North East Lincolnshire Safeguarding Children's Board

Annual Report 2014/15

LSCB CHAIR'S FOREWORD

I am very pleased to provide this overview of the North East Lincolnshire Children's Safeguarding Board (NELSCB) Annual Report 2014/15. This is my second Annual Report as Chair of the NELSCB, having taken over a rapidly improving Board from the previous Chair in June 2014.

The year has been characterised by deep reflection combined with a focused determination on continuous improvement and maintaining momentum within partnership activity.

The body of the report describes some of those improvements. For example, a recent system wide commitment to an outcomes-based approach is beginning to shape safeguarding business and giving us an ever sharper focus on safeguarding alongside an emphasis on Early Intervention. The transformation of Children's Centre's into Family Hubs has emerged as a key means of delivering this agenda and the board has shown its commitment to '*getting the basics right'* through stronger procedures and processes, robust quality assurance mechanisms and greater challenge from within the system. It has also been enriched through the exploration of sub-regional approaches to safeguarding through a recently created DCS/Chair/Police working group.

The progress we have made is notable given the current climate of the structural and financial turbulence across the public sector, which is unlikely to diminish in the foreseeable future. This progress therefore is testament to the energy and commitment of practitioners and partners to make things better for Children and Young People in North East Lincolnshire.

There is much more to be done, and the body of this report describes some of that, as does the final section, which looks forward towards progress to be made into 2016.

Rob Mayall

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1. EXECUTIVE SUMMARY

This Annual Report 2014/15 describes the work of partners to make North East Lincolnshire a safer place for children.

The following Executive Summary provides a brief overview of each of the main sections highlighting, where appropriate, progress as well as areas for development.

1.1 Local Background

North East Lincolnshire has a relatively stable population, with above average levels of child poverty, high unemployment and reducing, but still high levels of teenage pregnancy.

Progress has been made towards reducing the numbers of children formally in need of specialist children's services. In particular, the number of children subject to a Child Protection Plan has reduced significantly but not as much as we would wish. The reduction in part is due to concerted multi-agency efforts to ensure children are on the right plan for their level of need combined with additional investment in staffing and workforce development.

1.2 Governance of Safeguarding

Governance arrangements for the Local Safeguarding Board were last reviewed in March 2015 and are now stable, with a Leadership Board, an Operational Board and a series of dedicated Sub-Groups. Levels of partner engagement in governance arrangements are strong, although attendance at Leadership Board meetings fell during 2014, and this is now being addressed.

Particular attention has been given to a more coherent and consistent approach to activity across Sub-Groups, with revised terms of reference for all groups and expectations of regular reporting against 'Score Cards' which highlight levels of activity, key performance indicators, the difference that activity has made and identified 'next steps'.

There are good links with other partnership groups and linkages across the system are beginning to develop, including sub-regional working, although further work is required to exploit the potential of collaborative working across strategic agendas, partnership groups and geographical boundaries.

1.3 Progress Against Recommendations from 2013/14

There were seven specific recommendations in the 2013/14 Annual Report. These are reported on more fully in the body of this report, but the headline message is that good progress has been made on all recommendations, including the stronger engagement of young people in Section 11 activity, good practice in relation to children Missing from Home and the development of a Core Data Set and embedding the use of LSCB Performance Score Cards.

However, in one key area, early intervention, we are yet to see the expected levels of decline in the numbers/proportions of Children In Need(CIN) or on Child Protection (CP) Plans and this remains an issue on which to focus. Additional staff within the Safeguarding and Reviewing Service (CSRS) has led to increased oversight of quality assurance over the last 12 months which has been one of the factors connected with the reduction of CP cases. Staffing for social workers within the MASH/CASS has also stabilised and this too is having a positive impact on the reduction of CIN caseloads.

1.4 Progress Against Priorities

Neglect

Neglect referrals into Children's Social Care represent the highest proportion of any referral type with over 66.5% for Neglect. As such, we have made addressing concerns about neglect a priority

area, with the primary aim being that families receive help much earlier to prevent escalation into statutory services.

A Neglect Strategy was launched in November 2013. It sits alongside the Prevention and Early Intervention Strategy. A Sub Group of the LSCB oversees the implementation of the strategy.

Activities of note include: bespoke Neglect training for over 500 participants, developing Neglect Awareness in educational settings and embedding the use of the Neglect Assessment Tool.

The impact of this activity is being seen through the earlier identification of neglect, underpinned by an increasing proportion of Common Assessment Framework (CAF) activity being noted as neglect related. Again, however, we have not yet seen any noticeable reduction in the proportion of Child Protection cases under the category of Neglect. This suggests that more needs to be done to ensure our work addressing Neglect achieves the impact we are seeking. Amongst a suite of activities, there will be targeted activity in areas where there are higher rates of neglect referrals.

Multi Agency Early Support

The development of the Prevention and Early Intervention Strategy in 2013 pulled existing good practice into a coherent and inter related set of activities and included an overarching performance framework. In 2014, an extensive re-structure enabled the creation of 0-19 family hubs, with associated Early Help Practitioners and practice. The impact of these changes has yet to be measured but there are already processes in place that suggest the foundations for early support are strong; including Multi-Agency Family Hub cluster allocation meetings; work streams in place to further develop the Family Support Pathway and a developing Communication Strategy.

North East Lincolnshire Council, supported by the Local Safeguarding Children Board submitted a proposal for large-scale Innovation Programme relating to Prevention and Early Intervention, as part of the Social Care Innovation Fund. Work began on the bid in the Autumn of 2014, notification was received it had been successful in March 2015. The aim is to adopt four different practices to create a new model for social care and the broader Children and Young People's workforce. This will change how organisations work together to safeguard vulnerable children, how staff work, how we interact with service users and how we deliver the change we need. We have called this approach the Creating Strong Communities (CSC) Model. The four constituent parts of the CSC model are:

- Family Group Conferring
- Signs Of Safety
- Restorative Practice
- Outcome Based Accountability

This approach will result in a large-scale Workforce Development Programme, with some additional resources to enable us to deliver the change we desire for children and families within the Borough.

Plans for 2015/16 include the further development of the workforce in line with the Creating Stronger Communities Model, the development of data profiles for 0-19 yr. olds and more focussed commissioning of activity to meet identified needs.

Addressing Child Sexual Exploitation

North East Lincolnshire has a strong, integrated approach to Child Sexual Exploitation.
A range of services are provided with a keen focus on prevention through outreach activity, curriculum packages and effective disruption tactics.
Comprehensive performance data provides evidence of positive impact in this area of activity with both victims and perpetrators.

CSE activity in 2014/15 has featured the increased use of child abduction notices and a focus on building awareness and resilience through Sexual Relationship Education – with 600 participants in these activities.
Priorities for 2015/16 include the implementation of Phase 2 of 'Say Something If You See Something' campaign and additional training for elected embers to increase their awareness of CSE issues.

Maintaining Continuity in Child Safeguarding Arrangements in a Changing Public Landscape

The Education Sub Group of the Safeguarding Board has overseen the first annual audit of safeguarding in schools, eliciting a 100% response, the second audit will report in Autumn 2015, with expectations that safeguarding practice will have improved on the previous year .This group has also devised and published example documentation including a model safeguarding policy transition guidance. It has also worked jointly with the Police to raise awareness in education establishments of the new Prevent legislation and associated statutory duties.

The Health Sub Group has undertaken audit work to help assess safeguarding standards in health settings, resulting in reports, action plans and focussed support from the designated nurse where required. The audit of GP practices showed a marked improvement in safeguarding awareness and arrangements. Strong lobbying for a local Sexual Assault Referral Centre(SARC) has paid dividends with a paediatric SARC now provided by Hull and East Yorkshire Hospital's Trust.

1.5 <u>Safeguarding Vulnerable Children</u>

The underpinning organisational arrangements to support many of the most vulnerable children in North East Lincolnshire have been maturing over the last two to three years. Processes and procedures in the Multi Agency Safeguarding Hub are becoming increasingly sophisticated and effective with a robust audit calendar in place and a stable staffing group that is helping to reduce caseloads. Additionally, the implementation of Closure Panels has contributed to a safe *stepping-down* of cases.

Children subject to a Child Protection Plan

Strong progress has been made towards improving the efficiency and effectiveness of activities in this area. Children's views are being captured more consistently, there is greater challenge from Chairpersons and this is evident in CP Conferences. Due to practical developments, parents now leave conferences with a 'live' plan.

Children Experiencing Domestic Abuse and Harmful Sexual behaviour (HSB)

A 'one system' approach to Domestic Abuse is under development. This is a long-term piece of work, but will ensure a systems wide approach to this issue – across partners and partner groups. Appropriately, the profile of this issue remains high, not least because of the Council's Safe and Stronger Communities Scrutiny Panel making Domestic Abuse part of its work programme for 2015/16.

A HSB Operational Group has contributed to putting both a Referral Pathway and a Training Pathway in place. An innovative HSB programme in one primary school is to be extended to other schools in 2015/16.

Looked After Children (LAC)

Numbers of LAC have stabilised in 2014/15. An increasing proportion are in placements with relatives. Work to engage children and *hear their voice* is under continuous development and the use of Viewpoint software has increased. Nearly all Reviews are being held within timescale. Single practice alerts (now known as Quality Assurance Notifications or QANs) have been implemented providing more robust and consistent alerts to Social Workers and others about

issues identified in cases. Resource Allocation Meetings have been successfully introduced to ensure consistency of decision making, prevent drift, and apply resources in an equitable manner.

Missing from Home and Care

In line with a recommendation in the 2014 Annual Report, approaches to Children Who Go Missing have become more standardised, with more consistent approaches applied across different groups of children. There is a good understanding of the volumes and features of children going missing and there are good multi agency arrangements in place to respond to children going missing. Efforts have been made to improve placement stability in order to reduce the likelihood of those in care going missing.

Allegations Against Professionals

There has been a slight reduction in allegations (45 versus 50 in 2013/14) Processes have been continuously improved following an external audit of LADO activity in 2014. Further work is required to capture user feedback and there is an intention to further strengthen quality assurance processes with dip sampling of Local Authority Designated Officer (LADO) records.

Corporate Parenting

Work in this area has been re-vitalised, resulting in corporate parenting having a significantly higher profile in the Council, the introduction of a number of processes in place which ensure that Members are well sighted on LAC issues and practical actions to enhance quality of life for LAC (decisions around internet access/allowances).

1.6 Partner Agencies and their Contributions to Safeguarding

North East Lincolnshire is characterised by strong relationships between and across partners. Partner engagement in safeguarding is strong, evidenced by their engagement in the various groups and Sub Groups of the Safeguarding Board as well as a wide range of operational activity in relation to safeguarding. This section of the report highlights specific activity by partners including their priorities for the forthcoming year.

Significant structural changes in the Police and Probation Services have created challenge, but there remains a strong commitment from partners to fulfil their safeguarding duties and help make North East Lincolnshire a safer place for young people.

A cycle of individual meetings between the Chair and statutory partners has created opportunities for issues to be raised, challenge to be made and support provided.

1.7 Policies Procedures and Guidance

New policies have been introduced and others have been revised as part of a structured cycle. All procedures are reviewed on a six monthly basis. The LSCB website has been re-vitalised, but feedback tells us that it still needs to be more young person friendly and this is being addressed in partnership with a representative group of young people.

1.8 Learning and Development Activity

Learning and development activity is strong. The volume of activity and participation has increased on 2013/14 (going to 3300 participants from 2500 participants). Satisfaction levels are high as indicated via the self-declared ‘impact on practice’.

New approaches to training (bite size) have been used including new training activity (E.g. safe sleeping), the introduction of impact evaluation and this fosters an approach which is open to change, challenge and continuous improvement.

The Learning and Improvement Framework is now in place and as it becomes embedded will drive all learning and improvement activity.

1.9 Monitoring and Quality Assurance

There is a QA Sub Group overseeing this area and in 2014/15 it has developed and implemented a series of audits as part of a clear plan for multi-agency and themed activity. Section 11 auditing, in particular has become far more sophisticated, and challenging with a meaningful engagement of young people. A CSE Challenge Day was well received by partners and resulted in clear improvement actions.

The Board's approval of the creation of a QA Coordinator post is evidence of a commitment to this area of activity. The full impact of this post holder has yet to be felt but is already contributing to developing the Quality Assurance calendar and programme for 15/16 having been appointed at the end of quarter 4, 2014/15.

1.10 Child Death Overview Panel (CDOP)

The number of child deaths has remained low. The Board receives the annual report from CDOP which also informs the Learning and Improvement Framework and subsequent activity. During 2015 it is intended that we further explore collaboration with neighbouring CDOPs to secure more efficient and effective working.

1.11 Engagement with Children and Young People

We identified in our previous annual report that this was an area for development.

There have been a number of notable examples of the engagement of Children and Young people, most significantly in Section 11 processes. 'The Voice of the Child' is a key line of enquiry in inter agency audit activity and the Child's Voice is increasingly being heard in day-to-day interactions with Children and Young People (examples are evident in case file audit outcomes and include children involvement in CP Planning processes). A wide range of further examples are described in the body of this annual report.

Further activity to capture the Voice Of Children And Young People in a coordinated way and evidence how it impacts on the services we provide remains a key area for development in 2015.

2. LOCAL BACKGROUND

2.1 Population

North East Lincolnshire's population is 159,804. There are 34,309 Children and Young People under the age of 18 years who live in North East Lincolnshire. 50.6% are male and 49.4% are female, this is 21.5% of the total population in the area. The proportion of the population who are under 18 is decreasing while the proportion of those of aged 65 and over is increasing.

Over the 5 years (2009-2013) the annual number of births in NEL, has decreased by 1.7%.
Overall the population of Children and Young People aged 0 to 19 inclusive decreased by 2.0% between 2010 and 2014. The numbers of 0 to 4's and 5 to 9's has risen by 2.6% and 11.7% and the numbers of 10 to 14's and 15 to 19's has dropped by 9.6% and 10.8% respectively. Population estimates for 2014 show that the largest proportion of Children and Young People were aged 0 to 4 years (27%), while the fewest children were aged 10 to 14 years (23%).

NEL's pupils are predominantly White British (90.8%) with a small, but increasing proportion from a Black or Minority Ethnic (BME) background (6.8%) compared with national figures of 75.4% in primary schools and 77.1% in secondary schools. The proportion of Children and Young People with English as an additional language is also increasing gradually with 3.9% of pupils having a language other than English at the time of the January school census 2015.

Approximately 26.7% of the local authority's children are living in poverty (all children), compared to 18.6% nationally (2012). There are significant differences in some wards in the proportion of children in poverty within our most deprived wards to our most affluent.

The NEL Neglect Strategy is aligned to the Prevention and Early Intervention Strategy and as of March 2015 17.8% of all referrals had a referral client category of Neglect, however, it is accepted that neglect features as a secondary factor in a much higher number of cases.

The proportion of children entitled to free school meals is 19.0% (NCY1 to 11). In primary schools this is 21.4% (the national average is 19.2%) and in secondary schools this is 16.9% (the national average is 16.3%).

2.2 Child Protection(CP)/Child In Need(CIN) in this area

At 31st March 2015, 1941 children had been identified through assessment as being formally In Need of a Specialist Children's Service. This is a decrease from 2366 as at 31st March 2014.
The numbers of children subject to a Child Protection Plan fell from 407 in March 2014 to 226 in March 2015.

2.3 Looked After Children

At 31st March 2015, 265 children were being looked after by the LA (a rate of 77 per 10,000 children).
62 (or 23%) live outside the Local Authority area. This is a combination of living with family or friends out of Local Authority, with foster carers, placed for adoption, placement order, health establishment or Youth Offending Institution etc. 33 live in residential children's homes, of whom 8 (26%) live out of the authority area.

- None live in residential special schools
- 199 live with foster families, of whom 19.6% live out of the authority area
- 8 live with parents

In the year 2014-15

- There have been 36 adoptions, this is an increase from 20 children adopted in 2012/13 and 30 children adopted in 2013/14.
- 20 children became subject of special guardianship orders, this is an increase from 5 in 2012/13 and 11 in 2013/14.
- 162 children have ceased to be looked after, of whom 6.2 % subsequently returned to be looked after.

The Local Authority operates 8 children's homes, with 33 beds in total. All were judged to be good or outstanding in their most recent Ofsted inspection. There has only been one external inspection within the Annual report timescales.

- Youth Offending Service 2011 – 3 minimum judgment (Top Score). 2014 Short Quality Screening (SQS) 92, 92, 97 in 3 key areas (Highest score seen).

3. NORTH EAST LINCOLNSHIRE LOCAL SAFEGUARDING CHILDREN BOARD

GOVERNANCE

3.1 LSCB Structure

The LSCB structure (Please see appendix 1) consists of the LSCB Leadership Board which is responsible for ensuring the effectiveness of local safeguarding arrangements. The LSCB Operational Board is responsible for the delivery of the LSCB business through its scrutiny of the work of the LSCB Sub Groups. Sub Groups are aligned to the LSCB statutory functions and priorities. These are listed in Appendix 1.

LSCB Sub Groups all have a set of performance indicators based on the LSCB Core Data Set; all groups provide quarterly Score Card reports to the Operational Board, which enables it to monitor performance and Sub Group activity in response to emerging themes, patterns or declines in

performance. The Operational Board reports thematic information and performance variations to the Leadership Board.

Interagency audit tools are used to implement a themed practice audit calendar, a number of inter-agency audits have been undertaken including Child Sexual Exploitation, Neglect and Thresholds. The Section 11 audit activity (partnership audits) has been revised and is now held biennially and includes a challenge event. There is a comprehensive Learning and Improvement Framework, aligned to LSCB priorities and learning from Serious Case Reviews.

3.2 Membership of the Leadership Board

The LSCB member representation meets the requirements of Working Together 2015. Where agencies or interests are not represented on the Leadership Board, they are represented on the Operational Board and Sub Groups.

3.3 Leadership Board Attendance Audit

Attendance at the Leadership Board averaged 81% in 2015, which is a slight reduction from 2014. Non-attendance is monitored and in 2015/2016 will be rigorously addressed against the LSCB standards.

3.4 Lay Members

The Board's two Lay Members have been in post for 2 years; both are from a community background and contribute fully to the work of the Board. Their tenure has been extended to provide continuity and stability.

3.5 Joint Working with Other Partners

The NELSCB 2013/14 Annual Report was shared with the Chair of the Health and Well Being Board and the Police and Crime Commissioner. The report was also presented to Elected Members. There are good links between and across the LSCB and the Children and Young Person's Partnership Board and the Health and Wellbeing Board. These processes are currently being strengthened and require formalising in governance arrangements. Regular strategic meetings are held between the chairs of the LSCB, Health and Well Being Board and Safer and Stronger Executive Group in strengthening partner relations. The Chair of the Children and Young Person's Partnership Board (CYPPB) sits on the LSCB Leadership Board and reports to the Board on the progress of the CYPPB delivery of priorities. This arrangement allows for challenge by LSCB with regard to the work of the CYPPB. The Safeguarding Statutory Partners meet on a regular basis.

3.6 NELCB Resourcing and Budget

The NEL LSCB team comprises of:

- Strategic Manager for Safeguarding (Since June 2014)
- NEL SCB Manager
- Quality Assurance Officer
- LSCB Administrator

The annual income and expenditure of the board (financial year 2014/15 is attached at appendix 2).

3.7 NELSCB Business Plan

The NELSCB Business Plan sets out the strategic priorities for North East Lincolnshire Safeguarding Children's Board (NELSCB) for 2013-15 and how they will be achieved. The Leadership Board provides the mandate for each of the Sub Groups who are key to the successful

delivery of the LSCB Strategic Priorities and the LSCB Statutory Functions. (The Terms of Reference for the LSCB Boards and Sub Groups are at appendix 3).

3.8 Progress against the recommendations from the 2013/14 LSCB Annual Report

Address neglect through Early Intervention activity and reduce the proportion of Child Protection (CP) cases with Neglect as the main reason for referral.

The Neglect Sub Group defined key actions to support an overarching strategy that aims to shift the balance from statutory intervention to early help and support. These have included;

- Promoted universal professionals to be trained/ supported to name, describe, and assess neglect.
- Delivered and embedded bespoke training on neglect for **517** practitioners.
- Embedding public/professional awareness of signs/symptoms of neglect in targeted areas.
- Initiated a training programme within schools to ensure staffs are aware of assessment tool, training pathway and referral process.
- Building on the knowledge/skill/competency of first line managers to support their staff to recognise neglect and intervene effectively.
- Neglect referrals into NELC Multi Agency Safeguarding Hub (MASH) have been consistently high representing **66.5%** of all Child Protection Plans as of 31st March 2015. This is consistent with the national trend. Currently there is no downward trend in the data for Child In Need (CIN) and CP.
- Key messages about the impact on children of living with neglect is beginning to change how early help professionals respond with increased confidence to use the Neglect Tool.

Fully implement the Early Help and Neglect Strategies.

The following elements were achieved through the continued implementation of the Prevention and Early Intervention Strategy.

- PEI Strategy & Implementation Plan in place.
- Restructure complete in place from 1st April 2015 offering multi agency prevention and early intervention services across the 0-19 age range.
- The Family Hubs work in 5 geographical clusters and bring together family support services including Sure Start Children's Centre's, Health Visiting, School Nursing, Integrated Family Support Services and some of our Youth Provision.
- Early Help Coordinators replaced CAF Coordinator role.
- CAF process is still in place until launch of Single Assessment & Revised Child Concern Model etc.
- Teams of Early Help Family Support Advisers allocated to each cluster.
- 5 Family Hub clusters identified – new weekly Family Hub cluster allocation meetings in place (multi agency) to ensure appropriate level of support allocated.
- Work streams in place to further develop the Family Support Pathway, Single Assessment and review the processes & procedures in relation to these.
- Development of Communication Strategy.

Increase evidence of the Voice of the Child in relation to contributing to service developments and for the most vulnerable, their engagement in plans and actions which affect their futures.

Consultation Tools for gaining the views of Children and Young People are being reviewed and developed. All LSCB partners have begun identifying processes in place to capture the child's voice. The Quality Assurance Sub Group is now coordinating activity to develop a pro-forma based on the 2015 Working Together for agencies to consider in relation to how each addresses the issue of what children say they want from Safeguarding Services and their overall welfare.

The involvement of young people in the Section 11 Audit in January 2015 actively challenged organisations on how service delivery was informed by children's involvement. The recent Section 11 follow up event has evidenced real progress by organisations in this area.

Standardise our approaches to Missing from Home.
Improvements have been made to performance data; this has enabled a complete set of performance figures which has formed the baseline for future comparisons. Operational & Risk Management Groups have been established with partner agencies. Every child who has been missing is discussed at each Risk Meeting, irrespective of whether they have been missing from home or from care, and appropriate actions agreed.

A Debrief Officer has been appointed, located within Young & Safe. Debriefs are conducted within 72 hours of a young person being found. If a child is identified as at risk of CSE on *found reports* then a referral is made to the CSE Group if they are not already known.
Disruption tactics are employed wherever possible including *Evictions* and *Child Abduction Notices*. YPSS/Police patrols are deployed in the area of addresses identified as being of concern.

Implement a review cycle for all Safeguarding Policies and Procedures.
The LSCB have commissioned Triex a company specialising in safeguarding procedures to manage, review and revise the LSCB procedures. The procedures are reviewed and revisions made arising from local or national policy changes on a six monthly basis. Where important changes are needed to the procedures before the six monthly reviews these are made in ensuring guidance is as current as possible and reflects local practice.

Increase our understanding of workforce learning and development needs and the impact of activity.
A more robust safeguarding training evaluation process was implemented in 2014/15 with new forms assessing delegates distance travelled from the beginning to end and 3-6 month follow up to measure impact on.

The Creating Stronger Communities (innovation) Programme which is funded by the Department for Education will embed the Signs of Safety, Restorative Practice and Outcome Based Accountability approaches in supporting practitioners work with children and families. The LSCB training programme will be reviewed and revised to take account of the new approaches and to build in ongoing sustainable learning opportunities for the future.

A Learning and Improvement Framework Action Plan has been developed which will drive forward all Learning and Improvement Activity. All Sub Group chairs contribute to the action plan by inputting learning activity and impact. The LSCB Learning and Development Strategy has been approved and published, it sets out how the LSCB will ensure safeguarding training/learning activities are based on local need.

Embed the use of Score Cards and the Core Data Set as a means of individually and collectively understanding our business and performance.
The LSCB Core Data Set is aligned to the data sets which informs each of the LSCB performance Score Cards. There are a number of Score Cards associated with the LSCB priorities and core functions. The Operational Board hold quarterly performance challenge boards. There has been a particular focus on ensuring that the *Difference Made* is evidenced and the *Voice of the Child* is evidenced within the scorecard.

Score Card leads have received Outcome Based Accountability (performance informed model for delivering against outcomes) training. Work is continuing on improving the quality of the Score Cards and in ensuring data is validated. The Leadership Board performance report will consist of a number of agreed *Bell Wether/Key Indicators.*

4. OUR FOUR PRIORITIES

The following section provides a progress report against the four LSCB strategic priorities.

4.1 Addressing Neglect

What did we say we were going to do?

- The LSCB recognised that Prevention and Early Intervention in dealing with Neglect was an area for significant development to ensure families receive targeted help much earlier to prevent concerns escalating requiring statutory intervention.
- From April 2014 to March 2015 the Neglect Sub Group defined the following key actions to support an overarching strategy that aims to shift the balance from statutory intervention to early help and support.

What have we done?

- Promoted universal and early year's professionals to be trained and supported to name, describe and assess neglect by building competence in the workforce and ensuring they participate in relevant training on the Professional Competency Pathway for Neglect.
- Developed, piloted and embedded bespoke training on neglect for **517** professionals and established **4** Practice Enhancement Workshops on the Voice of the Child; Using the Assessment Tool for Neglect; Supervision and Management of Neglect; SCR's and Neglect and Neglect Awareness Induction training.
- Begun to embed public and professional awareness about the signs and symptoms of neglect and the impact upon Children and Young People with current targeted activity on the South Ward where there is high prevalence.
- Co-led an official launch of the 'Living Well and Neglect Matter's' campaign, which included multi-agency engagement, NELC communications; NSPCC public affairs teams in partnership.
- Accessed 5 primary schools in the South area to deliver the Neglect Awareness training to ensure that (**100**) staff are aware of the bespoke Assessment Tool, Training Pathway and Referral Process.
- Led on **12** public awareness raising activities from two hour inductions sessions for all council employees to all Child-minders; Day Nursery Providers; Housing and Public Health Forums; Refuge Collectors and Home Start reaching **260** people.
- Built on the knowledge, skill and competency of first line managers across all agencies to support their staff to recognise neglect and intervene effectively by understanding scale, type, impact and risk.
- Promoted and embedded the best practice Assessment Tool for Neglect as a means of obtaining an objective measure of strengths and difficulties in a family where neglect is an identified potential concern.
- Collaborated with the Quality and Assurance Sub Group on an Inter-Agency Audit Plan and outcomes in relation to neglect cases.

Evidence/Impact/Difference Made

- Neglect referrals into NELC MASH have been consistently high for some time representing **67.7%** of all Child Protection Plans as of 31st March 2015. This is consistent with the national trend. Currently there is no downward trend in the data for Child in Need (CIN) and Child Protection (CP).
- Key messages about the impact on children of living with neglect is beginning to change how early help professionals respond with increased confidence to use the Neglect Tool but this is a slow process.
- An uptake in the use of the Assessment Tool for Neglect within the Family Hubs demonstrating increased confidence and competence in earlier identification and assessment.
- Professional feedback:
- "Using ***the Neglect Tool Workshop****: 72% feel very confident and 27% feel confident in putting knowledge they have learnt into practice. 91% found workshop excellent, 9% good. Quote: Be more persistent and look beyond 'fine*' SCR's ***Level 2 Keeping the Neglected Child in Focus****: 44% feel very confident and 56% feel confident about putting the knowledge learnt into practice. 76% found course excellent, 24% good.* ***Level 3 Keeping the Neglected Child in***

Focus**: 85% strongly agreed that the training would positively impact upon their practice "Be tenacious and not to be afraid to challenge assumptions; **Neglect Awareness Training

- *'Ensure I really listen to hints from children that they may need to speak to someone, ensure I pass on concerns and don't disregard anything the child says'.*
- *'I will be more honest and direct when speaking to parents'.*
- *'It can happen in any household'.*
- *'More confident in signs and symptoms of neglect and how to approach parents'.*
- ***One parents view on using the Assessment Tool for Neglect**:*
    - *It really helped me to recognise my strengths.*
    - *I knew I could do better on a couple of things and now I am.*

Next steps

- Target areas which have higher rates of statutory child neglect referrals (South ward from May 15; East Marsh from September 15) by ensuring locality based Primary Health Care Providers, PCSO'S, School Nurses, Health Visitors, Nursery Nurses, Voluntary Sector, Dentists, Publicans and Taxi Drivers all have the same messages about what to do if they have concerns that neglect is occurring.
- Flooding each locality with the 'Help' message and new posters in parent led locations to highlight early help messages.
- Distribute 1,000 'credit cards' with information about neglect.
- Identify Professional Champions to sustain and build the momentum of this work to ensure the strategy is not dependent upon key individuals but that a culture of tackling neglect is at the forefront of professional thinking.
- Complete the task and finish activity to develop unitary wide evaluation forms to capture the voice of Children and Young People and families on the impact of the help received and learning for professionals.
- Write, test and deliver the practice enhancement workshop on attachment, brain development and neglect. We are looking to form a partnership with CAMHS to deliver this.

4.2 Multi Agency Prevention and Early Intervention

What did we say we were going to do?

- Develop a Prevention and Early Intervention (PEI) Strategy and Implementation Plan.
- Restructure teams across Children's Centre's/Children's Health and Integrated Family Services to develop a Family Hub Model for families with children 0-19.
- Develop a Family Support Pathway across the spectrum of need.
- Review and revise the Child Concern Model & Thresholds of Need document.
- Develop a single assessment across the spectrum of need.
- Develop the workforce – Signs of Safety approach.

What have we done?

- PEI Strategy & Implementation Plan in place.
- Restructure complete – new structure in place from 1st April 2015 – Early Help Coordinators replaced CAF Coordinator role, however CAF process is still in place until launch of Single Assessment & Revised Child Concern Model etc.
- Full caseload audit of all open CAF's.
- Teams of Early Help Family Support Advisers allocated to each cluster.
- 5 Family Hub clusters identified – new weekly Family Hub Cluster Allocation Meetings in place (multi agency) to ensure appropriate level of support allocated.
- Work streams in place to further develop the Family Support Pathway, Single Assessment and review the processes & procedures in relation to these.
- Development of Communication Strategy.

Evidence/Impact/Difference Made

The PEI Strategy/Implementation Plan has been shared widely with partners and there has been sign up by the Leadership Board.
It is difficult to evidence difference made for this area of work at this point in time as the revised structures and Family Hub model only went live on the 1st April 15 which is the next reporting period.
A full caseload audit of open CAF referrals prior to the restructure resulted in a number being closed with outcomes achieved and those that remain open mainly have a lead practitioner or agency identified.
This process has resulted in the strengthening of the QA process for new referrals to ensure that assessment and supporting evidence is robust.

Next steps

- Launch revised Family Support Pathway, Single Assessment Process & revised Thresholds Documentation as Practitioners Handbook/Toolkit.
- Further develop Allocations Meetings to meet 0-19 agenda.
- Continue Communication Strategy with partner agencies to fully embed new processes – reinforce the role of LP.
- Continue to develop relationships with partner agencies in clusters & further develop data profiles for 0-19's.
- Commission interventions/activity to meet identified need.
- Further develop workforce in line with Creating Strong Communities Model – Signs of Safety/Restorative Practice/FGC/OBA.
- Review all training – Competency Framework.
- Further develop IAG – Family Information Service helpline & website.

CAF data for 14/15
2238 CAF referrals opened during the year.
2179 CAF's closed in year, with:
- 69% with outcomes achieved or closed at pending (16% increase on previous year).
- 13% stepped up to CIN (18% reduction on previous year).

End Q4 – 1838 open CAF's

Children's Centres

What did we say we were going to do?

The aim in 2014/15, was for Children's Centre's to extend their offer, which mainly focused on families with children aged 0-5 years, to a wider family focused age range of 0-19 years. Families expressed an interest in being able to access services locally for their children post 5 years and the workforce were fully involved/informed in the proposed restructure.

What have we done?

The restructure met its timeframe and moved into the Family Hub Model on 1st April 2015, offering Multi-Agency Prevention and Early Intervention Services across the 0-19 age range. The Hubs work in 5 geographical clusters and bring together Family Support Services including Sure Start Children's Centre's, Health Visiting, School Nursing, Integrated Family Support Services and some of our Youth Provision. All of these services work across the cluster areas, with other services, partners and the community.

Evidence/Impact/Difference Made

During 2014/15 Children's Centre's completed 17 Neglect Tools, one parent explained*; 'It really helped me to recognise my strengths…I knew I could do better on a couple of things and now I am.'*

Next Steps

We know that some families need extra help and support with issues that arise during a child or young person's life. Family Hubs are now able to offer the support needed to help families work through these issues. The extra support may be provided by a range of professionals who now meet on a weekly basis in each of the Family Hub cluster areas to discuss referrals for Prevention and Early Intervention support. All staff employed to work out of Family Hubs will have their learning needs mapped within supervision during 2015/16 to ensure they access training using the Professional Capability Framework for Neglect.

4.3 Addressing Child Sexual Exploitation

Young and Safe CSE Multi-Agency approach

What did we say we were going to do?

- To engaging the wider community including young people.
- Ensuring consistent drive and delivery on the CSE Action Plan through the CSE Ops group
- Continued development and delivery of CSE training both LSCB level 2 and briefing sessions.
- Development of training evaluations to show increase of knowledge and ability to deal effectively with incidents of CSE.
- To ensure that Health is represented fully at both risk and Operational groups
- Ensure all health services include a recognised risk assessment tool for CSE, such as the 'Spotting the signs'.
- Development of Child Exploitation On Line Protection (C.E.O.P) and how this is delivered in schools linking into Curriculum for Life and Safer Relationships 4 Young People (SR4YP)
- Develop marketing and communications strategy alongside "Say Something if you See Something" (SSSS) campaign to offer training, support and guidance to the leisure, licensing and retail industries.
- To develop the "Voice of the child" to ensure that services, process and policies can be improved and developed with the thoughts and views of young people.
- To develop parent support alongside Parents Against Child Exploitation (P.A.C.E) and NELC Family Resource Services (FRS).
- Developing Parenting Support Groups through Triple P Programme

What have we done?

- Refreshed all current Terms of Reference (TOR's) in relation to the CSE Ops and Multi Agency Risk Assessment (MACE) meetings
- Completed new MACE practice and guidance document.
- Health now fully represented at both Risk and Operational groups
- Health now use single assessment BROOK pro forma / Spotting the signs
- Completed victim and suspect tactical plans for all operational officers within Humberside Police
- Compiled Appendix A in preparation of governmental focus visits, including OFSTED and Home Office
- CSE strategy completed and authorised through LSCB Leadership group, to be launched July 15th 2015
- Progress reported on the current CSE action plan, currently driven by the CSE Operational sub-group.
- Refreshed the Multi Agency Child Exploitation practise, guidance and procedures
- Completed third self-assessment refresh using the Bedfordshire Tool self-assessment.

- Refresh of the 'Healthy Relationships' educational offer to schools/academies for the academic year starting 2015. This to be renamed Safe Relationships for young people (SR4YP) after consultation with young people currently accessing services.
- Resources for schools/academies added to the Curriculum for Life resource area.
- Young and Safe CSE practitioners booked onto CEOP ambassadors course in July 2015, this will then be cascaded out in train the trainer sessions in corporation with the current SR4YP
- LSCB level 2 training updated and bespoke briefing packages developed for a variety of audiences including health staff including GP's
- Progress reported on the audit undertaken in December 2014 and actions implemented as per the recommendations and findings of the audit.
- Continuing development of parenting work through Integrated Family Services Triple P Programme, for both CSE and CEOP delivered by Young and Safe.
- Voice of the child continued to be developed through Viewpoint & ME Assessments

Evidence/Impact/Difference Made

- 34 Operation PRIAM patrols, 204 hours.
- 635 young people contacted on the streets of North East Lincolnshire from June 2014 – March 2015.
- 73 young people risk assessed through the MACE process to identify level of risk, required actions and support package.
- 100% of all young people referred have been risk assessed through the MACE process
- 90% (65) female & 10% (8) males, giving a 9:1 split
- 78% (57) young people referred to young and safe for support through interventions specific to CSE
- 12% (16) young people not referred to young and safe as deemed at not at risk of CSE and not requiring any support from this service area, potentially referred to other areas of YPSS such as young carers and access partnership
- 74 crimes have been recorded and investigations commenced
- 23 Child Abduction Notices issued.
- 38 adult perpetrators identified by Humberside Police
- 12 successful prosecutions 90% success rate
- Over 30 years in sentences received
- 6 LSCB CSE level 2 training sessions delivered, with 103 attendees
- Over a 90% mark of excellent provided to the training within the evaluation.
- Attendees have commented on how much more confident they feel in now identifying the signs and symptoms of CSE and where to seek assistance.
- 12 briefing sessions delivered to 398 attendees, including front line health practitioners, including GP's and NELC elected members
- 1 young person in secure settings due to CSE
- 5 Young People placed in Local Authority Care due to CSE

Next Steps

- Develop Marketing/Comms plan through "See Something Say Something" (SSSS) campaign delivering targeted training and messages to tourism & Licensing, this in particular developing training for all licensed taxi drivers, Hotels and Bed and Breakfasts and retail outlets such as Freshney Place.
- Humberside police adopted trigger plan in relation to "Say Something If You See Something" through Operation Make Safe.
- Further develop young person's campaign through National Working Group (NWG) "Say Something", Linked to the missing persons charity.
- Strengthen links with front line Health professionals through training and referral.
- Continue to develop and offer CSE briefings, Elected members, GP's and others.
- Review Operation PRIAM and its functions through proactive risk management.
- To launch the strategy of both CSE and missing and SSSS on 15th July 2015.

- To continue to develop process through the action plan and audit plan.
- To appoint through competitive interview process an independent missing persons officer.
- To seek business admin support in relation to the MACE process.

4.4 Safeguarding In Education

What did we say we were going to do?

Provide assurance that all North East Lincolnshire's educational settings are meeting their safeguarding requirements; promote consistency and a coherent approach to safeguarding; and facilitate a tangible link to the LSCB.

Enable discussion and identification of emerging safeguarding issues; ensure there are inter-agency mechanisms in place to address these.

Ensure the effective dissemination of safeguarding guidance, evidence based practice and recommendations from national and local Serious Case Reviews and that key inter-agency safeguarding processes are effectively embedded.

What have we done?

Provided reassurance on the effectiveness of the safeguarding arrangements of all NELs' education establishments by:
- The publication of the first annual audit for the 2013/2014 academic year with a 100% response rate.
- Revised the 2014/2015 audit documentation which is due for publication in autumn 2015.

Raised awareness through performance reporting:
- That internal/unpublished data is unverified; not comparable nationally and local arrangements dependent.
- Of the increasing number of electively home educated (EHE) children; the complexity of tracking children missing from education (CME); the increase in permanent exclusions; and the associated number of children educated in alternative provision.

Devised and published example documentation including:
- A model Safeguarding Policy.
- Casework recording guidance and transition documents.

Worked jointly with the Police to raise awareness of the new Prevent legislation and continually raised the profile of the sub group and dissemination of its work streams.

Evidence/Impact/Difference Made

In the 2013/2014, of the 68 (100%) submissions received, 24 (35.29%) educational establishments self-assessed themselves at a Level 1 overall; 42 (61.77%) at Level 2; and 2 (2.94%) at Level 3. No establishment scored itself at Level 4.
Children Missing from Education (CME) casework tracking and reporting systems are robust despite the increase in school autonomy; the Elective Home Education (EHE) casework recording inconsistencies that were initially identified have been addressed a business case has been prepared to address the evidenced increasing volume of cases and associated workload.
Regular acknowledgement of the awareness raising of the group and dissemination of work streams through primary and secondary head teacher communications and meetings.
The resurrection of the former termly Child Protection Co-ordinator Meetings with effect from July 2015.

Next steps

To continue to improve the quality of data reported on and raise the EHE and CME challenges in appropriate forums.

5. SAFEGUARDING VULNERABLE CHILDREN

5.1 Multi-Agency Safeguarding Hub and Children Assessment Safeguarding Service (CASS)

We can see a marked improvement in the quality of referrals being taken by the Principal Social Workers (PSW) within the MASH and this was recently recognised in an external audit of the service an external audit of the MASH in October 2014 and April of this year.
Multi Agency decision making in the MASH is improving and this is evident when referrals are viewed at the weekly multi agency Service Challenge Meetings where the referrals to the service from the previous week are viewed and discussed. We are now beginning to incorporate Signs of Safety into the language of the referrals in order to underpin our practice with this approach and that of our partner agencies.

MASH PSW's also offer advice to professionals and families. This is an additional pressure for the MASH PSW's but is vital work if we are to ensure that work with children and families is preventative and that the Early Help offer is strong. We are working with colleagues in the Early Help/Family Hubs to ensure that families are supported at the time they most need support and after any statutory interventions in terms of step down support.

The continued improvement within the MASH has led to an increase in quality of service to Children and Families and has reduced caseloads due to a more thorough analysis at the point of referral.

Attendance at the Challenge Meetings by multi agency professionals has decreased as the appropriate people do not always attend, aside from those multi agency partners working in the MASH. We continue to theme our Challenge Meetings. Our expectation remains that multi agency partners invited to the Challenge Meetings will attend but where they are unable to attend weekly due to their own agency pressures they can attend the meetings appropriate to their role.

We also undertake "road shows" to partner agencies to ensure that we can respond to any queries or concerns and listen to proposed solutions.

Retention of Staff and Case Loads

Staffing for Social Workers has stabilised and this is having a positive impact on the reduction of caseloads.

North East Lincolnshire has a higher proportion of CIN per 10,000 of the population than other Local Authorities.

Closure Panels are in place in CASS to ensure that all cases are stepped down safely with senior management oversight.
296 cases have been reviewed at closure panel and 239 of those cases were closed to CASS at panel since January 2015. The 20% of cases that did not close required further work to be completed prior to being able to safely step down.

Early Help (EH) professionals now form part of Closure Panels to review Thresholds and Step Down.

EH Heads of Service have contacted all schools to advise that if they have concern in respect of a child to contact Family Hubs to discuss the child rather than escalate immediately to MASH. This is initially to prevent the increase in referrals that happens prior to each holiday period.

The Child in Need (CIN), Child Protection (CP) and Closure Panels in CASS are ensuring that cases are progressing in a timely manner. We aim to ensure that Children and Young People are on the right plan at the right time with the safety and wellbeing of those children being our priority. The panels have identified causes where delay has been a potential and decisions have been made to progress cases. This is particularly evident in CP and LAC (S20) cases.

There has been a historical rise in the number of Looked After Children (LAC), Numbers are now stabilising and as of March 2015 there are 268 children that are classed as LAC. A percentage of the LAC cases are children that are placed with relatives. Increasingly we are having to issue proceedings in order to secure these placements of children with their relatives. This is a change in practice and as a result of the now very restricted access for families to legal aid. We are also required to financially support these placements, although it is a very good outcome for children to remain with their extended family and is more cost effective than long term Local Authority Care. This area requires improvement and development in the service as to how these cases are managed.

Audit

We have a robust Audit and observation Calendar now established in CASS. Audits are undertaken by internal managers and an external auditor. We have recently undertaken several multi-agency case file audits also through the LSCB Quality Audit Sub Group. The results of all audits are shared in audit meetings on a quarterly basis with a group of Senior Officers including the Deputy Chief Executive audits highlight strengths and areas for improvement and discussion is held as to how we will meet the unmet need.

Within audit meetings, data is also interrogated to inform all parties of the current picture which our data is telling us and to aid discussion in order to shape a collective response as to how we will strengthen practice.

This Audit process is demonstrating service improvement and is now well established within the service area.

We have also launched the Social Work Performance and Accountability Framework. This is a proactive tool for Social Workers to monitor their performance against the expectations of them in respect of timeliness and progression of cases. Social Workers have welcomed this tool in the main as it follows the ethos of “High Support and High Challenge” now being adopted across the Local Authority through Restorative Practice.

5.2 Children and Young People Subject to a Child Protection Plan

What did we say we were going to do?

- To continue to roll out Viewpoint in conjunction with partner agencies to ensure children’s views are collated for service development.
- Further developing the challenge role of the chairperson to ensure that agencies thoroughly evidence their decision making.
- Continue to review dual status children at the earliest stage i.e. those children who have a child protection plan and have become looked after to ensure that children have one plan that everyone works with.
- Increase observed practice and promote the chairperson challenge as part of ensuring the quality of the conference process.

What have we done?

- The roll out of Viewpoint continues. To date we have focused on implementation at conference of Viewpoint that is now embedded but with the need to increase use and uptake. Conference chairs identify who will assist a child/young person in accessing this software as well as ensuring that all other options to support participation/attendance at conference are explored. The challenge role of the chair person has shown improvement following briefings for IROs on the professional challenge, on the use of Quality Assurance Notifications and from audits and observed practice. Audits of minutes confirm that agencies thoroughly evidence their decision making.
- Children with a dual status are reviewed at the earliest opportunity to ensure children have one plan that promotes their needs.
- A bespoke tool for observed practice was developed for use with IROs during 2014/15 and a pilot use of the tool commenced late 2014. It has now been used at a small number of conferences and summarised for the Quarterly Performance Review.
- In addition to the above we have refreshed and re-developed the performance book to ensure that key data is captured for management oversight and service improvement and report quarterly to the LSCB via the newly embedded Outcome Based Accountability Score Card, (OBA).

Evidence/Impact/Difference Made

- Between 1st April 2014 to 31st March 2015 the service conducted 778 Child Protection Conferences (on cases open as at 31st March) compared with 670 the previous year. All children Child Protection (CP) or Looked After Child (LAC) have up to date plan to address safety and welfare.
- From a high of 407 children with a Child Protection Plan in March 2014 numbers have reduced to 226 as at March 2015.
- Case tracking is completed between CP reviews to check progress against the plan and challenge as appropriate.
- All parents now leave conference with a hard copy of a draft plan following the introduction of multimedia TV screens allowing plans to be developed with participation from all attendees during conference.
- Distributing minutes in shorter timescales to inform Core Groups and families.
- Two separate audits have been completed, as requested by the LSCB, into cases where CSE is identified as the stated issue and where neglect is identified as the stated issue. The findings of the audits have led to reflection on practice and changes in practice.

Next Steps

- Further work as above to capture and monitor child participation and Voice of the child.
- Further Development of the Signs of Safety process and approach to conference.
- Data and performance reporting to be further streamlined to coincide with relevant boards and interface with other service areas.
- Risk paper to be produced regarding the potential impact of removal of market supplement on vacancy and recruitment of appropriately experienced and qualified staff and ensuring NEL is competitive with other authorities.
- Introduction of a self-audit checklist for conference chairs regarding the minimum standards for conference and the model of CP plans complementing the Signs of Safety model and use of language to make plans explicit and outcome focused.
- Follow up process for tracking and addressing outstanding issues from Quality Assurance Notifications (QAN/SPA).
- Extending use of QANs to partner agencies at conference.
- Further development of Observed Practice and its use in IRO workshops and training.
- Producing an action plan to be implemented for IROs in response to local Serious Case Reviews.

5.3 Children Experiencing Domestic Abuse

What did we say we were going to do?

Working collaboratively across the Local Safeguarding Children's Board, Safeguarding Adults Board, Health & Well Being Board and Safer & Stronger Communities Board, develop a strategic "One System" approach to Domestic Abuse.

What have we done?

- During the spring and summer of 2014 a Domestic Abuse Needs Assessment and Asset Mapping exercise was undertaken by Public Health which highlighted a number of recommendations and was presented to the Health & Well Being Board and Safer & Stronger Executive Board for consideration.
- In November 2014 a meeting was held between the Chairs of all 4 Theme Boards mentioned above and it was agreed to develop a jointly owned "One System" approach to Domestic Abuse and that a steering group be established.
- In December 2014 the Health & Well Being Board agreed to supply £95k funding for the 2015/16 period for the continuation of the Independent Domestic Violence Advocate, the Independent Sexual Violence Advisor and the MARAC Coordinator. All business critical roles that are currently not mainstreamed.
- In January 2015, the Council's Safer & Stronger Communities Scrutiny Panel met as a Crime & Disorder Committee to discuss Domestic Abuse and were presented with the local findings framed around the Centre for Public Scrutiny "10 Questions to ask if you are scrutinising Domestic Violence". The Committee agreed that Domestic Abuse would form part of the Safer & Stronger Communities Scrutiny Panel Work Programme for 2015/16 so as they could track progress.
- Up to March 2015 the steering group has been working to develop a revised domestic Abuse Strategy with a clear Road Map and Action Plan for delivery, taking into consideration the recommendations contained within the Needs Assessment and any wider activity that needs to be incorporated.

Evidence/Impact/Difference Made

"Domestic Abuse remains a concern locally and it is accepted that the One System approach to Domestic Abuse is a long term piece of work. Humberside Police data for the 2014/15 period indicates that North East Lincolnshire is higher than the force average in relation to incidents and offences (North East Lincolnshire recorded 3,885 incidents compared to a force average of 3665 and 1,111 offences compared to a force average of 999) and lower than the for force average around arrests (North East Lincolnshire recorded an arrest rate of 37% compared to a force average of 46%). Repeat victimization at MARAC has also increased from 33% of cases presented in a 12 month rolling period to 43% of cases presented. However this needs to be set in the context of more cases being heard at MARAC (475 cases from Apr14 - Mar15 set against 371 cases for the previous year) and is also attributed to victims being more confident to report due to the support they are receiving which in turn increases the repeat victimisation rate".

Next steps

"The Steering Group will continue to meet on a monthly basis providing regular reporting into the Theme Boards around progress and areas that require more strategic input around resource and commissioning. In relation to the present recorded levels of Domestic Abuse, it is acknowledged that the current provision around IDVA support needs to be strengthened to reduce risk and provide much needed support to victims. In addition wider opportunities around Early Intervention needs to be maximised in order to address the longer term culture. As part of the ongoing reporting back to the Theme Boards Chairs, information will be provided around gaps and opportunities in relation to current provision to inform resourcing and commissioning decisions".

The MASH has a Police Designated Decision Maker who shares incidents of Domestic Abuse. Should the child require statutory social work intervention the case will be allocated to a qualified Social Worker. Should the family not meet the threshold for statutory intervention then a CAF will be initiated and/or universal services can be accessed by the family.

Historically, tackling Domestic Abuse has been coordinated individually via the 4 theme boards, (Safer & Stronger Communities Board, Health & Well Being Board, Local Safeguarding Children's Board, Adult Safeguarding Board). Recently there have been strategic discussions between the four local theme board chairs to develop a new One System Approach. A One System Approach will bring together in its entirety all elements of the agenda including, strategy and delivery models, resource considerations and most importantly joint accountability and ownership.

A Domestic Abuse Strategic Group has been established and will report directly and regularly into the four theme boards on progress.

5.4 Harmful Sexualised Behaviour

What did we say we were going to do?

The mandate of the Harmful Sexualised Behaviour (HSB) Operational Group is to drive forward the project and implementation plan for HSB.

What have we done?

- Protocol/procedures are in place and are reviewed annually.
- A Referral Pathway has been developed and multi-agency team meeting monthly (AIM Information Exchange Meeting) – referrals are RAG rated (Red/Amber/Green).
- Outcomes measures and a reporting structure are in place and agreed.
- Police now have all cases of a sexual nature coming through Protecting Vulnerable People Unit to support consistency of referral process.
- A data dashboard complete and new data collection format agreed.
- Joint Working Protocol is in place between NSPCC and Youth Offending Service to deliver interventions as above.
- Clear Intervention Pathway at all levels of concern:
- Green – School Pilot – Parents workshop of internet safety and children's access to inappropriate people and material, school assemblies on staying safe and rules for life, based on the PANTS campaign. Group work and 1-1 work sessions delivered by schools to children whose behaviour is a concern. Setting personal rules.
  Amber – Medium level of intervention provided via YPSS.
  Red – 30 week therapeutic intervention package delivered via NSPCC.

Evidence/Impact/Difference Made

- The pilot of the Green Intervention Programme in schools was very successful. 100% of parents reported they felt more confident in keeping their child safe online.
- A number of assessments have identified undiagnosed learning needs which have led to CAMHS assessments
- Training Pathway in place which meets the needs of the whole service area.

Next Steps

- Victims Service to be considered in conjunction with the Victim Strategy.
- In order for us to be able to actively engage young people in undertaking the AIM assessment and potentially therapeutic work to address behavior, solicitors in the area need to be trained on the benefits of not recommending a "No Comment" interview and denying allegations if evidence is clear that a young person will be prosecuted.

- We need to further develop the HSB programme piloted at Wybers Wood School to be rolled out to other schools.

Data; 1st April 14 – 31st March 15

Referrals	40
AIM assessment	19
Risk assessment	10
Psychological assessment	3
Other assessment	3
No assessment required	12
Awaiting more information	4

Training:

HSB Awareness Raising training	340
Understanding and Responding to Sexualised Behaviour	100
Change for Good Programme (Amber level of intervention)	25

5.5 Looked After Children

What did we say we were going to do?

- To refresh and re-develop a set of performance indicators that ensure management oversight on performance and areas for development.
- To continue to roll out Viewpoint in conjunction with partner agencies in order to collate feedback for service development.
- To review the young person's participation in the IRO Service and work with the Corporate Parenting Board and Council for Children in Care to develop a Consultation Group of young people specifically to advise and assist with the quality of the IRO Service.
- To formalise the programme of Observed Practice within the IRO Service to drive up quality and consistency of service delivery whilst providing a feedback tool and reflective supervision as part of the overall quality assurance process.
- To implement a monthly and quarterly audit programme for IRO cases to ensure good practice and areas for improvement are captured and action planning for the team can be based on thematic learning.

What have we done?

- We have refreshed and re-developed the performance book to ensure that key data is captured for management oversight and service improvement and report quarterly to the LSCB via the newly embedded Outcome Based Accountability (OBA) Score Card.
- The roll out of Viewpoint continues. To date we have focused on the implementation of Viewpoint that is now embedded but with the need to increase use and uptake. IRO`s identify who will assist a child/young person in accessing this software as well as ensuring that all other options to support participation/attendance at reviews are explored. Further work will be undertaken during 2015/16 on increasing children's attendance at reviews.
- The Council for Children in Care (CfCIC) meet to address issues and have developed their contribution to the pledge. Their views are fed into the Corporate Parenting Board. A resource has been identified to develop consultation with young people specifically in relation to this service and this work will commence in July 2015.
- Observed Practice sessions are being implemented.
- The Audit Programme has been superseded by the LSCB Audit Programme. IRO`s have also been involved in auditing cases identified in the LSCB Audit Programme and attended practitioner sessions. The service has used thematic team meetings to reflect on cases and the associated practice issues.

- In addition to the above the implementation of the single practice alerts (to be called quality assurance notifications in the future) to alert social workers, their supervisors and service managers to issues identified on cases in a more formally recorded format.

Evidence/Impact/Difference Made

- 1049 LAC reviews are recorded as having taken place during 14/15 for 498 reviews , where IROs visited the child on a date prior to the date of the review this is compared to 897 in the previous year. This figure is likely to be higher but has not been recorded and therefore cannot be evidenced. Information not being recorded was due to workload pressures. There will never be 100% due to other factors, such as children refusing to work with the IRO.
- Work is being undertaken in 2015/16 to ensure data recording is as accurate as possible.
- 94% of the 1049 reviews were held within timescale which means that 14 children had a late review.
- There is evidence that the use of single practice alerts has had an impact on children's cases.
- There are some good examples of children/young people participating in their reviews.

Next steps

- To ensure that the Performance Work Book continues to evolve and captures the right information and data to assist in future service planning and improvement.
- To obtain feedback on the IRO Service Provision from children and professionals to inform developments and incorporate into future service delivery.
- To review what "Keeping in Touch" could look like in the context of cost, workload management and children's feedback.
- To undertake audits of the SPA`s (to be known as Quality Assurance Notifications) to collate thematic practice issues and use these to develop learning themes and improve practice.
- IRO work to continue to be subject to an audit programme linked with the LSCB Quality Assurance Framework.
- Include baseline performance data (aligned to LSCB Score Cards were in place) and narrative/charts explaining data.

5.6 Court Safeguarding

Care Proceedings Rise in Care Proceedings

There has been a historical rise in the number of Looked After Children (LAC), Numbers have stabilised and as of June 2015 there are 265 children that are classed as LAC. A percentage of the LAC cases are children that are placed with relatives. Increasingly we are having to issue proceedings in order to secure these placements of children with their relatives. This is a change in practice and is as a result of the now very restricted access for families to Legal Aid. We are also required to financially support these placements, although it is a very good outcome for children to remain with their extended family and is more cost effective than long term Local Authority Care. This area requires improvement and development in the service as to how these cases are managed.

Resource Allocation Meeting (RAM)

A RAM panel has been in place for over a year now within Children's Social Care. The purpose is as follows:

- Children and Young People should be able to live with their own family whenever this is safe to do so. Additional support and assistance may be required for this to be possible.
- Where this is not possible, every effort will be made to provide services within the locality or as close to home as possible.
- Whatever the primary need, in order to maximise outcomes for Children and Young People, all aspects of their life must be considered in planning for them.

- Planning should begin by looking at the needs of the child or young person and the family's ability to meet those needs, with support if necessary, but must take account of finite resources.
- Plans should always have as their aim reintegration into the local community (with timescales).
- All placements should represent Value for Money.

Role of the Group

- To ensure consistency of decision making and appropriateness of admissions to care.
- To prioritise the allocation of resources to maximise efficiency.
- To ensure that applications for additional funding are appropriate and to ensure that placements represent value for money.
- To prevent drift and ensure that planning is robust and appropriate to meet the child's needs.
- To identify trends in the profile of the looked after population and to identify needs and gaps to inform commissioning plans.

All members of the RAM panel are senior managers within Children's Social Care and have decision making powers within the Local Authority. The panel is chaired by the Assistant Director of Children's Services.

5.7 <u>Missing From Home and Care</u>

<u>What did we say we were going to do?</u>

2014 Annual report recommendation: *Standardise our approaches to Missing from Home and Care.*

Operational & Risk Management Groups have been established with partner agencies. All notifications of children Missing/Absent from Home & from Care and notifications when found go into a secure in-box and can be directly accessed by key personnel. Every child who has been missing is discussed at each risk meeting, irrespective of whether they have been missing from home or from care, and appropriate actions agreed.

Children Missing from Care are managed in the same way as Children Missing from Home with information sharing and risk management being key factors.
In 2014/15 13% of individual children who went missing were Looked After Children (22 individuals) while 24% of all episodes of children going missing involved these children. (112 episodes) 2 thirds of missing episodes lasted less than 23 hours and 70% of Looked After Children going missing are between 13 & 15 years old.
A number of these children became looked after as a result of repeated episodes of going missing and risk taking behaviour and, in the majority of cases, missing episodes reduced.
There is regular management oversight of missing reports and the Missing in-box is checked on a daily basis.
Close co-operation between Police, Social Care, Education and Youth Services ensure that robust searches are conducted, Child Abduction Notices issued when appropriate and disruption tactics employed.
Debriefs are conducted within 72 hours, the key factors identified to date being emotional difficulties and wanting to spend time with friends.

There are close links between the Missing Risk Management Processes and CSE Management and Looked After Children have access to the same services as all other children. There is strong multi-agency involvement in all plans for children at risk of CSE.
We are aware of a national trend for children's homes to be a target of CSE gangs and individuals but this is not a pattern we have observed in NEL to date.

<u>What have we done?</u>

Placement stability

There has been an increase in the % of children with 3 or more placements from 10% to 11.7%. The change is not so much attributable to placement breakdown as it is to having to accommodate children with emergency carers before settling them with carers on a longer term basis.

NELC has continued to deliver a good level of long term placement stability in spite of increased pressure on placements and resources since 2012. Performance has dipped to 70% in 2014/15 but is still likely to above England average and in line with statistical neighbour average.
Health performance remains above 96%. There have been further improvements with initial health assessments now being completed by the LAC Health Team.

Evidence/Impact/Difference Made

Placement stability and enduring relationships are the only way in which children will recover from the deficits in their early lives and become more resilient individuals.
The new health assessment process has enabled health issues to be identified at the earliest stage and effective interventions begun. There are several case studies, particularly of young women involved in CSE which demonstrate the positive impact of this.
The new SDQ process includes a monthly discussion with CAMHS so that issues identified can be addressed quickly and emerging themes identified.

Stability and support in education has enabled a number of young people to attend university and/or gain long term employment.
Regular surveys of Care Leavers & looked after children demonstrate that they value the support they receive and, of particular importance to them are the relationships they build up with their workers.

We are successful in maintaining contact with Care Leavers. Where young people struggle to adapt to adulthood, this ongoing contact gives them the chance to make poor choices but still come back for support from a group of professionals they have usually known for a number of years. There have been several remarkable case studies to illustrate this point.

Next Steps

Continue to improve processes for recording and monitoring children who go missing and use information from debriefs to inform individual plans and identify themes.

Ensure that there is learning from placement disruptions and that foster carers are trained and supported.

Increase capacity in the Looked After Children Education team to reduce risks posed by children being excluded from school.

5.8 Allegations against People Who Work with Children

What did we say we were going to do?

- An External Independent Audit Report from April 2014 had suggested that the forms used to record allegations should be revised and simplified.
- The LADO service is developing a tool to capture user feedback and has introduced an observed practice quality tool.
- That workshops to disseminate learning from cases will be incorporated into the LSCB Training Calendar and Portfolio to ensure that it is available and accessible to those managers and staff that may need to make referrals via the LADO process.

What have we done?

- There have been 45 allegations made to the LADO during this period. These were classified as being based on the following concerns: 8 Emotional Harm, 4 Neglect, 24 Physical Harm and 9 Sexual Harm. Consideration was given to revising the forms used in North East Lincolnshire but they are deemed to be helpful to the process and provide a clear record of what was reported and what actions were taken to resolve matters.
- We have yet to conduct a formal user feedback exercise but the designated officers do receive positive comments about the usefulness of their role. An Observed Practice Tool has been developed and observed practice sessions completed.
- In addition to the above an audit tool to reflect the quality of the work undertaken by the Designated Officers has been developed and used by the Strategic Manager for Safeguarding to audit cases and provide feedback.
- The annual report outlining themes arising out of cases and practice issues is disseminated to the LSCB and Corporate Parenting Board. Workshops are still to be rolled out.

Evidence/Impact/Difference Made

- Appropriate referrals have been made to relevant governing bodies when required to ensure future safeguarding.
- 83% of cases were resolved within 3 months falling slightly short of the target of 90%.
- 15 cases were substantiated (there is sufficient evidence to prove the allegation).
- 2 cases were Malicious (there is sufficient evidence to disprove the allegation and there has been a deliberate act to deceive).
- 8 cases were false (there is sufficient evidence to disprove the allegation).
- 13 cases were unsubstantiated (there is insufficient evidence to either prove or disprove the allegation. The term, therefore, does not imply guilt or innocence).
- Several cases have emerged where, despite following safe recruitment practices, the staff member has been dismissed due to his or her conduct with children and/or convicted of a criminal offence. It is becoming increasingly clear that simply to follow safe recruitment practices is not enough. All indications are that there is a need for continuous oversight of staff practice reinforcing the need for supervision, a robust approach and response to whistle blowing and whistle blowing policies and coupled with recognition that staff must be proactively encouraged and enabled to report colleagues whose behaviour raises safeguarding concerns.

Next steps

- To develop a User View Evaluation Tool to enable us to improve the service to partner agencies.
- To develop the use of technology to allow virtual meetings to take to assist in maintaining the frequency of case reviews.
- To continue to audit LADO records through 'dip-sample' to ensure consistency and quality assure the process for timeliness, effectiveness and impact.
- To continue to incorporate a programme of Observed Practice within the Children's Safeguarding and Reviewing Service to promote the advice and guidance offered to professionals when referring LADO cases.
- To develop and deliver workshops to share learning from the outcomes of cases referred into the allegations management process.

5.9 Corporate Parenting

What did we say we were going to do?

The Corporate Parenting Board will have access to the performance reports, stakeholders and senior officers from services that directly impact Looked After Children (LAC). In addition, broad aims for success of the CP provision and Elected Member responsibility are set out in the current strategy document alongside the CP Pledge, where LAC express their wishes and feelings for the service and the senior management team set out their promises to LAC in return. The CP Board gives a focus to the statutory duties and responsibilities of elected Members as Corporate Parents.

The Operational Group – the CP Working Group – felt the impact of re-structures and staff turnover. We said we wanted to re-establish and refocus the new group. The Council for Children in Care (CfCiC) had quite naturally lost membership as the members of the group had grown and left the care system. Secondary to that is the increasing numbers of a younger cohort where the traditional CfCiC model was no longer appropriate. We said we had to have new interest for LAC to be a part of this group.

What have we done?

- Developed and published a CP booklet aimed at raising awareness among elected members as to their parental responsibilities. Each elected member had a copy delivered directly.
- Championed through the Board an examination of the levels of pocket money to residential and LAC which resulted in a raise of cash-in-hand (pocket money) and acknowledgement of on-going allowances for clothing, magazines, hobbies etc.
- Discussions at the Board endorsed the issue of open internet access for young people in care. With a recognition of the risks and safeguarding considerations for this vulnerable group, all residential units will be getting internet/Wi-Fi access, not blocked or gate-kept by Local Authority restrictions.
- Budget and resource changes are brought to and discussed at the Board.
- Senior Officers also have membership of the LSCB Board and report to the CP Board. This will be enhanced following a request to particularly share issues around CSE and Missing from Care.
- LAC complaints are a standing item and the open discussion identifies themes, ongoing issues and queries resolution and changes that result.
- Board Members receive monthly, the Reg 33 reports from each residential unit, giving opportunity to bring themes and key points forward for discussion. Similarly, Ofsted full inspection reports are shared, discussed and acknowledged where appropriate with letters to the unit managers.
- Financial flexibility for LAC has been a constant discussion at the Board and is partially resolved with the introduction of unit specific credit cards, giving LAC some flexibility in consumer options, working around the necessary rigid restrictions of council spending and financial arrangements.
- Via the Board, elected Members are encouraged to visit residential units on pre-arranged (and sometimes unexpected) occasions.
- The CfCiC continues to meet and via members of the Board gives a voice to LAC. Their input has had a direct impact on topics referenced above. The content of the Pledge is heavily influenced by the CfCiC.

Evidence/Impact/Difference Made

- The CP Booklet has high-lighted the Parental Responsibility of Councillors towards LAC.
- Sharing the Reg 33 reports with Elected Members gives them a direct insight into the work of the residential units and the interaction with Ofsted Inspectors.
- The increased pocket money and access to the internet speaks to the “normality” of family life for those children in residential care.
- The CP Board has members who also sit on the LSCB, the Children’s Partnership Board, Children’s Scrutiny and this enables information sharing, benchmarking and challenge.
- CfCiC continues to meet and give a voice to Looked After Children.

Next steps

- Awareness raising for new Councillors, offer CP training via Member Development.
- Development of database of employment experience opportunities for LAC across the Local Authority and its partners and local business.
- Assess impact of CP Booklet.
- Revision of CP Strategy & CP Pledge including publication.
- Develop format for CP annual report, requirements of Strategy & Pledge.

- Confirmation of the incumbent to the role of CP Coordinator following organisational restructure.
- Increased membership of the CfCiC.
- Members of the working group to be confirmed the outcome of structural changes

5.10 Private Fostering

What did we say we were going to do?

A Private Fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative for 28 days or more.
The number of children in private fostering arrangements of which NELC were aware from April 2014 to end March 2015 are as follows:-

The Private Foster Carer becomes responsible for the day to day care of the child or young person in a way which will promote and safeguard his/her welfare. Responsibility for safeguarding and promoting the private foster child rests with the parent or other person who has parental responsibility.

What have we done?

The Local Authority's duties and functions under the Children Act 1989 and regulations state that it is **NOT** the responsibility of the Local Authority to approve or register private foster carers but to assess the suitability of the placement in relation to each particular child and particular private foster carer, their household and premises. However, it's the duty of the Local Authority to satisfy themselves that the welfare of children who are or will be privately fostered within their area is being or will be satisfactorily safeguarded and promoted.

Evidence/Impact/Difference Made

Visiting and reviewing patterns are once every 6 weeks minimum for visits and once every 6 months, minimum for private fostering review meetings.
There are performance management processes in place to monitor performance and assure quality.

Next steps

- Due to the small amount of Private Fostering cases recording on CCM is not as accurate as it should be.
- To rectify this issue all PSW's will be trained again on CCM and the recording requirements for Private Fostering placements.
- The team have been sent a One Minute Briefing (concise brief report) and this will be followed up in the team meeting.
- Raising the awareness of Private Fostering continues from teams through the provision of advice and the distribution of leaflets.

5.11 Asylum Seekers

We have a small number of unaccompanied asylum seekers this year. We work closely with the Immigration Services to age assess the young people and should they be eligible we offer them appropriate accommodation. Young people age assessed to be to 18 years or younger are opened to the Through Care Service and do become LAC children. We always try and place these young people in an area that meets their needs of ethnicity and diversity.

6. PARTNER AGENCIES

6.1 Humberside Police

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Humberside Police are committed to involvement in all LSCB partnership working at all levels. The Chief Superintendent or Superintendent hold bi-monthly meetings with Board Chairs across the Humberside Police geography, and is committed to our continued active involvement in all relevant LSCB work In particular we are co-located in the Multi Agency Service Hub where we play an active role in safeguarding decisions around children at risk of harm. The meetings also include attendance by the Director or Deputy Director of Children's Services.

Since April 2015 a commitment has been made that attendance at LSCB Board Level Meetings will be at a rank of no less than Supt. or DCI line management to LSCB/LA area.

We have continued to be the lead agency in development of the local CSE strategies, chairing the NEL Multi Agency Strategic Meetings, and the Multi Agency Meetings identifying and safeguarding children at risk. We participate fully in all Multi Agency Audit Processes and Serious Case Reviews, integrating the learning points into our strategies at the earliest opportunity. As an agency that covers four Local Authorities (LA's), not only do we bring the Police view on LSCB matters, we are also able to bring best practice and learning points from other areas as we strive for the highest standards.

In April 2015 the force moved to a new Operating Model this resulted in an increase in senior management. There is a DCI responsible solely for NEL, giving greater resilience for partnership working at a strategic level. While the Police service are subject to budget cuts during 2015 the number of investigators covering the South Bank PVP (NE and N Lincs) is to be increased. All investigators within the PVP will take the appropriate training to be accredited investigators at all levels of sexual and physical abuse concerning children. The Police will continue to contribute fully to all development of policies and procedures by the local LSCB, and contribute to audit procedures. The new operating model placed PVP within the communities command, allowing for greater sharing of information and building better working relationships. There are two bases (Clough Road, Hull and Brigg), servicing four LA's which currently includes 5 x DCI's and 9 x DI's.

The remit of the PVP is in line with the 13 strands of Public Protection as defined by the College of Policing. This ensures our commitment to safeguarding the public is managed under one core function within the Police. Within the PVPU there are dedicated teams dealing with Missing and Exploited, DV, Safeguarding Adults and Children and the Management of Sexual and Dangerous Offenders. There has been an increase in staff, which in turn has seen an increase of workloads within the PVP and weekly meetings are in place to monitor these within the Organisation which include regular feedback on performance.

Child Sexual Exploitation, Domestic Abuse and Serious Sexual Offences are now within our force control strategy, placing priority and scrutiny in these significantly important areas of crime.

What have you done in your organisation to improve safeguarding for Children and Young People?

Update on activity

- Humberside Police is settling into the new Operating Model to meet future demand in a period of budget cuts.
- Within the restructure the protection of children from harm is recognised as one of the priority areas of business and is within the control strategy.
- In April 2015 the Protecting Vulnerable People (PVP) team (including safeguarding of children) on the South Bank of the Humber became one team and moved to Brigg.

- The benefit of this is a corporate response to child protection working to a single operating model, incorporating best practice from across the force. It also enables a larger joint team in order to match resources to demand.
- Within this model Humberside Police remain committed to providing a Police Supervisor to decision make alongside partner agencies within the NE Lincs MASH, and have added Police admin support based within the MASH.
- Humberside Police have also set up a Missing and Exploited Team (MET team), including a South Bank based team specifically to deal with Missing children and CSE.
- All child safeguarding issues are dealt with by a single police team who are specifically trained for this role.
- Demand within the team has risen substantially during the year. During 2014/2015 while resources based within the PVP team covering NE Lincs rose by approximately 80%, crimes dealt with by the team rose by approximately 140%. This is partly due to the increased remit, but also due to an increased reporting of sexual offences locally, which reflects the national trend and also increased awareness of perpetrators of sexual exploitation of children as we refine our intelligence tools.
- For CATS records specifically dealing with children we have seen a 19% rise in the number of jobs for 2014/15 compared with twelve months previous. For Section 47 cases the rise is 8%.
- Officers within the MET team are recognised nationally as leaders in the use of Child Abduction Notices to disrupt offenders who target children for sexual exploitation.

Partnership Working

- Humberside Police remain committed to working with our partner agencies to safeguard all children within NE Lincs
- Our attendance at LSCB meetings remains high.
- We sit as panel members on all Serious Case Reviews and contribute to LSCB audit processes.
- Police are key personnel in the Multi Agency Child Exploitation (MACE) meetings collating the intelligence to identify children at the highest risk of exploitation to make sure they have a wraparound multi-agency approach to safeguard those children.

Next Steps/Planned Developments

- Representation at sub committees will be on a geographic basis with a Chief Inspector allocated to specifically work with NE Lincs LSCB and LSCB.
- The increased demand placed on police resources has been recognised and there is a current shift in resources to address this issue in an attempt to reduce this.
- The MASH team will remain co located with partner agencies.

6.2 Serco (School Improvement Services)

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Serco plays a full and active part in the governance and delivery of safeguarding in North East Lincolnshire. Examples of activities in 2014/2015 include, the signposting of new guidance "Inspecting Safeguarding in Early Years, Education and Skills Settings" (published June 2015) to all settings through a variety of forums including the Early Years Settings Senco Forum. Providing support to a number of settings when safeguarding issues have emerged. Attending the Hate Crime Group of Safer Communities with a particular focus on racially motivated Hate Crime where this impacts on children in schools and/or their families.

Next Steps/Planned Developments

- Ensure that any statutory guidance is circulated to all schools in North East Lincolnshire with briefing notes circulated to head teachers. Principals and governing bodies
- Monitor the use and maintenance of the Single Central Record in maintained schools

- Serco staff to receive updated training as required in relation to safeguarding procedures
- School and Early Years Settings Ofsted reports analysed to identify safeguarding aspects of the inspection, with annual report to LSCB

There has also been an analysis of the safeguarding elements of Ofsted reports, which showed no strong messages or trends. This will be an ongoing source of intelligence to inform – safeguarding in schools.

6.3 Children's Services

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Children's Social Care (CSC) is a significant contributor to the work of the LSCB, having staff on several Sub Groups, including that of the chairs. In particular we have contributed to the Neglect Campaign and the Child Sexual Exploitation (CSE) partnership work within has improved safeguarding locally. In addition to work undertaken as part of the learning from Serious Case Reviews (SCR) was co-lead by CSC, which resulted in the multi-agency workshops which were positively viewed by all in attendance.

CSC attend with the Operational and Leadership Board and have supported the development of the Score Card approach, which has led to the LSCB to understand the areas issues better and focus on next steps.

CSC is actively engaged in the Domestic Abuse work and the recent developments on this agenda are aimed at improving our collective responses.

What have you done in your organisation to improve safeguarding for Children and Young People?

In terms of what we have done within our own organisation, these have been extensive for greater detail see the earlier sections on the MASH and CASS.

CSC has increased the number of Social Workers in its front line services, in response to the increase in safeguarding activity. Significant time and energy has been focused on ensuring all agencies understand its referral process and the linked thresholds in respect of our services. We have worked with colleagues to develop and enhance the Early Intervention and Prevention Offer, so families and professionals always get a response at the level appropriate to the identified concerns. The MASH challenge sessions have opened up the referral response process to multi agency challenge and actions.

Service developments have continued and CSC has developed champions linked to key areas of practise.

CSC has lead on the Signs of Safety approach to safeguarding and are a key contributor to the Creating Stronger Community Project, which will see significant numbers of multi-agency staff working and supported in this culture change programme will aim of improving outcomes for Children and Young People.

Next Steps/Planned Developments

Continued developments of the Early Intervention and Prevention approach based around the new Family Hubs.

- Explore greater interpretation with Adult Safeguarding.
- Continue to reduce Social Work caseloads.
- Focused work on Child in Need cases to reduce the very high numbers currently in the service.
- To have written the revised Social Work Performance Framework.

6.4 NSPCC

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

- Services delivered by the Grimsby NSPCC Service Centre are focused upon improving the safety and well-being of Children and Young People in NELC.
- All work undertaken by the NSPCC involves strong collaboration and partnership working.
- The NSPCC initiated a pilot service '**Coping with Crying'** in NELC in May 2014. This is a short film which is shown in Children's Centre's to expectant parents by trained staff. The target of reaching 1,000 parents within 18 months is on track.
- The NSPCC is a lead agency for the **Harmful Sexual Behaviour** Pathway and has co-written and developed the inter-agency protocol implemented in April 2014 The NSPCC delivers the **Change For Good** Treatment Programme to those Children and Young People at the highest threshold of risk. We have co-written and developed awareness raising training material and delivered this to over **250** professionals within NELC since October 2014.
- We will continue to deliver a range of core services, including: **Video Interaction Guidance** for attachment based problems; **Triple P** pathways 4/5 to tackle neglect**; FEDUP** for children and parents who are impacted by substance use; **Family Smiles** for children and parents who are impacted by parental mental health; **Face to Face** for Children and Young People who are looked after or live in kinship care and **Turn the Page** for Children and Young People who display harmful sexualised behaviours.
- The NSPCC has contributed to writing, piloting and delivering a series of training and practice enhancement workshops for the Professional Capability Pathway on neglect.
- The NSPCC are making a five year commitment to test assessment and intervention models to tackle neglect. The **Thriving Families** initiative went live in April 15 and chimes with NELC's PEI Strategy and the LSCB Strategy for Neglect to maximise opportunities for collaborative work and support integrated systems and processes.

What have you done in your organisation to improve safeguarding for Children and Young People?

- We ensure staff has an annual Professional Development Review that is reviewed twice a year to ensure that staffs are appropriately trained for their role.
- NSPCC practice standards require a robust level of management oversight on open cases.
- Key Performance Indicators include:
- Each open case supervised each calendar month. There is an expectation that reflective supervision is well evidenced and that safeguarding and child protection is prioritised from referral through to case closure. The child's voice must be evidenced.
- Children and Young People who are open cases to the NSPCC to be seen and spoken to a minimum every 28 days.
- There are up to date risk assessments on each open case file.
- A minimum of two cases per practitioner must be audited by a team manager each month. The Service Manager must audit 4 cases each month for compliance and quality.
- We have incorporated Signs of Safety into our supervision process.
- We undertake Peer Audits to promote learning.

Next Steps/Planned Developments

- Thriving Families implemented in April 2015 will work with families that have been identified a experiencing neglect for Early Help to prevent escalation to statutory services.
- We will work in partnership with LSCB partners to evaluate outcomes to measure the impact of this work over the next five years.
- We will implement the bespoke North Carolina Assessment Tool and use this alongside the Graded Care Profile (version 2) to assess neglect.
- We will train staff in the Safe Care Parent Training Model to work with neglecting families.

6.5 North East Lincolnshire Clinical Commissioning Group

What have you done as part of the LSCB partnership to that has improved safeguarding for children and you people?

North East Lincolnshire Clinical Commissioning Group (NELCCG) has been represented on the Leadership Board by the Deputy Chief Executive. The Operational Board has been attended by the Assistant Director for Service Planning and Redesign, and the Designated Nurse and Doctor. The Designated Professionals have worked with relevant providers to ensure appropriate health professional representation on all LSCB Sub Groups.

The Assistant Director and the Designated Nurse have co-chaired the Safeguarding in Health Sub Group. The Sub Group has explored the identification of meaningful outcomes which will improve arrangements across the health economy to safeguard children.

The CCG provider contracts include the requirement to incorporate LSCB priorities & local standards into their services.

What have you done in your organisation to improve safeguarding for Children and Young People?

NELCCG does not directly provide any services to children. However, the NELCCG is required to ensure they, and all their commissioned providers, operate safe systems which meet S11 statutory duties, and safeguard children.

NELCCG identified 10 standards to be included in all contracts for services commissioned by, or on behalf of, NELCCG. These standards reflect provider requirements arising from S11 Children Act 2004, and Care Quality Commission Fundamental Standards – Regulation 13. Assurance has been sought from each commissioned provider to ensure compliance with the standards.

During the year, the CCG increased its specialist professional capacity to support both the LSCB and CCG, with the recruitment of an experienced full-time Specialist Nurse shared with North Lincolnshire CCG.

The Designated Professionals were involved in supporting clinicians in health providers, in particular named professionals, and practitioners in partner agencies on the appropriate management of complex cases.

NELCCG had a duty to support the improvement in quality of primary care services. The CCG, through their Designated & Specialist Nurses and Named GP have promoted opportunities for practices to improve their safeguarding contribution. An audit of GP arrangements was undertaken in the year, though the report was not finalised until after year-end.

Next Steps/Planned Developments

NELCCG have developed a work plan for 2015/16 which will support delivery of the LSCB priorities. The work plan will be dynamic and respond to emerging issues/ learning (locally and nationally) but will include:

- Supporting & improving the quality arrangements required in independent contractor services.
- Development and roll out of safeguarding training and supervision strategies for Northern Lincolnshire Health Economy (in collaboration with North Lincolnshire CCG).
- Embedding monitoring of safeguarding children arrangements for all provider health services, working with other health commissioners to ensure consistency of approach and elimination of gaps in services for vulnerable children/families.

6.6 CAFCASS

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

Locally Cafcass is based in Hull comprising a Team of one Service Manager and 16 Family Court Advisers (FCA) undertaking Work After First Hearing in respect of Private Law (WAFH) and Public Law cases. All team members undertake Public and Private Law work covering the geographical areas of North East Lincolnshire, North Lincolnshire, Hull and East Riding of Yorkshire. The Work to First Hearing Team (WTFH) is also based in Hull comprising 0.25 Service Manager and 5 FCA's. This is a dedicated team preparing Safeguarding Letters prior to First Directions Appointments in respect of all private law applications to the Courts.

All staff are involved in Performance Learning Reviews and formally assessed against safeguarding objectives on a quarterly basis. At the last point of assessment over 90% of staff were graded as Good for safeguarding.

Effectiveness of Safeguarding Arrangements

A key focus during 2014/15 was continued improvement following our "good" Ofsted judgement in April 2014. Cafcass has a robust programme of internal audits to assure the effectiveness of safeguarding in both public and private law.

We provide tools for practitioners to use in self-assessment in order to benchmark the quality of their own work.

Practitioners are supported extensively and scrutinised routinely to ensure the effectiveness of their safeguarding practices.
Reports to court are routinely quality assured and practice observations are undertaken, as set out in our Quality Improvement and Assurance Framework.
Further assurance is provided through yearly national audits and our Key Performance Indicators (KPIs). A national audit of practice was undertaken in November 2014 with the objective of providing a snapshot assessment of the standard of casework. The audit measured the progress of work since the audit in September 2013 and the Ofsted inspection of April 2014. The conclusions were positive, reporting the percentage of work graded as "good" at 65%. This represents a significant improvement of 16% from the previous year's audit.

We will undertake three thematic audits in 2015/16, focusing on further improvements required. These will look at the extent of the improvement in the joint working between the Independent Reviewing Officer (IRO) and the Guardian; the Guardian's involvement and agreement to any position statement filed in proceedings; and evidence in WAFH of the improvement in analysis of assessment and increased use of research and tools.

We continue to respond to, and facilitate, developments within the family justice system and in particular the move, in private law towards supporting parents, where possible, to make safe decisions outside of court proceedings. We are currently piloting a programme announced by the Ministry of Justice, to provide advice and to encourage out of court pathways for separating parents, where it is safe to do so.
The supporting separating parents in dispute (SSPID) helpline was launched in November 2014. Callers are put through to a Cafcass practitioner who can talk through the difficulties of separation, offering support, guidance, and information.
We also ran a six month pilot of a safeguarding advisory support service for mediators, aimed at providing support in cases featuring child protection concerns.

Cafcass is also working on the Parents in Dispute Pilot, in partnership with the Tavistock Centre for Couple Counselling. The chief aim of the project is to support separating parents involved in high conflict disputes in the family courts.

A significant emerging issue in recent years has been Child Sexual Exploitation (CSE), We are implementing a CSE strategy which involves consolidating systems to capture data on CSE in cases known to us; providing mandatory training on CSE to our staff, running workshops to increase awareness; reviewing policy guidance to staff; creating dedicated management time to support the delivery of the strategy at a national level; and creating CSE ambassadors within each service area.

To ensure that our staff are able to safeguard children as best as possible, Cafcass has an extensive workforce development strategy

6.7 National Probation Service

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Through its agency level remits described above, the National Probation Service (NPS) is fully committed to the safeguarding and welfare of children. The NPS is organised on a Divisional basis and the North and North East Lincolnshire Local Delivery Unit forms part of the NPS North East Division. The North East Division has designated a lead 'Head of LDU' as the policy holder for implementing safeguarding policy across the division.

- The Head of NPS North and North East Lincolnshire has lead responsibility for Safeguarding children; is accountable to the Deputy Director for the NPS and the National Offender Management Service. Within North East Lincolnshire a manager at Senior Probation Officer grade has responsibility for the operational safeguarding and the promotion of child welfare. During the last year the following activity has been completed as a result of the NPS' commitment to the LSCB and safeguarding children.
- The North East Division provides a Business Delivery Plan for which is strategic in purpose and cascades service delivery responsibilities to relevant leads, ensuring safeguarding is accounted for.
- Safeguarding updates are communicated locally and across Humberside via lead Senior managers and operational lead Senior Probation Officers. As part of a National Service, governed on a Divisional level, a briefing and bulletin system is in operation to ensure all staff receive current safeguarding information ranging from policy, legislation implementation and practice guidance.
- Senior Managers take responsibility through direct supervision of middle managers to ensure staff have taken appropriate measures to safeguard children as part of operational case management. Senior Managers are also responsible for commissioning internal audits and through the SCR or SFO processes, action plans are implemented according to findings.
- Management forums which include Senior Managers, Operational managers and Business administration managers include and focus on the contribution to safeguarding. This is replicated for practitioner team forums which include findings from quality assurance activities to enhance practice.
- The focus has remained during the last year in respect of safeguarding being central to the business of the Mappa SMB and at all levels of Mappa case management.
- The protocol between Mappa and the LSCB has been retained to provide clear continuity of information sharing.
- The NPS currently operates the Safeguarding Children Policy written and approved by Humberside Probation Trust (HPT) which has long had established policies and procedures. Policies have been continually reviewed to maintain compliance with organisational change and the implementation of legislation.
- Following organisational changes implemented as part of the Transforming Rehabilitation Reforms the NPS has sought to enhance clear and straightforward guidance to staff to be able

to recognise and respond to child safeguarding concerns. The NPS has clear complaints and 'whistle blowing' policies and systems in place with clear timescales. .

- NPS has clear structures and arrangements in place. In addition to line-management arrangements, each office has an identified middle-manager (Senior Probation Officer) who takes a Local Delivery Unit lead on safeguarding issues. Their lead role is publicised and known by all relevant staff.
- As a result of the direct operational link to the LSCB, In North East Lincolnshire, proactive and constructive work has commenced to realise the NPS contribution to addressing Child Sexual Exploitation (CSE). This is evident in the operation of a multi-agency approach with partners to identify and assess targeted approached to protecting Children and Young People in North East Lincolnshire.
- The NPS has worked closely and effectively with the Humberside Lincolnshire and North Yorkshire, Community Rehabilitation Company (HLNY CRC) to safeguard children through the appropriately targeted sentencing recommendations for offenders, ensuring that the risk escalation process is robust and is fit for purpose in ensuring duties of both agencies are discharged immediately to protect children.

What have you done in your organisation to improve safeguarding for Children and Young People?

Central to the work of the NPS in the management, assessment and rehabilitation of offenders and in supporting victims of crime, is the need to promote safeguarding across all areas of service delivery. This includes;

- The Pre-sentence stage to assess the risk of serious harm presented by an offender towards Children and Young People and the recommendation of sentencing options to mitigate and reduce such risks.
- Working directly with offender in the community and in prison through the statutory supervision framework to target their criminogenic needs and the associated risks to young people.
- The NPS works on a statutory basis with victims of offences specified within Schedule 15 of the Criminal Justice Act 2003. This allows for the child's voice to be heard in respect of sentence planning, risk management activities, the formation of licence conditions to manage any risks to children (which can include no contact or supervised contact, exclusion zones, directed residence and prohibited activities).
- Cases managed through the Mappa framework facilitates the safeguarding responsibilities of relevant authorities and provides further accountability to a collaborative approach to the management of safeguarding practice.
- Feedback is sought by victims on a regular basis and its importance is recognised through a Service Level Agreement of the NPS which is performance managed to ensure victim feedback which includes the active engagement of adult of child victims to inform practice.
- The need to take all actions necessary to safeguard children is a priority within NPS Service delivery. The focus and emphasis of the NPS is on managing risk to children (with a corresponding focus on welfare in the context of risk management).
- Through the NPS assessment process safeguarding is a clear requirement within each Offender Assessment System (OASys) and practitioners have the very clear expectation that sentence plans are constructed collaboratively with the offender and include specific objectives targeted at safeguarding.
- An Integrated Quality Assurance model operates within the NPS to quality assure NPS delivery and safeguarding practice providing a consistent cycle of audit and development of practice to enhance our safeguarding provision.
- Staff are well versed in referral procedures to Children's Services, the recording of risk assessments, risk management plans completed within a multi-agency environment and management oversight requirements for referrals. Probation Officers are skilled in identifying the need for early help and assessment where required and work proactively and where appropriate transparently with families to manage safeguarding issues.
- The NPS promotes the fact that safeguarding is the responsibility of all members of staff and not limited to operational employees.

- Additionally in order to successfully implement the Transforming Rehabilitation reforms YOS youth to adult transitions have been revised to account for the NPS role for allocating which organisation (NPS or CRC) will manage specific cases including the provision of key link practitioners and managers in NPS and YOS.
- The NPS locally has developed enhanced Public Protection Instructions which are commissioned and endorsed via a strategic Public Protection Governance Group of managers and practitioners. These include instruction and expectations for carrying out a range of offender management activities focused on safeguarding.
- Practitioners take direct account of the diversity needs of offenders and their families in order that services and interventions can be appropriately targeted and achieved through a collaborative approach with families, ensuring the voice of the child/young person is appropriately represented.

Next Steps/Planned Developments

- As the National Probation Service moves forward, updated safeguarding training is being implemented across the country available to all staff via an e-learning package. The NPS continues to engage with North East Lincolnshire Child Sexual Exploitation strategies and will continue to play a key role in working closely with LSCB partners. Additionally, quality assurance activity is planned to continue in order to continually assess the NPS contribution to safeguarding, the robust management of those offenders who are assessed as presenting a risk of serious harm to Children and Young People and to strengthen our services to victims to ensure the voice of the child remains at the centre of risk assessment, risk management and intervention with offenders and victims.

6.8 Community Rehabilitation Company

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Humberside Lincolnshire and North Yorkshire Community Rehabilitation Company has contributed to the leadership and operational meetings of the LSCB and participated in the Section 11 Audit. We responded to the few action points identified and evidenced progress at the follow up challenge day in June 2015. Safeguarding remains a key focus for staff within HLNY CRC and is a key element of internal practice audits which take place on a quarterly basis. In additional, our Quality and Practice Manager, Julie Edwards, audits a random sample of safeguarding cases on a monthly basis. An HLNY CRC Safeguarding Policy which harmonises the policies of the previous probation Trusts has been developed. The new Policy is compliant with Working Together to Safeguard Children 2015 and reinforces staff responsibilities in relation to safeguarding cases.

What have you done in your organisation to improve safeguarding for Children and Young People?

All frontline HLNY CRC staff in North East Lincolnshire have completed Level 1 Safeguarding training; the majority have completed Level 2 and the remainder are booked on to forthcoming training events. Routine safeguarding enquiries are undertaken for all HLNY CRC probation clients and staff are aware of the need to consult the Multi- Agency Safeguarding Hub where offenders are residing with or have frequent contact with children. Management oversight is a key aspect of safeguarding work within HLNY CRC. Staff routinely discuss concerns with their line manager and safeguarding cases are discussed on a regular basis within staff supervision. Priority is placed upon home visits and staff are encouraged to undertake these when children will be present. Internal audits evaluate staff contribution to core groups and case conferences.

Evidence/Impact/Difference Made

Staff have completed e-learning in respect of Child Sexual Exploitation and further training in this area will be an appraisal objective for 2015/2016. A representative attends monthly multi-agency CSE meetings and we have worked closely with Humberside Police to ensure appropriate information sharing and risk assessment processes are in place with regard to CSE suspects.

Next Steps/Planned Developments

The forthcoming year will be one of considerable change for HLNY CRC as our providers, Purple Futures, begin to implement service redesign and the new operating model. Safeguarding will remain a key priority in service delivery and we will continue to update the Leadership and Operational LSCB meetings as changes progress. Staff have been identified to undertake the Signs of Safety training event and this learning will then be cascaded amongst all operational staff and relevant staff from our partnership agencies. We are also currently building links with the Troubled Families programme to ensure a commitment to referring HLNY CRC clients for early help and a holistic approach to supporting offenders and their families towards positive change.

6.9 Children's Health Provision

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

- CHP staff prioritise attendance at LSCB Sub Groups.
- Work with partners to support the work of the LSCB.
- Individuals have:
    - Participated in working groups to support audits
    - Address capturing the "Voice of the Child"
    - Develop training packages
- There is a CHP clinician who plays a key role in supporting the decision making processes within MASH.
- Named Nurse has supported LSCB training delivery on neglect.

What have you done in your organisation to improve safeguarding for Children and Young People?

- The Head of Complex Health Care post has now incorporated the statutory role of Designated Clinical Officer for Special Educational Needs and Disabilities.
- Developments within CHP safeguarding team have allowed the recruitment of a further Specialist Practitioner.
- School nurses:
    - Support the needs of Children and Young People within educational settings.
    - Provide drop in facilities for young people to raise individual health concerns.
    - Offer supportive interventions to children and their families.
    - Offer support to staff when managing the needs of children in their care.
- There has been a revision of the guidance for CHP staff in relation to providing court statements for legal processes involving children and families and there has been a significant increase in the numbers and quality of these being provided.
- In the year to 31st March 2015 significant focus has been given to addressing some of the key messages from Serious Case Reviews with staff groups in CHP.
- Attachment training has been delivered by the Family Action Support Team (FAST) to the Health Visiting teams.
- Focus of interventions within FAST service delivery has been adapted to pursue "Early Interventions".
- Training has been delivered to Health Visitors around managing "Routine Enquiry" to assist in addressing Domestic Abuse issues.
- Safeguarding Children Supervisors attended two day bespoke NSPCC training carried out in two cohorts to develop their supervisory skills.
- The Safeguarding Team sought training for practitioners in relation to court appearances.
- Health Visiting Services have been delivered from Children's Centre's across the area.
- Staff have assisted in the work to support the formation of Family Hubs.

- Communication links with health colleagues in relation to children attending A&E, with staff in maternity services and the LAC team have progressed in 2014/15 and continue to be developed via the safeguarding teams in both organisations.

Next Steps/Planned Developments

Future plans include:
- The development of School Nursing Skills of staff in relation to Adolescent Mental Health.
- Pursuing the roll out of the Signs of Safety approach across the provision.
- Working with colleagues to deliver a child focused services.
- Safeguarding Specialist Practitioner to create direct links with CAMHS, Adult Mental Health Services and Domestic Abuse Services.

6.10 Northern Lincolnshire and Goole NHS Foundation Trust

What have you done as part of the LSCB partnership that has improved safeguarding for Children and Young People?

Overview of Trust in relation to Safeguarding Children.

The Trust provides a combination of services to clients within the Primary and Secondary Care Sectors of North East Lincolnshire, North Lincolnshire and Goole. The Trust has an Executive Lead at Board level and an overarching lead for Safeguarding (Adults and Children) across the Trust and is compliant with its statutory duties in having in place identified named professionals for safeguarding.
Governance arrangements are in place to oversee and quality assure our safeguarding processes alongside the day to day advice that is available to practitioners from our team of Specialist Nurses and Doctors.
The Trust is signed up and complies with the LSCB Safe Recruitment Protocol.
Achievements
- NLaG and specifically the safeguarding team have continued to work across a broad range of safeguarding areas and issues such as Child Exploitation, Domestic Violence, Female Genital Mutilation, Early Help and Early Identification/Reduction of all forms of abuse including Emotional and Neglect.
- Child exploitation is a key area that has received much focus over the last 12 months. NLaG have systems in place to flag both victims and perpetrators when they come into contact with health professionals and are actively involved in the multi-agency approach to tackling CSE.
- Additional training has been undertaken to ensure that front line staff are able to identify and assess risk when they first meet Children & Young People. NLaG is presently developing its CSE strategy to further enhance its response and ensure a consistent approach across its 3 LA areas.
- Domestic Abuse continues to increase across the region and within NLaG Domestic Violence (DV) forms part of all safeguarding training as well as standalone DV training which has led to an increased awareness amongst all staff groups. NLaG participate in MARAC and have cascade frameworks to enable information to be shared with appropriate professionals across the Trust.
- Early Help continues to be an area that we are developing and over the last 12 months there has been a significant drive to increase the number of Early Help Assessments undertaken by Midwifery whilst continuing to promote the process within the community care professionals such as Health Visiting and School Nursing. Early Help continues to be a key aspect of early identification of Neglect/Abuse and a major factor in helping to reduce abuse.
- NLaG provide a 'Family Nurse Partnership' team which aims to assist new young parents in developing their parenting skills and lessen the impact that poor parenting has on your future generations. This team has recently been expanded due to its success and ensure more young parents are able to access its services.

The Safeguarding Children Training Strategy has been in place since June 2011 and has recently been reviewed in line with National Guidance. Training figures are monitored monthly by the trusts

Safeguarding Children Forum and additional training events are developed to ensure staff have the most up to date information. All staff members of NLaG have individualised training plans in place which are reviewed as part of the Performance Review Process. Attendance at training continues to increase on a month by month basis.
The Trust has a Safeguarding Supervision Strategy in place and have recently widened mandatory Safeguarding Supervision to more professionals groups than those previously included (Health Visitors, Paediatric Nurses, Midwives and Gynaecology) and is also available to other staff members as required.

What have you done in your organisation to improve safeguarding for Children and Young People?

What difference has it made to the lives of children and young people?

For Children and Young People who enter NLaG services via A&E, there is earlier identification of risk and as such a better service is given. Communication pathways exist to ensure that Secondary Care information is effectively shared with Primary and Community Services and therefore the children receive prompt follow up when necessary.
Systems are in place to highlight additional service needs when children attend at the Hospital and are on a Child Protection Plan or under the care of the Local Authority as well as systems which identify risk in relation to Domestic Violence.
As a result of the above, children have had speedier/more effective Single and Multi-Agency Interventions.
FNP continue to provide a service to in excess of 100 young parents and in some specific cases the impact of this work as meant that parents make significant enough changes to make the difference between keeping or losing a child.

Have there been any organisational/financial changes which have impacted on your ability to safeguard children?

NLaG has been relatively stable in an organisational sense and therefore any change as not specifically impacted on its services to Safeguarding Children. Financially NLaG is in no different position to most other Trusts in, so far as it has a financial deficit. There has, however been no significant impact on services delivered to Children and Young People.
The Trust undertakes regular audits covering safeguarding at both frontline service and organisational level (examples of these are in relation to quality and appropriateness of referrals). Audit outcomes are managed by the safeguarding children forum and reported to the Trust Governance and Assurance Committee.

Next Steps/Planned Developments

In February 2015 an external audit was commissioned from KPMG to review the safeguarding processes within the Trust. The audit has given significant assurance that NLaG has a safe and effect safeguarding system in place, however does make a recommendation that NLaG should undertake a Gap Analysis to ensure that the increasing safeguarding workload is able to be effectively managed within the current resources of whether there is a need to increase the current capacity of the team.

Priorities for 2015/16
- Gap analysis with regards to current team resources.
- Continue to increase uptake of safeguarding training throughout all departments within the Trust.
- Maintain an on-going audit programme to ensure safe delivery of safeguarding processes within the Trust.
- To maintain the current commitment to working with partner agencies in order to safeguard and promote the welfare of children across the NLaG boundaries.

- In conjunction with our commissioners continue to review the current provision for Domestic Violence within NLaG in so far as working with our current partners in direct case management and early detection within our client groups.

7. POLICIES PROCEDURES AND GUIDANCE

What have we done?

The NEL SCB procedures were compliant with Working Together 2013 and are in the process of being revised in line with Working Together 2015. The LSCB commissioned Triex to manage, review and revise the LSCB procedures. The procedures are reviewed on a six monthly basis.

Evidence/Impact/Difference Made

Significant changes have been added in respect of national guidance. The application and effectiveness of safeguarding procedures are measured as part of case file audits and Serious Case Reviews which is an ongoing process. The LSCB have produced Resistant Parenting guidance following learning from SCRs. Guidance for practitioners in respect of "Bruising to Non Mobile Babies Policy" has been developed and will be agreed by the Board on 2015/16. Both the Child Sexual Exploitation guidance and Harmful Sexualised Behaviour guidance have been updated in 2014 as part of ongoing development and review. There have been 3,590 visits to the website during 2014/15.

The LSCB built on the existing Council supported LSCB website and have developed a dedicated LSCB Website supported and financed by the Clinical Commissioning Group. The website has dedicated sections for children, young people, families and practitioners SCRs, procedures, training, performance, good practice and national research.

Next Steps

Youth Action are involved in reviewing the Young Person's section in ensuring it is young person centred. The LSCB website will be developed on an ongoing basis and is overseen by the LSCB Operational Board. Each of the LSCB Sub Groups feed into the Operational Board in respect of required updates to the website.

8. LEARNING AND DEVELOPMENT ACTIVITY

What have we done?

In the training year April 2014 – March 2015, 180 safeguarding courses were run (increase of 40 from previous year) and 3315 participants were trained (increase of 878 from previous year). These are made up of both single and interagency courses. In addition to the rolling programme of training and continued focus on CSE, Working with Resistant Families and Neglect Awareness. This training year saw the introduction of Safe Sleeping and Child Death Process briefings run as bite size sessions to make attendance easier, in addition to this, new courses were introduced relating to identifying and working with Children and Young People displaying harmful sexualised behaviour. The Neglect training package was also further extended to provide practice enhancement workshops around using the neglect tool, the voice of the child in assessing neglect and for supervisors and managers.

The LSCB Board signed off the Learning and Improvement Framework and an action plan is now finalised to drive forward all Learning and Improvement Activity, this is fed into by all Sub Group Chairs capturing all learning activity across the Sub Groups. The LSCB Learning and Development Strategy has been approved and is due to be published on the LSCB website the strategy sets out how the LSCB will ensure safeguarding training/learning activities are based on local need, meet the needs of practitioners, in being able to recognise and respond to need and risk.

Evidence/Impact/Difference Made

The new evaluation process has been implemented in 2014/15 with new forms assessing delegates distance travelled from the beginning to end of the course in knowledge and confidence (all courses) and 3-6 month follow up to measure impact on practice on LSCB priority courses/events. The average distance travelled on all courses in both delegate knowledge and confidence, is movement of three points up the scale (1-10) and over all courses the average knowledge and confidence score at the end of the course was 8 out of 10. Feedback on the following courses delivered over the year was;

- Child Sexual Exploitation - 88% found the training excellent, 12% good.
- Level 2 Neglect - 69% found the training excellent and 31 % good.
- The Voice of the Child in Assessing Neglect: Practice Enhancement Workshop - 63% found the workshop excellent, 33% good and 4% average.
- Level 3 Neglect - 67% felt the workshop was excellent and 33% good.
- Working with Resistant Families Training - 99% found the course excellent, 1 % good.

Next Steps

- Bespoke safeguarding training is being developed for Elected Members to attend in 2015; this is to ensure they are aware of their role and responsibilities in this area.
- A further simplified multi-agency training audit is being carried out in 2015 to help inform the content of the training programme and highlight any development issues, this will have more of a focus on highlighting practitioners who have not accessed training, understanding why this is and breaking down barriers to learning.
- The Creating Stronger Communities (innovation) programme will embed the Signs of Safety, Restorative Practice and Outcome Based Accountability approaches in all that managers/supervisors and practitioners do in relation to their work with children and families. A programme of learning is being developed using a model that identifies Coaches and Practice Leads/Champions in each area who will support the embedding of these approaches through disseminating the learning within their teams as well as to planned multi-agency action learning groups. The LSCB training programme will need to be reviewed and revised to take account of the new approaches and to build in ongoing sustainable learning opportunities for the future.

9. MONITORING /QUALITY ASSURANCE ACTIVITY

What did we say we were going to do?

The Quality Assurance Sub-Group (QA Sub-Group) is a multi-agency group led by the Strategic Safeguarding Manager with the core function of conducting multi-agency audits and quality monitoring within LSCB partnerships. Its aim is to provide the LSCB with an overview of Safeguarding Practice within North East Lincolnshire identifying and monitoring progress and development in priority areas of provision and practice such as Child Sexual Exploitation, Neglect and effectiveness of identification and referral processes. Through the audit and performance monitoring process the QA Group can alert the LSCB to emerging themes, advise and assist with the forming of action plans and where indicated promote improvements or changes to practice to achieve better outcomes for children.

During 2014/15 the Quality Assurance Sub-group has focused on reviewing its function and purpose and developing a schedule of audits to meet local and national drivers. The group has reviewed its Terms of Reference and membership and undertaken a calendar of planned activity. The QA Group has linked its activities with the LSCB key priorities for multi-agency audits to inform an overview of safeguarding practice across NEL and promote practice improvement through learning from audits.

Working with the LSCB

The LSCB has endorsed the resourcing, recruitment and appointment to a dedicated Quality Assurance Coordinator post to facilitate the implementation of the Audit Calendar and build in flexibility to the audit process to meet emerging need. The QA Co-ordinator post is shared with the Safeguarding Adult Board and recruitment took place in quarter 4 of 2014/15.

The Sub Group has worked closely with the LSCB Business Manager to build on previous audits undertaken such as Supervision, Neglect, Education and Section 11 audits. It has produced action plans and reports for the board following audits and held Challenge Days to enable a multi-agency approach to analysing audit findings and share experience from a multi-agency perspective.

The group has also identified the need to improve methods and consistency across partner agencies in how we evaluate the effectiveness of our audit programmes and develop audit tools and processes to provide on-going multi agency audit across children's service provision.

How much have we done?

The QA Group has held monthly meetings since July of 2014 and reported on and coordinated a number of themed audits into CSE, Referral Thresholds and Neglect.
Its terms of reference have been revised and a robust structure put in place that specify function of the group and its key priorities.
The group completed an in depth CSE audit and held a CSE Challenge Day that resulted in a comprehensive action plan being overseen via the NEL lead for CSE.

The group has developed an interagency audit tool aligned to Ofsted criteria and this has been trialled for use in audits into 2015/16. The group has also followed up the findings and outcome from a previous Neglect Audit to inform a revised audit for 2015/16. The group also conducted a supervision audit that again led to the need to revise the Audit Tool for Supervision to be more applicable to all partners.

How well have we done it?

Throughout 2014/15 the group has had consistent representation from key partners and attendance is good but has seen the impact of the restructure of policing in Humberside placing capacity issues on consistent police representation and attendance.
The revised Terms of Reference was agreed by the group and has been endorsed by LSCB and the Audit Process Pathway developed by the QA Co-ordinator has been implemented to ensure timeframes for audits are adhered to.
An audit programme including Neglect and Threshold was completed during quarter 4 of 2014/15 for implementation during early May and June 2015. S11 Audit processes have been progressed and provided assurance at board level that standards are on the whole being met by all partners.

Evidence/Impact/Difference Made

NEL LSCB now has a robust multi-agency audit group and process in place that is shared and owned amongst key partners. Going forward to 2015/16 the QA Group has a clear plan for themed audits and is able to adjust its tools and methods to meet emerging needs.
The QA Group links with the Performance monitoring for all Sub-Group activity and produces an overarching performance summary for the LSCB on a quarterly basis.

The findings from the CSE Challenge Day held January 2015 were received by the Leadership Board and have impacted on changes to the overall CSE strategy. Multi agency analysis sessions have been held to develop accurate overview of CSE in NEL. CSE Audit Action Plan is now in place and managed by CSE Operational Board via the designated Sub Group. Progress will be reported on through the QA Score Card. Progress against the CSE Strategic Action Plan reported to April Leadership Board.

Positive agency feedback was received regarding the evidence of joint working and awareness was raised regarding the prevailing difficulties with victim engagement and key worker relationships as a priority. All agencies are aware of CSE guidance & referral pathway and the previous risk/screening tool was shown to be insufficient for risk, need & planning and as a result has been revised and a more effective risk tool is being implemented to address gaps.

Audits for Thresholds and Neglect were scoped during 2014/15 and have since been implemented in the 2015/16 audit calendar.

The S11 audit completed during 14/15 enabled a S11 Challenge Event to be held and assurances re compliance reported to the April 2015 board.
The QA overview of the Supervision audit has been used to inform the need for and development of a more applicable multi-agency partnership tool to evaluate supervision for 2015/16.

Areas of Challenge and Next Steps:

Partnership working - For the QA Group to effectively capture and evidence the practice from all partners and to link with the adult audit process and partners in the adults and voluntary sector, ensuring that all involved agencies are included within audits through the development and maintenance of a mailing list for all agencies. Partners will be invited - following completion of audits - to comment and advise on effectiveness, barriers and ease of use of process, methodology and audit tools to inform development and to improve future audit effectiveness.

Child's Voice and User Views - For the QA Group to ensure its audit programme is effective in capturing and evidencing the impact of the child's voice and influence and the engagement of parents and carers in service provision.

Consultation Tools for gaining the views of Children and Young People are being reviewed and developed. All QA partners have begun identifying processes in place to capture the child's voice and the QA Sub Group is coordinating activity to develop a pro-forma based on the 2015 Working Together for agencies to consider in relation to how each addresses the issue of what children say they want from safeguarding services and their overall welfare. To establish what parents and carers say about services and interventions – their views will be incorporated into audits and themed tools will be more closely aligned to the OFSTED audit format with a view to consistent user views evaluation tools across the authority.

Future audits -
Themes will continue to focus on priorities and during 2015/16 include:
Thresholds
Neglect and Emotional Abuse
Decision Making at Conference
Domestic Abuse
Child Sexual Harmful Behaviour
Supervision
Unborn Planning/Interventions
Children Placed Out Of Area and Children Missing (from Home or Care)
Teenage Cusp of Care
Children involved in Youth Justice

10. AUDITS OF PARTNER AGENCIES

What did we say we were going to do?

In 2014/15 we introduced a more sophisticated approach to Section 11 activity which included a challenge event at which respondents to the audit engaged in dialogue with members of the leadership Board and young people and co-produced action plans for development.

The LSCB undertook a Section 11 Audit in January 2104. Organisations met the majority of standards, where standards were recorded as not being met they were actually partially met but further development had been identified. The quality of the audits was good on the whole, with a small number of gaps in information such as completion dates. A number of organisations provided more evidence to the Section 11 challenge panel that within their audit which identified the need to provide examples within evidence given.

There were no areas of significant concern. A general area of development for all organisations was the level to which they could evidence that service development was informed by the views of children and families. Young people were actively involved in the Section 11 process. Questions were developed and asked by the young people who asked "What is your organisation going to do to improve how you listen to and involve young people in future. Organisational leads found this element challenging and thought provoking.

A further challenge day was held 6 months after the initial challenge day in order to analyse the progress made by organisations. Progress made by organisations included strengthening processes such as recording, information sharing and ensuring practitioners are appropriately trained in safeguarding. There has been particular progress in how organisations have sought to ensure service provision is informed by the experiences of Children and Young People.

11. LEARNING FROM CHILD DEATH OVERVIEW PANEL/SERIOUS CASE REVIEWS

11.1 Child Death Overview Panel

What did we say we were going to do?

The Child Death Overview Panel (CDOP) reviewed 7 child deaths in 2014-15, which is 1 less than the previous year. This brings the number of child deaths since 2008 when the current CDOP process started to 85. Of these there are 3 (from 2015) that are still under investigation and as such the cause of death is not yet been categorised, additionally 27 deaths occurred before this categorisation was introduced. Therefore since 2010 for these 56 children the top three categories were:

1. **Perinatal/neonatal** (which includes prematurity, some types of cerebral palsy, bacterial infections and antepartum and intrapartum anoxia).
2. **Chronic medical condition** (which includes other types of cerebral palsy, liver disease, immune deficiencies).
3. **Chromosomal, genetic and congenital anomalies** (which includes Trisomies, other chromosomal disorders single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac).

What have we done?

Child deaths fall into two categories - expected and unexpected, the latter defined as *'the death of an infant or child which was not anticipated'*. Since the 2008, 45 (57.7%) cases were classed as unexpected.

Child deaths are also classed as whether there were any modifiable factors. Since 2008 13% (11) of deaths were categorised as having modifiable factors identified. Of the deaths with modifiable factors nearly half (4) were relating to inappropriate sleeping conditions.

Evidence/Impact/Difference Made

These are small numbers so there is a challenge on identifying trends. However we seek to identify any learning which is a key function of CDOPs therefore we have:

- updated our annual professional and public facing report - the public report is on the LSCB website, the professional one contains detailed information so has restricted circulation.

- tasked all CDOP members to take back the information and learning to their organisations and professional groups to inform and change practice where necessary.
- worked with the learning and development subgroup to put on briefing sessions for professionals working with children, young people and families to update them on the child death process.
- Worked with the lullaby trust http://www.lullabytrust.org.uk/ a national charity to offer briefings on the safe sleeping messages. This complements the local safe sleeping guidance that was updated recently for North and North East Lincolnshire.
- worked to support a (successful) bid to NSPCC to be a pilot site for 'Coping with Crying' research.
- identified a gap on ongoing bereavement support to parents, siblings and the wider family which has been highlighted and discussed with commissioners.

Next Steps/Planned Developments

- To review the child death process practice briefings.
- To continue to implement the learning from all child deaths.
- To complete the CDOP Annual report from 2014/15.
- To explore further collaborative working with geographical neighbours

11.2 Serious Case Review Process

What have we done?

Two SCRs have been signed off by the LSCB Leadership Board within the timescales of the Annual Report. One at the beginning of the period and one at the end.
The first SCR was undertaken using the SCIE methodology, this was the first time it had been used by us and we found the methodology challenging.
The second report used a hybrid methodology and colleagues reported that this was more appreciated by those involved.
A significant amount of training has been undertaken both on a single agency and multi-agency basis to address the issues raised in those SCRs.

The Sub Group has backed the key actions to ensure completed and followed up with further focussed seminars (see next section for more details).

Evidence/Impact/Difference Made

The SCR Sub Group set up a series of practice seminars for Multi-Agency professionals to ensure as many staff as possible had the opportunity to cascade the learning from our serious case reviews. This was to compliment the normal routes of team meetings, supervision, training and newsletters.

The seminars also dovetailed in the Signs of Safety methodology so as to reinforce this learning approach to all staff. The seminars focussed on the 'Just Don't Do Nothing' approach, and went through case examples and key learning from the SCRs.
Feedback from staff who attended was very positive and there was significant interest (220 attended).

The evidence of difference made remains a challenge. We have individual feedback about raised awareness and greater confidence in responding to the issues raised.
Some elements will be picked up in future Audits and training has been developed which has also highlighted positive feedback from attendees.
There is undoubtedly more work to be done in this area and we cannot assume that the absence of similar cases means we have succeeded.

Next Steps/Planned Developments

- SCR Seminars will be re-run later in the year to reinforce the key messages and multi-agency learning.
- The Sub Group is looking to develop a newsletter to highlight local and national learning from serious case reviews.
- Further investigation/discussion is to take place on evidencing the impact of the seminars.

12. ENGAGEMENT WITH CHILDREN AND YOUNG PEOPLE

What have we done?

The LSCB have developed a number of mechanisms in capturing the child, young person's voice and in demonstrating their influence.

- The young advisors are actively involved in the appointment of lay members and LSCB Chair.
- The "Youth Voice" are reviewing the content of the Children/ Young Persons section of the dedicated LSCB website in ensuring it is user friendly, accessible and approximately geared towards young people.
- "Youth Action" are undertaking work with the LSCB chair around what 'safe' means to a young person in North East Lincolnshire.
- Young people's safety is a regular agenda item on the joint meeting held quarterly between Young Peoples voice groups and senior managers and councillors.
- The Voice of the Child is a key element of the LSCB inter agency audits.
- Families are actively involved in informing the learning from Significant Incident Learning Reviews and Serious Case Reviews (SCRs).
- The roll out of View Point locally provides another medium for capturing views of Children and Young People.
- The Young Reporters have reported on number issues affecting them in promoting positive images of young people.
- The LSCB Quality Assurance Sub Group are reviewing and further developing tools for gaining the views of Children and Young People. The views of parents and carers will be incorporated into audits.
- The "Youth Voice" were involved in the LSCB Section 11 Challenge event in January 2015.
- The young people involved in "Youth Action" undertook LSCB safeguarding children training in supporting them in their work.
- Models and tools for the effective communication, engagement and participation of Children and Young People involved with or at risk of Child Sexual Exploitation are presently being developed.

Evidence/Impact/Difference Made

- The views of family and young people involved in SCRs has informed practice through the dissemination of learning through practice forums.
- The young advisors actively influenced the appointment of the two LSCB lay members and the previous and present LSCB chairs.
- The voice of the child is being placed at the centre of all LSCB activity, and is the focus of the work of the LSCB sub groups.
- 6 focus groups have been held with parents located in Children's Centre's where their views on what neglect is has been captured and noted to be entirely attuned with professional understanding of neglect. Feedback from parents has suggested that the posters/information need to be displayed in more general settings (e.g. Fast Food Outlets, Supermarkets, Taxi Offices, Sports and Social Clubs) in addition to family-focused settings (e.g. Children's Centre's, libraries). We are following through these suggestions within phase two of the public awareness campaign.
- Young People are involved in recruitment processes.

- The Children and Young Person's Plan has been jointly developed by Young People for Young People.
- The involvement of young people in the Section 11 Audit actively challenged organisations on how service delivery was informed by children's involvement.

Next Steps/Planned Developments

- To evidence and facilitate the influence of Children, Young People and Families make in informing safeguarding practice and service development.
- To capture the Child's voice through the sub group audits and development of tools.
- To ensure that all partnership activity and service provision incorporates an element of the voice and impact of Children and Families Views.

13. COMMUNICATIONS

What have we done?

The LSCB are developing a Communication Strategy targeted at the following groups of people:

- Children and Young People resident in, visiting, or accessing services/support from NELSCB partner agencies.
- Parents and carers resident in, visiting, or accessing services/support from NELSCB partner agencies.
- Professionals and volunteers in NELs children's workforce.
- The media.

Evidence/Impact/Difference Made

Communication methods
Website - Contains all Board published information and information for Parents, Children and Young People and those involved in supporting Young People. Provides information about all NELSCB Multi-Agency training courses.

Newsletters - Quarterly newsletters provide up to date information about board activities; new publications and any external information concerning the broader aspects of safeguarding children. Newsletters seek to keep frontline professionals up to date with best practice using information from local and national Serious Case Reviews and serious incident reviews and Thematic Case Audits.

Publications
The Board publishes a range of guidance intended to provide additional tools for frontline workers, most Board publications are available on the website and will be promoted in the newsletter. Information leaflets for parents are published and available on the website. All Serious Case Reviews are published on the Board website. This is subject to the conclusion of any court proceedings.

Board Events
A themed annual LSCB Conference provides an opportunity to look at safeguarding issues in depth and for staff from across the County to attend and take part.

There are established Youth Groups and Young People's Forums which provides opportunities for the Chair of NELSCB, Director Children Social Care and Chair of the Young and Safe Sub Group to share and discuss information regarding young people's agenda and 'What Matters'. The attendance by key strategic managers provides a meaningful link between the Board, Young People and Partners.

Minutes of Meetings
Minutes will be taken of all Board and Sub Group Meetings. Board members have a responsibility to cascade all relevant information to staff within their agencies. Information that requires to be more broadly disseminated will be published in the NELSCB Newsletter.

Media Releases
This may include serious safeguarding incidents which have generated press interest. Planned media releases will be issued to raise awareness of safeguarding within the community.

Next Steps/Planned Developments

The NELSCB Communication Strategy will be complete by October 2015.

14. CONCLUSION, CHALLENGES AND RECOMMENDATIONS

The range of challenges we have faced and continue to face in our commitment to continuous improvement is significant (as would be true of most LSCBs). This report describes progress against many of these, and also describes a wide range of areas for development, summarised in the Executive Summary. These will ALL be addressed, but can be captured in the following two over-arching challenges for 2015/16.

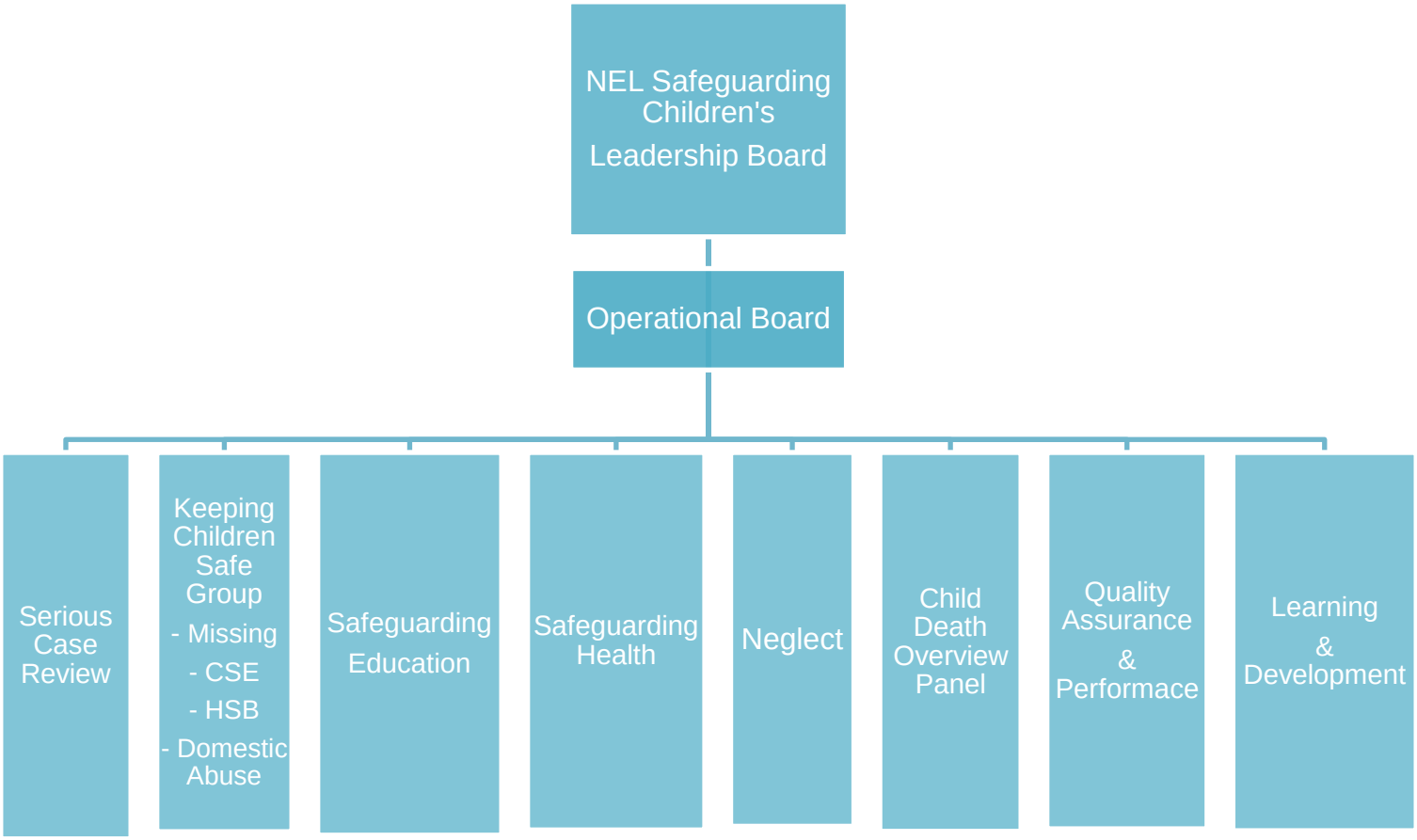
- Demonstrating the impact of Early Help (particularly in relation to Neglect) on making North East Lincolnshire a safer place for Children and Young People.
- Continuing to 'line up the system' - linking what we do across a range of strategic partners and where appropriate across boundaries and in so doing, secure greater effectiveness and efficiency. This was a challenge identified in the previous Annual Report and is strategic and long term

More specifically, and drawing from the areas for development identified in the Executive Summary we will:
- Fully implement the Early Help and Neglect strategies.
- Reduce the numbers of children on Child Protection Plans through more effective early help activity.
- Address neglect through Early Intervention activity supported by the four elements of the Creating Stronger Communities Model and reduce the proportion of Child Protection cases with Neglect as the main reason for referral.
- Give particular attention to collaborative safeguarding activity across geographical boundaries.
- Embed collaborative working with partners where there has been, or will be significant change (Police/Probation/CRC/School Improvement).
- Embed the use of Score Cards and the Core Data Set as a means of individually and collectively understanding our business and performance.
- Continue to address Child Sexual Exploitation through collaborative working and a focus on prevention, perpetrators and victims.
- Embed a 'One System' approach to Domestic Abuse.
- Embed performance reporting and quality assurance processes.
- Further improve systems and processes to capture the Voice of the Child in order to inform the development of better services.
- Explore the development of a CDOP across the boundaries of North East Lincolnshire and North Lincolnshire.

There is tremendous drive and energy in North East Lincolnshire and exceptionally strong partnerships. This, plus a clear view of what we need to do to improve and a clear and focussed approach to addressing these challenges provide the foundations for more effective services in an environment where Children and Young People are safe and can thrive.

Appendix 1

LSCB Structure



Appendix 2

The annual income and expenditure of the board (financial year 2014/15)

CORE INCOME

Made up of contributions from

Humberside Police	£15,000
Clinical Commissioning Group	£33,500
CAFCASS	£550
NEL Council	£77,500

ADDITIONAL CONTRIBUTIONS

Additional Contributions were received as follows

Clinical Commissioning Group toward commissioning Triex procedures	£15,000
Clinical commissioning group towards Serious Case reviews	£10,000
Humberside Police towards Quality Assurance support role	£15,000

TOTAL INCOME	**£162,550**

Staffing

LSCB Board Manager
LSCB Administrator

Staffing Sub total

Running Costs

Appendix 3

TERMS OF REFERENCE OF SUB GROUPS

The terms of reference for each of the LSCB boards and sub groups were revised during 2014 specifying reporting arrangements via Score Cards aligned to LSCB Core Data Set and LSCB priorities.

Leadership Board - Aims
The LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will cooperate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. The LSCB's role is to scrutinise local arrangements and it should therefore have a separate identity and an independent voice. It should not be subordinate to, nor subsumed within, other local structures in a way that might compromise it.
Outcomes - Evidence the effectiveness of local arrangements in safeguarding children. Demonstrate the difference made by the LSCB to safeguarding Children and Young People through the delivery of the LSCB business plan.

Operational Board - Aims
To scrutinise and support the work of the LSCB subgroups reporting to the Leadership Board on progress with the business plan; the identification of key safeguarding issues emerging from the work of the subgroups; overseeing the effectiveness of quality assurance / performance monitoring arrangements.
Outcomes - Performance indicators / audit mechanisms evidence the impact of safeguarding arrangements and the quality of practice. The work of the subgroups and Operational Board meets the identified outcomes within the LSCB business.

The Terms of Reference for each of the 11 sub-groups of the LSCB have been reviewed and revised. The key aims and objectives of each sub group are outlined below.

Child Death Overview Panel – Aims
To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death. To make recommendations to individual agencies based on action required to address any matters of concern affecting the safety and welfare of children in North East Lincolnshire.
Outcomes - Lessons learned from CDOP activities including modifiable factors identified through the review process are clearly communicated to all agencies and where appropriate the Public. Systemic or structural factors affecting children's well-being are given thorough consideration and action identified how such deaths might be prevented in the future.

Learning and Development Sub Group - Aims
To evidence the effectiveness and impact of safeguarding children training in informing practice and improving outcomes for children; to communicate key safeguarding messages, research, lessons and procedural expectations to agencies, professionals, in ensuring a consistent approach to safeguarding children and continuous learning.
Outcomes - Safeguarding training improves practice leading to improved outcomes for children. Professional practice is underpinned by continuous learning in safeguarding children.

Neglect Sub Group - Aims
To reduce the impact and prevalence of neglect in NEL over time, raise awareness at a public and universal level about the signs, symptoms and impact of neglect for Children and Young People aged 0-18 years old. To ensure that neglect is identified at an early stage and that it is responded to consistently, confidently and appropriately at the right threshold of need.
Outcomes - There is a reduction in the prevalence and impact of neglect upon Children and Young People in North East Lincolnshire.

Quality Assurance Sub Group – Aims

To ensure a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
Outcomes - There is a coherent and sustainable Quality Assurance and Performance Framework which is aligned to and informed by the NELSCB Strategic Priorities. All agencies contribute to and are committed to continuous learning and improvement within their respective agencies and collectively.

Safeguarding in Education Sub Group - Aims
To provide assurance to the Leadership Board that the LA, governing bodies of maintained schools, colleges, academies and all educational settings are meeting their requirements as laid out in "Keeping Children Safe in Education" published in 2014.
Outcomes – Quality Assurance including audit is undertaken as agreed to assure the effectiveness of all education establishments safeguarding arrangements. There is regular monitoring and review of schools, academies, colleges and other educational establishments, of safeguarding policies, practice and training

Serious Case Review Sub Group - Aims
Organisational lessons are learnt at a strategic level and changes implemented in informing practice and to prevent future incidents of serious child abuse or death.
Outcomes - To provide assurance to the LSCB, OFSTED, SHA, HWBB that recommendations arising from Serious Case Reviews have been actioned and learning from lessons have been clearly communicated and disseminated to all partner agencies and frontline staff.

Safeguarding in Health Sub Group - Aims
To advise on the 'working together' arrangements including commissioners of health services in North East Lincolnshire and commissioners of non-NHS services, to ensure there are effective, robust and collaborative safeguarding arrangements across the health economy, and across organisational and locality boundaries. These meetings will be spilt into two parts – Part A will be a clinically led meeting to discuss safeguarding issues and service issues / gaps that cut across the health economy, Part B will include commissioners and Strategic Leads where relevant issues from Part A will be discussed and if appropriate taken forward as a task and finish group.
Outcomes - Establishing effective relationships between and across health commissioners and providers to ensure that children's safeguarding arrangements are embedded. This will promote consistent safeguarding children practice across all health organisations and services and a coherence of commissioning arrangements with an alignment of safeguarding standards in contracts.

Keeping Children Safe
The four following sub-groups previously came within the Young and Safe Sub Group. All four areas will now sit as separate sub groups and will report directly to the Operational Board.

Missing - Aims
To monitor the prevalence, and responses to children missing from home, care and education.
Outcomes - NELSCB has a system to monitor the prevalence of and the responses to children who go missing, including gathering data from NELSCB members and other stakeholders in order to understand trends and patterns. There are effective arrangements in place across the partnership for reporting, referring and responding to concerns about children who are missing.

Child Sexual Exploitation - Aims
Develop a NELSCB Partnership strategy to combat Child Sexual Exploitation which takes account of learning from serious case reviews and good practice from other local authorities.
Outcomes - To reduce the likelihood of Children and Young People being sexually exploited and also to protect those who are involved by disrupting and bringing to account those who commit this form of child abuse.

Harmful Sexual Behaviour - Aims

To ensure that NELSCB is taking a consistent approach to the identification, assessment and intervention to those Children and Young People who are displaying problematic and Harmful Sexualised Behaviour. To ensure all Children and Young People who display HSB received a timely evidenced based assessments and intervention.
Outcomes - The Strategy and Operation plan is embedded across children's services. Children and Young People who display HSB are assessed and appropriate services are provided which reduces the risk to themselves and others.

Domestic Abuse - Aims
NELSCB is visible and influential through effective arrangements with other multi-agency partnerships working to reduce the incidents and impact of children suffering or living in households and families where domestic abuse is present. To ensure there is a co-ordinated timely response to Children and Young People who are suffering or living in households where domestic abuse is present.
Outcomes - There is effective recognition, response and services for Children and Young People who are either victims of domestic abuse or living in households where domestic abuse is present.
Early identification of and intervention for children, young people and families across NEL partnerships and agencies.