review<br>• To monitor the implementation of LSCB actions following a Serious Case Review.<br>• To provide direction to the DDG and QAG with regard to implementation and Quality Assurance of LSCB actions from Serious Case Reviews.<br>• To collate single agency responses to the actions following serious case Reviews. | |
| **6. Quorum** | 3 Agencies |
| **7. Review date for ToR** | September 2013 |
| **8. Frequency of Meetings** | Monthly |

**CHILD DEATH OVERVIEW PANEL**

| | |
|---|---|
| 1. Name of Group | Case Review Sub Committee |
| 2. Chair | Mike Forrester, Cumbria Police |
| 3. Vice Chair | Louise Mason-Lodge, Cumbria PCT |
| 4. Members of Group | Cumbria LSCB — Lynda Maudlin<br>Health Representative — Nicola Cleghorn<br>Cumbria PCT — Nigel Calvert<br>Children's Services — Catherine Witt<br>North West Ambulance Service — Vivienne Forster<br>Business Manager – Safeguarding Hub — Anne Cooke<br>Lead GP for Children's Safeguarding — Amanda Boardman |
| **5. Terms of Reference** | |
| • Reviewing all deaths up to the age of 18, excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law<br>• Collecting and collating information on each child and seeking relevant information from professionals and family members<br>• Discussing each child's case, and agreeing who will provide feedback to the family, in an appropriate and timely manner<br>• Determining whether the death was deemed preventable and decide what, if any, actions could be taken to prevent future such deaths<br>• Making recommendation to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible<br>• Identifying patterns or trends in local data and reporting these to the LSCB, and<br>• Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required. | |
| **6. Quorum** | 3 Agencies |
| **7. Review date for ToR** | September 2013 |
| **8. Frequency of Meetings** | Monthly |

**CHILDREN'S WORKFORCE DEVELOPMENT SUB-COMMITTEE**

| | |
|---|---|
| **1. Name of Group** | Children's Workforce Strategy Group |
| **2. Chair** | Michael Hutt (from 20th September) |
| **3. Vice Chair** | Elaine Price, Carlisle College |

| | | |
|---|---|---|
| **4. Members of Group** | LSCB | Lynda Maudlin |
| | Children's Services | Liz McKie |
| | Probation Services | Mike Craven |
| | Fire & Rescue Service | Steph Kershaw |
| | NSPCC | Iain McKay |
| | Connexions | Sarah Harrington |
| | University Hospitals of Morecambe Bay | Tammy Lamb |
| | Cumbria Police | Sarah Edgar |
| | Cumbria Partnership Foundation Trust | Sara Munro |
| | Secondary Schools | Terry Hobson |
| | Primary Schools | Clare Render |
| **5. Terms of Reference** | | |
| • To be reviewed | | |
| **6. Quorum** | 3 Agencies | |
| **7. Review date for ToR** | Annually | |
| **8. Frequency of Meetings** | Bi-monthly | |

**MISSING, SEXUAL EXPLOITED AND TRAFFICKED (M-SET) SUB-COMMITTEE**

| | |
|---|---|
| **1. Name of Group** | M-Set Sub Committee |
| **2. Chair** | To be confirmed |
| **3. Vice Chair** | |
| **4. Members of Group** | |
| **5. Terms of Reference** | |
| | |
| **6. Quorum** | At least half the group |
| **7. Review date for ToR** | Annually |
| **8. Frequency of Meetings** | |

## HEALTH SAFEGUARDING NETWORK GROUP (TO BE REVIEWED IN LIGHT OF HEALTH RECONFIGURATION)

| | |
|---|---|
| **1. Name of Group** | Health Safeguarding Network Group |
| **2. Chair** | |
| 3. **Vice Chair** | |
| **4. Members of Group** | NHS Cumbria — Moira Angel<br>NHS Cumbria — Nigel Calvert<br>University Hospitals Morecambe Bay NHS Foundation Trust — Jackie Holt<br>NHS Cumbria — Louise Mason-Lodge<br>Cumbria Partnership Foundation Trust — Sara Munro<br>North Cumbria University NHS Hospitals Trust — Chris Platton<br>Cumbria Health On Call — Sheila Richardson<br>NHS Cumbria — Dr Andrew Rotheray |

**5. Terms of Reference**

- Brings together the local NHS agencies for mutual support and co-ordination
- Provides assurance that the leadership of the commissioning responsibilities in relation to safeguarding of NHS Cumbria are being met
- Supports assurance to Provider Boards that the overall responsibilities of the NHS are being met
- Overviews the functions, systems and processes 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 in the system (vacancies etc)
  - Providing formal reports to the NHS Cumbria PCT Board.
- Identifies key issues for executive action relevant to policy committees (such as PEC)
- Creates an NHS liaison function with the LSCB.
- Develop and deliver a project / implementation plan for relevant area of accountability (all aspects of safeguarding) within the CQC Programme.
- Reports regularly to the CQC Director Delivery Groups on progress, risks, issues and benefits delivered
- Considers the long term/sustainability needs related to the CQC recommendations

| | |
|---|---|
| **6. Quorum** | Half the members of the group |
| **7. Review date for ToR** | Annually |
| **8. Frequency of Meetings** | Quarterly |

## QUALITY ASSURANCE PANEL

| | | |
|---|---|---|
| **1. Name of Group** | Quality Assurance Panel | |
| **2. Chair** | Fran Gosling-Thomas, Independent Chair | |
| **3. Vice Chair** | | |
| **4. Members of Group** | Voluntary Sector | Pam Hutton |
| | Children's Services | Lyn Burns |
| | Children's Services | Caroline Sutton |
| | Children's Services | Bev Morgan |
| | QAG Chair (East) | Lyn Moore |
| | QAG Chair (West) | Barry Carruthers |
| | QAG Chair (South) | Lyn Berryman |
| | LSCB Chair | Allan Buckley |
| | Independent Member | Shirley Reveley |

**5. Terms of Reference**

***To ensure service delivery is underpinned by a coherent quality assurance process which provides regular and robust challenge and scrutiny, to ensure learning from Serious Case Reviews is embedded, to improve outcomes for children and young people in Cumbria.***

- To develop and maintain a system which will identify key themes taken from serious case reviews, locally and nationally.
- To develop an audit tool which will gather evidence to measure whether lessons learned from case reviews are:
  - Being embedded in practice
  - Making a difference in terms of outcomes for children.
- To contribute to the development of those parts of Cumbria's Improvement Plan relating to:
  - Ensuring that the child's voice informs individual plans and the work of the LSCB (SG 13);
  - Developing and implementing robust quality assurance systems (SG 5)
  - Ensuring that learning from serious case reviews is embedded in policies and practice(SG 12);
- To establish quality measures of safeguarding practice based on:
  - The experiences of children and young people.
  - Key themes taken from serious case reviews, locally and nationally.
  - The findings of the Ofsted Report of April 2012.
- To establish and maintain communication and co-ordination with the Children's Trust Board's Impact and Evaluation systems.
- To report on the outcome of quality audits to the LSCB, and make recommendations for action arising from the audits.

To advise the Board on how to hold partner agencies to account, singly and on a multi-agency basis, for the quality of their safeguarding practice, specifically focusing practice on the needs and experiences of children and young people.

| | |
|---|---|
| **6. Quorum** | At least half the group |
| **7. Review date for ToR** | Annually |
| **8. Frequency of Meetings** | Bi-monthly |

**Each sub-committee will be expected to provide an update on the progress of their workplan to every meeting of the LSCB highlighting any issues/risks the LSCB need to be aware of.**