Agenda Item No: 12

CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2013-4

To: Health and Wellbeing Board

Date: 2nd October 2014

From: Felicity Schofield. LSCB Chair

1.0 PURPOSE

1.1 The purpose of this report is:

• to provide an outline of the main activities of the Cambridgeshire LSCB and the achievements during 2013-14 against the objectives in the LSCB Business Plan;
• to comment on the effectiveness of safeguarding activity and of the LSCB in supporting this;
• to provide the public and partner agencies with an overview of LSCB safeguarding activity;
• To identify gaps and challenges in service development in the year ahead.

1.2 Working Together (2013) states that the "chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The Annual Report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing Board". In submitting the report to this meeting, the LSCB is fulfilling this duty. NB this is a draft of the report as at the date of submission the report had not been presented yet to the LSCB on 23rd September 2014

1.3 Once published it will be put on the website www.cambslscb.org.uk

2.0 BACKGROUND

2.1 Since the beginning of 2014 OFSTED has been reviewing LSCBs, alongside the inspection of the Local Authority. One of the descriptors of a 'good' LSCB in the OFSTED framework is that "*through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period*"

2.2 In anticipation of this taking place, last year's annual report was written with the intention of capturing the difference the LSCB has made, the impact those differences had had on children and their families and the challenges still faced by all agencies working with children and young

people in Cambridgeshire. When the LSCB was reviewed by OFSTED in June 2014 a part of the Council's inspection of safeguarding and services for Looked After Children (LAC), the LSCB was judged to be 'good' and the annual report was praised.

2.3 The report is detailed by nature – there is an executive summary detailing the content at p3 of the report. Half of the report is taken up with appendicies which are referred to in the main body of the report.

3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1. The work of the LSCB detailed in its' Annual report is aligned to the following areas of the HWB strategy:

- Priority One: Ensure a positive start to life for children, young people and their families – ensuring the basic safety to the child or young person is the fundamental aim of the LSCB partners
- Priority Four: Create a safe environment and help to build strong communities, wellbeing and mental health, especially around the focus areas of domestic abuse and alcohol misuse and their impact upon children
- Priority Six: Working Together Effective, especially in demonstrating the LSCB's effectiveness in achieving its objective of co-ordination of safeguarding children work and the ensuring the effectiveness of that work

http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

4.0 IMPLICATIONS

4.1 The LSCB will continue to monitor and evaluate the effectiveness of services which safeguard children in Cambridgeshire and will identify any gaps in service provision and support the management of the risks to effective safeguarding

5.0 RECOMMENDATION/DECISION REQUIRED

5.1 It is recommended that the Health and Wellbeing Board:

- offer feedback and comment on the work of the LSCB
- Consider how the Health and Wellbeing strategy can support and enhance the work of the LSCB and vice versa

Source Documents	Location
The LSCB Annual report 2012-3	***http://www.cambslscb.org.uk/home_useful_links.html***
OFSTED framework for the Inspection for the Services for Children in Need of Help and Protection	***http://www.ofsted.gov.uk/resources/framework-and-evaluation-schedule-for-inspection-of-services-for-children-need-of-help-and-protection***

Cambridgeshire Local Safeguarding Children Board Annual Report 2013-4

Contents of report

1.0 Introduction

1.1 Chairs Foreword

It is my pleasure to introduce the Cambridgeshire local Safeguarding Children Board's 2013-14 Annual report.

This annual report sets out how, over the 12 months from April 2013 to March 2014, we have met our statutory duties and addressed the priorities we set for ourselves in last year's business plan. We have also tried to capture the difference we have made, the impact those differences have had on children and their families and the challenges we still face.

Much of last year was spent preparing for an inspection by Ofsted which took place not long after the end of this financial year in June 2014. We were therefore inspected on the work we describe in this annual report. It is to the credit of all those involved in partnership working across Cambridgeshire that the outcome of that inspection was so positive.

I should like to thank colleagues from all our partner organisations in contributing to the LSCB meetings, to its subcommittees, its training, multi agency case audits, serious case reviews and task and finish groups. Most of all, however, I should like to thank the staff in the LSCB Business Unit for their sterling work throughout the year.

Felicity Schofield
Independent Chair of the LSCB
September 2014

1.2 Executive summary

Purpose, governance and accountability: The first two sections (2 and 3) of the report detail the governance arrangements around this report and, more broadly around the role of the LSCB. There have been some national changes due to the re-issuing of the national guidance ***Working Together to Safeguarding Children*** (2013) at the beginning of the period under report and these sections detail the local approach by the LSCB to meet the requirements of the guidance and to interpret them in a way that enhances the efficiency and influence of the LSCB. This includes some commentary about the challenges to attendance and about the participation of partner agencies.

Section 4 focuses on the progress of the LSCB in achieving the objectives of the Business Plan which supports the **co-ordination of multi-agency safeguarding** in Cambridgeshire. The main areas of work around Child Sexual Exploitation; Domestic Abuse; Child Sexual Abuse, Parental Alcohol Misuse are detailed as are the efforts to improve governance arrangements and the participation and engagement with children and young people and their families.

Section 5 looks at the work done to review **multi-agency policies and procedures** in Cambridgeshire which is a statutory duty of the LSCB. Working Together 2013 led to the

Local Protocol for Assessment and the implementation of the Single Assessment by Children's Social Care. A focus of activity around embedding the Escalation Policy is described encouraging practitioners to raise their concerns about children and, where necessary, about the actions of other agencies in working with children and families.

Section 6 covers the monitoring and evaluation function of the LSCB. It details some of the **monitoring reports** that the LSCB reviews, including that of the work of the Local Authority Designated Officer (LADO) for managing allegations again professionals and of the work of the Local Authority around Private Fostering Arrangements. It also details the work of the LSCB in its multi-agency audit programme. The audits finding report from include the **Child Sexual Exploitation audit; Bruising to Non-mobile babies; Multi-agency Participation in Core Groups audit, and the use of Historical Information audit** as well as the overview that the LSCB has over audit activity in single agencies

Section 7 details some of the key data oversight that the LSCB has, which complimented learning for audits, whilst section 8 reports on the new **Learning and Improvement framework** which encapsulates the approach to and **learning from Serious Case Reviews** in Cambridgeshire. It reports on the impact from Serious Case reviews which the LSCB sought via the Learning and Improvement action plan that it completed in 2013-4.

Section 9 of the report describes the attendance by agencies at and the impact on attendees of the **LSCB multi-agency training and development opportunities**. These include the LSCB training courses, Local Practice groups, the Annual LSCB conference and the range of bespoke development opportunities on offer. In summary, the number of opportunities has increased as has the number of attendees and the impact measured continues to be a positive picture.

The final section of the report focuses on the **work of the Child Death Overview Panel** which is a joint group with Peterborough LSCB. This provides details on the work of the panel in reviewing all child deaths (excluding neonates) in order to ensure the response of agencies to these deaths were effective and in order to identify if there were any modifiable factors. The most identifiable of these is unsafe sleeping with infants; therefore this section describes the Safer Sleeping campaign which the LSCB initiated towards the end of the period under report.

2.0 Purpose of the report

2.1 Working Together (2013) states that the *"chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing Board".* The LSCB

also has a statutory duty to present the report to Children's Trust Board (Apprenticeships, Skill, Children and Learning Act 2009).

2.2 It is the intention of the LSCB to share this report with all partner agencies and with those that have influence over the services provided to children and families in Cambridgeshire. The purpose of this report is:

- to provide an outline of the main activities of the Cambridgeshire LSCB and the achievements during 2013-14;
- to comment on the effectiveness of safeguarding activity and of the LSCB in supporting this;
- to provide the public and partner agencies with an overview of LSCB safeguarding activity;
- To identify gaps and challenges in service development in the year ahead.

2.3 In writing this report, contributions were sought from Board members and the chairs of all sub-groups as well as from other partnerships. It also drew on the numerous monitoring reports that are reported to the LSCB on a statutory basis e.g. allegations against professionals working with children; private fostering. However, it does not seek to repeat these in full, rather to use them to inform this assessment of the effectiveness of the LSCB.

2.4 The business of the LSCB in the period under review in this report (April 2013-March 2014) was directed by the second year of a two year LSCB strategic Business Plan 2012-4 (see appendix 1 for the plan). Therefore this report seeks not to duplicate but to build upon the information shared in last year's Annual report which can be found here: http://www.cambslscb.org.uk/user_controlled_lcms_area/uploaded_files/Final%20for%20publication%20LSCB%20annual%20report%202012-3.pdf

3.0 Governance and Accountability

3.1 On April 15th 2013, Working Together (2013) came in to force. The revised statutory guidance requires as a bare minumum:

- that the LSCB assesses the effectiveness of the help being provided to children and families, including early help.
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The new guidance emphasised that whilst LSCBs do not have the power to 'direct' other organisations they do have a role in making clear where improvement to practice and service delivery is required.

3.2 The approach adopted and being developed across Cambridgeshire is two-fold – *challenging* partner agencies to ensure their practice improves through monitoring single and multi-agency saefguarding work, such as audit and case review work whilst also *supporting* partners to make those improvements. A summary of the challenges and improvement that the LSCB has made in during 2013-4 can be found at paragraph 3.29

3.3 In order to meet the requirements by the new guidance, the following changes to governance arrangements were made:

- Revised Terms of Reference for the LSCB were approved in November 2013 which embedded the expectation of the strategic nature of the partnership and ensured clarity in the scope of monitoring activity at the LSCB.
- Revised Terms of Reference for the Business Committee which defined the complementary nature of the Business Committee to the LSCB – the focus being more operational and the membership being revised and refined to being not only the chairs of the sub-group, but senior operational managers and safeguarding leads in key partner agencies.
- Revised Terms of reference and decision making processes for the Serious Case Review sub-group which have clarified membership and the task in hand in order to meet the new parameters of Working Together 2013 which in essence have devolved decisions around methodology and approach to the individual LSCB
- A new Learning and Improvement framework which sets out the local approach understanding the safeguarding system

3.4 In addition to the above changes, the LSCB also has these existing governance documents:

- LSCB Compact for signature (describes the mutual responsibilities of CCC and the Board partners).
- LSCB Constitution and Memorandum of Understanding between the Children's Trust Board and Cambridgeshire Local Safeguarding Children Board (updated and approved by both bodies in June 2012).
- A Structure diagram (please see Appendix 2 for the structure diagram)
- Terms of Reference for the sub-groups
- Draft memorandum setting out the strategic relationship with the Health and Wellbeing Board and the Safeguarding Adults Board

These documents are reviewed as part of the annual reporting/business planning cycle and are available on the LSCB website at www.cambslscb.org.uk. In the forthcoming year, work will continue on developing the governance arrangements with key strategic partnerships, for example the Health and Wellbeing Board and the Domestic Abuse Governance Board.

3.5 **Chairing of the LSCB**

The LSCB is chaired by an independent chair, Felicity Schofield, who has been chair since 2009. In the past, the appointment of the independent chair has been the responsibility of the Director of Children's Services; however Working Together 2013 assigned the responsibility to appoint and hold to account the Chair of the LSCB regarding the effectiveness of the LSCB to the Chief Executive of the Local Authority. During 2013-4, it was agreed that the Chief Executive would attend some of the LSCB meetings, and the Independent Chair also meets (on a one-to-one basis) with the Chief Executive and the Director of Children's Services on a regular basis.

3.6 In Cambridgeshire, the independent chair of the LSCB is also commissioned to chair the Business Committee, the Serious Case Review panel, and the Child Death Overview Panel, thus bringing continuity and consistency to the overall delivery of the Business Plan. The chair brings independence and challenge to the Board on a regular basis, for example ensuring that national policy and strategy has a local response from partner agencies and that the LSCB takes a lead on this – examples of this are over child sexual exploitation, missing children, child sexual abuse, safeguarding of disabled children.

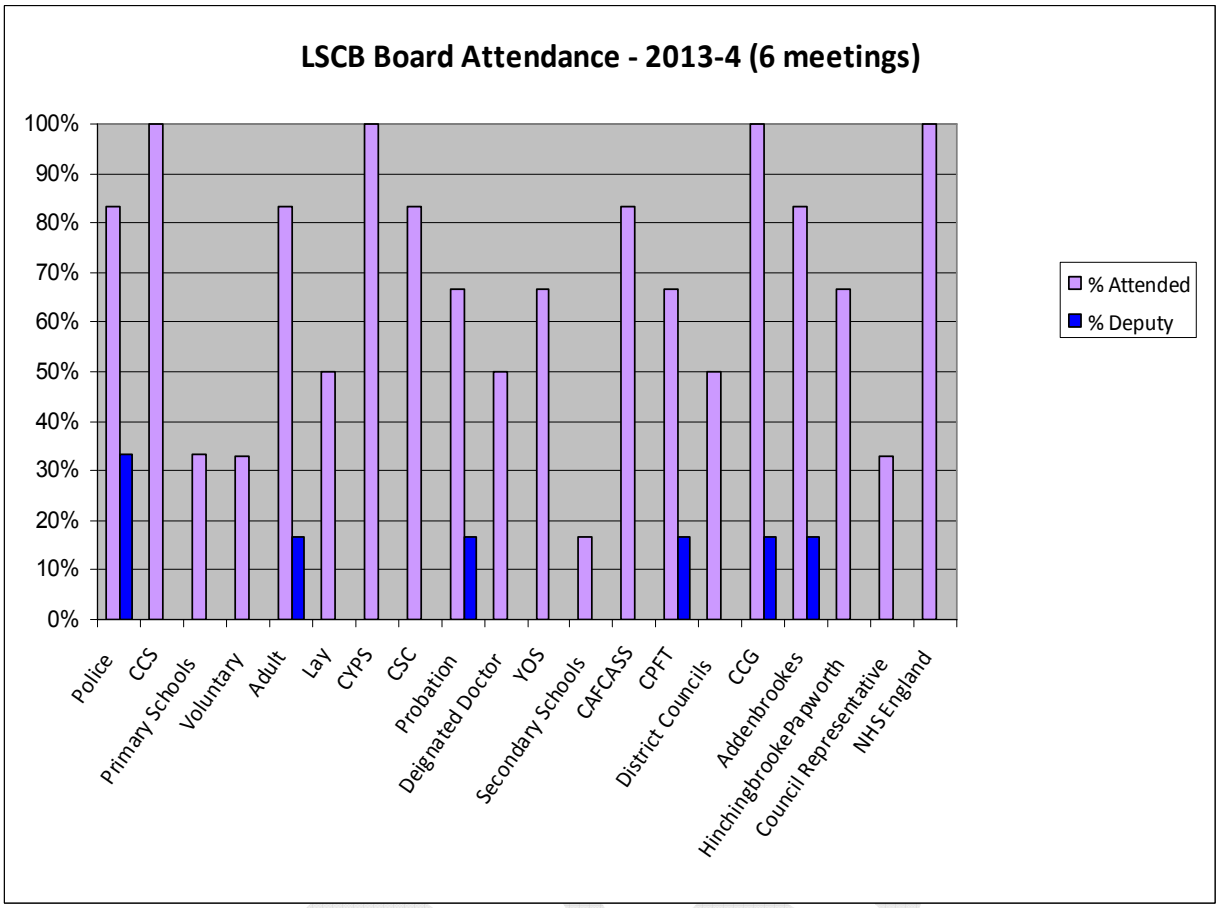
3.7 The independent chair also engages in the national debate and activity around the ever-developing role of LSCBs and during this year has attended regional LSCB chairs meeting, the national LSCB chairs' conference and has been part of a panel of LSCB chairs that advised OFSTED regarding the new review of LSCBs which came in to force in October 2013

3.8 More locally, the significant commitment to partnership work made by the independent chair of the LSCB was demonstrated by her consistent attendance at the Children's Trust Board meetings; the challenge and support given to the Local Authority Improvement Board (established to ensure the required improvements of the DfE Improvement notice issued in February 2013) and the Domestic Abuse Governance Board. There was also complementary attendance by a member of the LSCB Business Unit at the Children's Trust Area Partnerships, the Improvement Board (where required), the internal children's services improvement team and the Domestic Abuse Implementation group.

3.9 The impact of this approach has been the improved ability to spread significant messages about safeguarding across the county, for example around Safer Sleeping ad the learning from Serious Case Reviews.

Attendance at LSCB meetings by agency represented

3.10 The graph below depicts the percentage attendance by agency across the 6 meetings that took place over the year. Most of the agencies sent a deputy where possible and some had more that one attendee from their agencies at some of the meetings, for example, the Clinical Commissioning Group and the police.



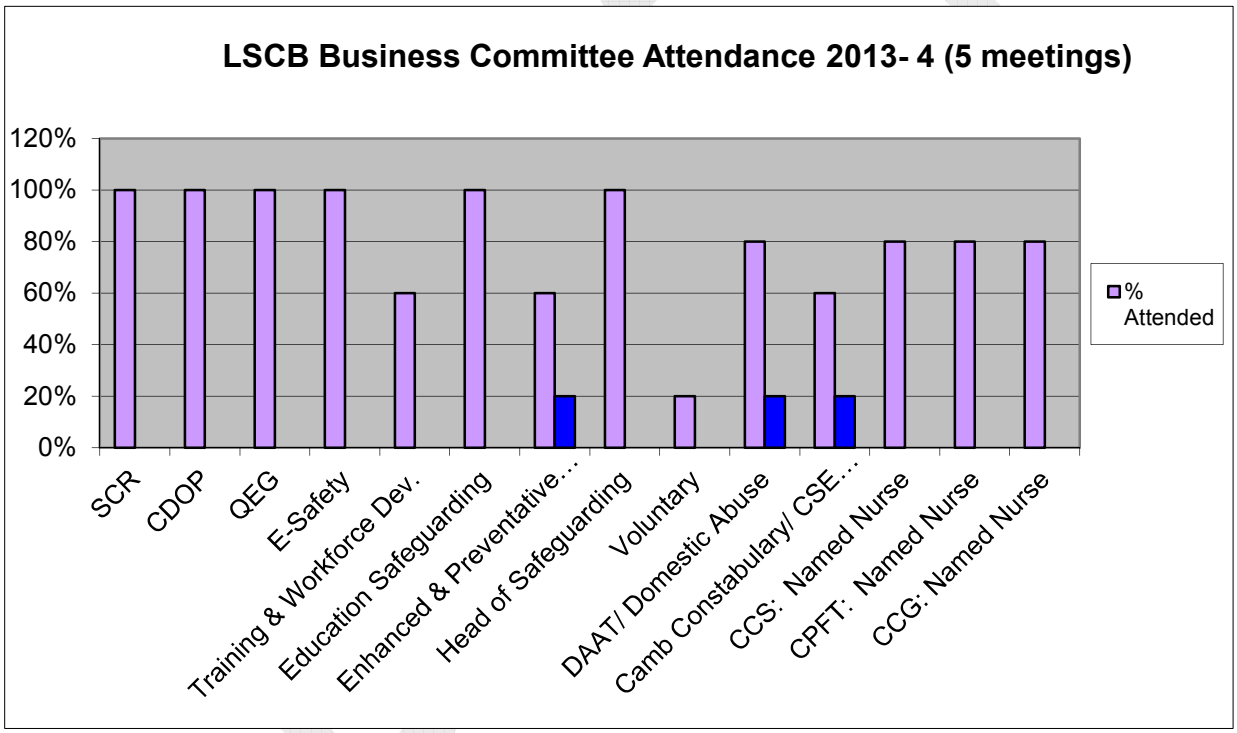
3.11 Representation from secondary schools presented a particular challenge this year. It is vital to have representation from the education sector – these members may be the only people on the LSCB who see Cambridgeshire children on a daily basis. However therein lies a challenge to effective representation: to expect an operational LSCB member to guarantee constant attendance is problematic, as is defining how they represent a whole sector. This was recognised quickly by the head teacher who was identified through the Cambridgeshire Secondary Heads group at the end of the summer 2013. He was only able to attend one meeting and subsequently resigned his member due to operational pressures. The LSCB also lost one of the primary heads that attended and the attendance of the other representative later in the year was compromised by her school being inspected by OFSTED. However at the time of writing (in the summer of 2014), the LSCB has a new secondary representative, the deputy head from Ernulf School in St Neots (also the Designated Person for safeguarding in her school) and two primary heads in regular attendance. It is hoped that these members of the LSCB will be able to offer their valuable perspective to the LSCB throughout the forthcoming year.

3.12 Other members who attended less that 100% were, on the whole, operational managers that had other priorities to attend to, therefore a list of deputies for each member was reconfirmed toward the end of 2013-4. The LSCB now has two lay members who attend on a voluntary basis – the attendance of these members

improved later in this period and their role as the lay voice is developing well, where they hold the position of challenging and supporting from the perspective of those outside statutory partner agencies

3.13 There were also observers at the some of the meetings during this period. The Chief Executive of Cambridgeshire County council attended in January as did a representative from the Department for Education in their monitoring and support role for the Local Authority's Improvement Plan. The informal feedback from these observers was positive.

3.14 In February 2014 the LSCB held a development day facilitated by Gladys Rhodes-White OBE, a former Director of Children's Service in Rochdale. The day was about challenge and about effective co-ordination of the response to Child Sexual Exploitation. The day was overwhelmingly well attended, with representation from nearly all areas of the safeguarding network – an indication of engagement with the LSCB and wider safeguarding agenda.



3.15 The Business Committee has gone through some significant changes in membership, due mainly to the changes in sub-group structure that took place over the year (reported at 3.21-3.22 below). The ending of the Area Safeguarding Committees during autumn 2013 meant that the chairs of these groups no longer had a role as chairs on the Business Committee. The Terms of Reference of the LSCB were amended accordingly to have representation from Children's Services by the Head of Service for Safeguarding and a Head of Service from Enhanced and Preventative Services. The addition of the representative from enhanced Preventative Services has allowed the LSCB to extend its overview of the safeguarding system, especially around gaining a greater understanding and effectiveness in implementation of the preventative aspect

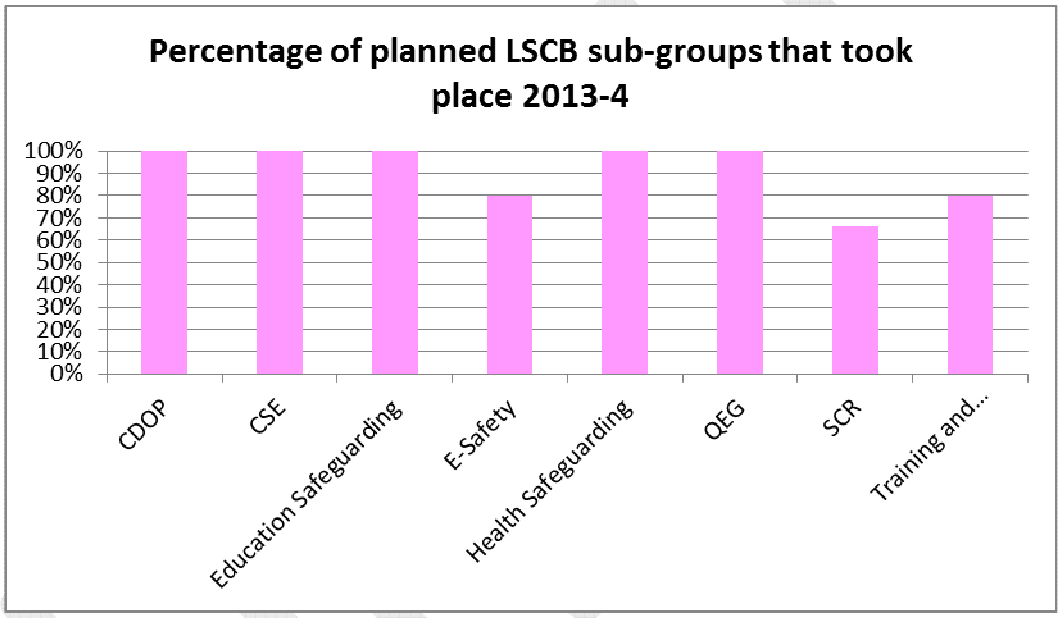
of the LSCB priorities and of the operation of thresholds.

3.16 For a few members, attendance is less than 100%, the reasons are due either to operational demands or to changes in personnel or new membership of the Committee e.g. the chair of the LSCB training and workforce group changed hands during the year, however the LSCB Training Manager was always in attendance.

3.17 It was proposed at the end of the year that the Local Authority's Principal Social Worker would join the Business Committee to enhance the understanding of the multi-agency network around social work practice and to take back the messages around effectiveness in safeguarding practice to that group.

LSCB sub-group activity.

3.18



3.19 The graph above depicts the percentage of planned LSCB-subgroups that took place during 2013-4. Where there is less than 100% of meetings that took place this does not represent ineffectiveness rather that the meetings were not deemed to be necessary. Most groups meet on a bi-monthly basis however the SCR sub-group is planned to meet on a monthly basis. Where there is not enough business to justify using partners' time, or the members are meeting in a different forum, for example on a particular SCR, the meeting is cancelled. Therefore cancellation is more likely to indicate responsiveness to the need of partners rather than ineffectiveness.

3.20 The Area Safeguarding Committees were ended in 2013. The Local Practice groups were considered to be better placed to get messages out to the safeguarding network. Additionally, the management structure in Children Social Care had changed so that the Head of Services were overseeing a function of social work rather than a geographical area – they had held the role of the Chair of the Area Safeguarding Committee. A proposal to have Working Together groups where by the multi-agency network in an

area would look and review child protection cases was planned however a lack of capacity and potential for duplication with other meetings. In the forthcoming year, the LSCB plans to make stronger links with the Children's Trust Area Partnerships so that the safeguarding agenda is part of the Area Partnership agenda.

3.21 The LSCB partners have worked hard to ensure that there is good representation at sub-groups and related activities. Where groups have faltered there is a mechanism to challenge this to ensure they are on track again. During 2013-4 the commitment and representation across all groups by Enhanced and Preventative Services has been particularly noticeable and work around the LSCB audit programme could not have progressed without the input of Children's Social Care and EPS audit managers and officers, as well as partners in health and education. In the forthcoming year the approach will be refined – each specific safeguarding concern which is a priority in the LSCB Business Plan will have a task and finish group and an action plan. These will be Safeguarding Disabled Children; Safeguarding children from Domestic Abuse; and Child Sexual Exploitation

Participation of partner agencies in the LSCB

3.22 The active participation by the LSCB's members in the agenda and activity of the Board could be said to demonstrate effectiveness of the strategic leadership of the safeguarding system. One way to gauge this is through the involvement in the LSCB agenda by members. Set out below are the contributions different agencies have made to the Board's bi-monthly meetings:

- Children's Services – Every meeting offered a full appraisal of progress against the Improvement Plan
- Children's Services - The Local Protocol for Assessment including arrangement for the Single Assessment
- Probation – Transforming probation – regarding the changes to the way that probation services will be offered nationally and locally
- Designated Doctor – Regional Audit of services for Children that have been sexually abused
- NHS England – A Serious Incident report Children Missing from Universal Health Services
- Clinical Commissioning Group – a review of the Commissioning of LAC services
- Enhanced and Preventative Services – A review of Early Help Position statement
- CAFCASS – a positive OFSTED inspection report

3.23 Other examples of effective partnership working were requested for this report. Agencies have been honest in their approach around their progress supported by the partnership. Positive examples include:

- Cambridgeshire Community Services (CCS) commented on their improvements in safeguarding supervision and training including multi-agency LSCB events (making up 20% of attendees), focussing on the voice of the child and better awareness around CSE
- The Domestic Abuse co-ordinator commented on improvements in IDVAs

safeguarding practice and work with young people in schools, as well as development in approaches to young people involved in relationship abuse

- The police emphasised their commitment to improving children's safeguarding work and have also made huge and rapid progress in their response to domestic abuse following a critical HMI report
- The Drug and Alcohol Action Team gave many examples of progress in focussing on the needs of children – the joint working with the LSCB has enhanced the approach of both the DAAT and the LSCB in this area
- CAFCASS described a range of activities

3.24 However agencies have been candid in their assessment of the challenges to their effectiveness: Examples of this are given:

- Capacity to deliver is a challenge – whether it be in the delivery of the Freedom programme through children's centres, or an increase in demand seen by the police as they seek to "make safeguarding everybody's business" in their organisation.
- The voluntary sector representative offered commentary around the impact of funding pressures meaning that there were less staff in direct practice with children and families to safeguard
- The increase in numbers of children subject to Child Protection plans has meant more work for staff and challenges in running the system – however the Child protection conference attendance figures maintained the same proportions of professionals across the agencies involved throughout the year despite a doubling in the number of conferences.
- Challenges remain around data, both from the LSCB perspective and from the Domestic Abuse governance perspective – however the lay members on the LSCB have this in their sights to maintain a challenge to improve.

3.25 Partner agencies representatives offered their perspective on the LSCB's effectiveness, for example:

- The voluntary representative stated that the LSCB had progressed in effectiveness not only as a partnership but that he could also see progress in the LSCB influence beyond – e.g. the Children Trust partnership
- CCS felt that the systems for raising awareness around particular issues e.g. CSE and cascading information were really useful and effective
- Police felt that the Business Plan supported delivery in some key safeguarding areas.

3.26 The LSCB also had oversight of all of the monitoring reports required by the Children Act 2004 – the key elements of these are précised below section 6

3.27 The LSCB Budget.
The LSCB has a budget made from multi-agency contributions from the following agencies in 2013-4

- Children's Services
- Cambridgeshire Constabulary
- Cambridgeshire Probation
- Cambridgeshire Clinical Commissioning Group
- NHS England
- Cambridgeshire Community Services
- Cambridgeshire and Peterborough Foundation Trust
- Cambridgeshire University Hospitals Foundation Trust
- Hincinbrooke Hospital Trust
- Papworth Hospital Trust
-

Details of the budget can be found at Appendix 5

The Challenge and Support approach of the LSCB

3.29 The balance of the LSCB's challenge and support roles and what this means within the LSCB and its constituent agencies developed during 2013-4 and formed the basis of thinking around the subsequent LSCB business plan for 2014-6 (at appendix 3). The support function is clearly seen in some of the key functions of the LSCB, for example the multi-agency training programmes and the provision of policy and strategy to support safeguarding services.

3.30 The impact of challenges made by the LSCB is harder to measure. However, below are some of the examples impact over the period under review:

- Requesting a report regarding Safeguarding of Young People in the Secure estate from the Youth Offending LSCB member – the report given gave assurance and resulted in an agreement for ongoing monitoring of this.
- The challenge regarding the statutory duties to Children Missing from home and care resulted in a clarity of approach, clearer information sharing around data between the Local Authority and Police and improved systems and response e.g. return home interviews
- The ongoing challenge to explain the fluctuation in the number of children subject to a Child Protection plan led to useful discussions around the impact of this on other agencies.
- The challenge around attendance and participation in child protection conferences and core groups led to changes and improvements by the IDVA services and in the development of a Memorandum of Understanding regarding health professionals' input.
- The awareness of the lack of senior 'ownership' of the domestic abuse strategy raised by Community Safety led to a challenge which supported the establishment of the Domestic Abuse Governance Board
- Ongoing monitoring of attendance and non-attendance by agencies at LSCB events resulted in improvement for example in police attendance at some Local Practice groups

- Children Missing from health services – a letter to commissioners from LSCB Chair arising from an SCR.
- The various challenges and changes arising from the SCR process are documented below at section 6.

4.0 The LSCB: The Co-ordination of Safeguarding in Cambridgeshire

Progress against the Business Plan – a summary

4.1 The Business Plan summarises the work plans of the different subgroups (see structure chart at Appendix 2). The key headlines in terms of progress are described here. The measurement of the impact of the work of the LSCB is noted where is can be demonstrated.

4.2 **Priority one Priority One: Effective Responses to Specific Safeguarding Concerns**

In the area of **Child Sexual Exploitation and Missing Children,** the LSCB co-ordinated the progress of partner agencies' work in this area. Key headlines included:

- A review and refresh of the joint Cambridgeshire and Peterborough LSCB multi-agency strategy.
- A survey on the Youthoria website of 400 young people regarding their

perspective of Child Sexual Exploitation and how the messages about these types of safeguarding risk should be delivered to young people.

- The LSCB commissioned a play about Child Sexual Exploitation which was shown to year 9 pupils in a variety of settings in Cambridgeshire. The company commissioned to perform the play did so 47 times in total, with 6114 young people seeing the play and 781 professionals attending to support the young people during and after the performance.
- The dedicated police CSE team, sited in the MARU, has become more established and works with partner agencies and local policing to develop its approach to problem profiling
- The LSCB training programme has courses specific to this area and Local practice groups and bespoke workshops have been held on the topic. The LSCB also ensures that single agency safeguarding training contains this topic.
- The LSCB conducted a multi-agency audit regarding the response to Child Sexual Exploitation in Cambridgeshire. The audit found examples of good practice and a trend of improvement in the effectiveness of response. It highlighted areas for improvement, for example around engagement with families which have been included in the LSCB strategy refresh. Further details of the findings of this audit are reported at paragraph 6.18
- The CSE implementation group – joint across Cambridgeshire and Peterborough has continued to work on the action plan, and will continue to work on areas such as a comprehensive dataset re CSE and missing and communication with families on the issue.
- The LSCB have worked with partners in Community safety to identify the gap and the need for a response for young victims of sexual violence, resulting in the commissioning of two Young Person's Independent Sexual Violence Advocate posts – which will be recruited to in the autumn of 2014

4.3 The protection of children from **Sexual Abuse** was another priority that the LSCB had been focussing on during this year and the previous year. Key headlines included:

- An increase in the number of children subject to child protection plans where the main category was sexual abuse increased over the year to 8%, and sexual abuse is being identified in over 10% of assessments by children's social care
- The LSCB has continued to offer training in this area.
- The LSCB have agreed that sexual abuse will continue to be a focus in its work streams, however no longer a priority for action apart from the risk from CSE.

4.4 The focus on the impact on children and families from **Domestic Abuse** continued to be a priority for the LSCB:

- A multi-agency mapping report of the interventions available for children and young people across Cambridgeshire was completed by the LSCB Domestic Abuse task and finish group.
- Key recommendations included the introduction of a method to screen and have a shared understanding of the impact on domestic abuse; the identification and

introduction of an evidence-based toolkit for practitioners; exploration of a way of measuring impact of interventions and a way to co-ordinate services across Cambridgeshire so that all children and young people can access a service response when required.

- The LSCB has funded the training of possible trainers to roll out the Barnardos Domestic Violence Risk Identification Matrix as a response to the mapping report – the first cohort were trained in March 2014 and the roll out of this will continue throughout 2014-5 and will be reviewed for impact by the LSCB Domestic Abuse Task and finish group
- During the year, the challenge from the LSCB contributed to the establishment of the County Council Lead Domestic Abuse governance Board

4.5 During 2013-4 the LSCB continued a focus on **Parental alcohol misuse** which arose from an SCR in 2012-3:

- There was a useful audit conducted in to the safeguarding of children by adult alcohol treatment services which informed practice improvements led by the DAAT, the commissioners of the services. The service was re-commissioned in 2014 and the LSCB contributed to that process
- A series of joint workshops and local practice groups were facilitated by the LSCB and DAAT jointly and provided practitioners with a brief intervention to support changes in alcohol use by adults. There was also training around Foetal Alcohol Syndrome.
- Though there were only 153 referrals in the year for parental alcohol misuse, it was recognised as risk factors at the end of over 300 assessments of children by Children's Social Care.
- Future work will be part of the LSCB training programme and data will continue to be monitored by the LSCB. The messages about parental alcohol use arising from the SCR continue to be part of the LSCB focus on Embedding the Learning from these reviews
- Much closer working with the DAAT has enabled the LSCB to support change and have an overview of the safeguarding work being carried out – for example the introduction of two Children's Link workers in treatment agencies

Priority Two: Effective Safeguarding and Early Intervention

4.6 The key headlines around this area which were part of the monitoring and evaluation function of the LSCB include:

- The ongoing support and challenge that the LSCB gave to Children's Services regarding its improvement journey.
- The governance of the development of the Multi-Agency Referral Unit
- The monitoring of thresholds through audit activity – which evidenced that thresholds are being applied consistently across cases and services
- The monitoring of risk to the delivery of the Business Plan and of the risks to effective safeguarding through the use of the Risk Register
- Support the design and roll out of the Multi-Agency Safeguarding referral form to

support a clearer identification of risk by reporting agencies

4.7 **Priority Three: Communication and Engagement:**

During 2013-4 the LSCB developed a targeted approach to the participation of children and families in it activities, through its specific work streams. Key headlines included:

- Work described above about the raising of awareness regarding CSE amongst children and young people through the Youthoria Survey and delivering Chelsea's Choice
- Contribution and support of the development of the Children, Families and Adults participation strategy
- Receiving and analysing ongoing feedback from practitioners at training and Local Practice Groups
- Focusing audit activity around the experience of practitioners e.g. the core group audit and follow up Local Practice groups.
- Including young people and parents as trainers on LSCB training course and the LSCB conference was about Engaging Services users – we had a keynote speaker who was a parent who had received services.

Priority Four: Performance management

4.8 Some of this is reported on in the section about audits in section 6, however the LSCB:

- Introduced and implemented a new Learning and Improvement Framework which encompasses all of the ways of understanding how the safeguarding system is working, including a new dataset.
- Completed and report the section 11 audit and monitored improvement on this – this also lead to the decision that partner agencies would embed the s11 standards in future commissioning of services
- Carried out audit activity which has influenced practice and strategy (see section 6)

5.0 Policy and Procedures

5.1 In April 2013, Working Together to Safeguarding Children was re-issued by the DfE. It was significantly reduced in size as a response to the challenges made by Professor Eileen Munro regarding the increasingly prescriptive nature of policy and procedures associated with social work and safeguarding practice and specifically reflected in the previously issued versions of Working Together. There were two key requirements for the LSCB arising from Working Together. One was the publication of a Learning and Improvement Framework, which was approved by the LSCB in May 2013 and is reported on in section 8 later in this report.

5.2 The other requirement was for the Local Authority to present a Local Protocol for Assessment to the LSCB for approval. Working Together 2013 ended the requirements of

the Framework for Assessment (2000) which requested an initial and a core assessment of each child in a family. The local authority in Cambridgeshire proposed a single assessment of the family to be completed within 45 working days. The Local Protocol for Assessment was approved at the LSCB meeting in March 2014, following consultation with a multi-agency task and finish group.

5.3 The main challenges from other agencies were the need for clarity about their contributions. The potential for 'drift' in the single assessment was also identified. These concerns were built in to the protocol. The implementation of this document was at the end of the period being reported on in this report – the impact of the single assessment will be monitored throughout the forthcoming year and reported on in the next Annual report.

Other policies and procedures during 2013-4

5.4 **Escalation policy** As a result of a serious case review in 2012-3 the LSCB reviewed and re-issued its escalation policy. The purpose of the policy is to enable and support staff across agencies to understand their responsibility to escalate concerns regarding children and also to challenge if they feel that services are not responding to the needs of the child or young person effectively. It also supports concerns around poor practice in the multi-agency safeguarding context. It emphasises some key messages in order to facilitate this approach, for example for staff to seek the support of safeguarding leads in their own agency in order to support escalation. The policy has been widely circulated and discussed at key forums across the county. Examples of escalation were sought from practitioners in order to demonstrate that this was understood. Some examples demonstrated that some agencies e.g. schools and children's centres had a good understanding of their role in making challenges – often around decisions around thresholds made by children's social care, however there were also examples around information sharing by other agencies, which were seen to be hindering the safeguarding of children.

5.5 Evidence, such as feedback from practitioners, suggests that whilst those staff who are constantly engaged in the safeguarding of children are robust in escalating their concerns and challenging, those who are involved less frequently or are not involved in the decision making around children's safety e.g. whether to report suspected abuse or neglect, still require some support and advice on how to do so. The LSCB will continue to focus on this safeguarding behaviour through its Embedding the Learning Approach pilot with the NSPCC and the Tavistock during 2014-5

5.6 **Cultural Competence Safeguarding Guidance**

This practice guidance was produced as a response to the Learning and Improvement plan arising from case reviewing activity between 2012-4. The document can be found on the LSCB website at www.cambslscb.org.uk. The impact of this guidance is yet to be witnessed – multi-agency audits still demonstrate this as a point of weakness across the safeguarding system in Cambridgeshire

5.7 **Parental Mental Health and Child Sexual Behaviour Service**

These two policies were updated and presented to the LSCB Business Committee during the year for approval and sign off. The work was led by safeguarding leads and practitioners in the relevant agency on behalf of the LSCB, evidencing further the participation of partners in the activity of the LSCB. The Parental Mental Health revision includes a new safeguarding tool for practitioners working in adult mental health services to identify and act upon child safeguarding concerns. The Cambridgeshire Sexual Behaviour Service steering group ratified the update of their protocol in line so that practitioners can access easily their service. It is hoped that the revised protocol will help to promote the availability of the SBS service to offer advice and support to other professionals at as early a stage as possible so that problem sexual behaviour can be identified at an early stage.

5.8 The LSCB also continued to monitor the impact of earlier policy work. Two audits regarding the effective implementation of policies around bruising in non-mobile infants and of the application of thresholds are reported on later in section [xx}

6.0 LSCB statutory function: Monitoring and evaluation

6.1 The LSCB has oversight of a series of monitoring reports regarinding specific areas of safeguarding activity – these are précised below:

The Local Authority Designated Officer for Managing Allegations against Professional

6.2 The LSCB receives a 6 monthly update from the Local Authority Designated Officer (LADO) The focus of the LADO role is the management of allegations against adults who work or volunteer with children in the public, independent or voluntary sectors. The LADO must act where it is alleged that a person who works with children has:

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

6.3 This year there has been a change in personnel with a new LADO coming in to post in June 2013. The LADO unit, as well as the management of risk posed by some professionals, also engage in these other activities:

- Management of contacts and referrals
- Chairing Complex Strategy Meetings and Professionals Meetings
- Fulfilling the 'duty to cooperate' role for Children, Families and Adults Services in the Multi-Agency Public Protection Arrangements (MAPPA)
- Liaison with the Probation and Prison Services
- Consultancy and Training role

6.4 A total of 285 'referrals' or contacts were received into the LADO Unit. This is an increase in the number of referrals and contacts over the preceding year, when there were 256 referrals

87% of referrals received during 2013/14 did not meet the LADO threshold for action (this is identical to last year's figure of 87%). A significant majority required the agency or organisation to undertake their own internal investigation using their own disciplinary procedures, referring back to the LADO if the concern increased.

The roles in relation to those being referred were as follows:

Role	Total	13/14	12/13
Education	73	26	35
Early Years	73	26	15
Residential Care	39	14	12
Sport	5	2	5
Foster Carers	27	9	4
Health	12	4	9
Children's Social Care	7	2	3
Transport	12	4	4
Other	33	12	11
Not working with children	4	1	2
Unable to determine	0	0	0

6.5 Of the 285 referrals received into the unit, only 37 (13%) led to a CSM being held. This is the slig*h*tly higher than last year's 12% of referrals leading to a CSM being held.

6.6 Allegations from school settings thus make up 41% of all referrals leading to a CSM (21% last year); 17% are foster carers (6% last year); 9% are social care staff (18% last year); 2% are health workers (6% last year); 0 football and other sports (12% last year); 0 voluntary organisations (16% last year); Early Years 12% (6% last year) and 14% forms the rest (transport, police, other)

6.7

Physical	43%
Sexual	28%
Inappropriate electronic communication	0%
Downloading indecent images of children	20%
Emotional abuse/neglect	9%
Other conduct (suitability issues, such as issues arising outside of the workplace)	0%

6.8 The number of allegations are fairly small – 41 in total. Therefore and analysis of the trends is not really possible from the quantitative data – in the previous year 2012-3 48% were allegations around sexual abuse, in the period under review this figure is 28%

6.9 During 2013-4, of the allegations thus far that were substantiated, 3 individuals were dismissed. Criminal investigations were instigated in all these cases. One resulted in a

prison sentence; one resulted with a requirement to sign the Sex Offenders register and on resulted in a dismissal with a referral to the DBS. Other resulting criminal work is ongoing in two cases.

6.10

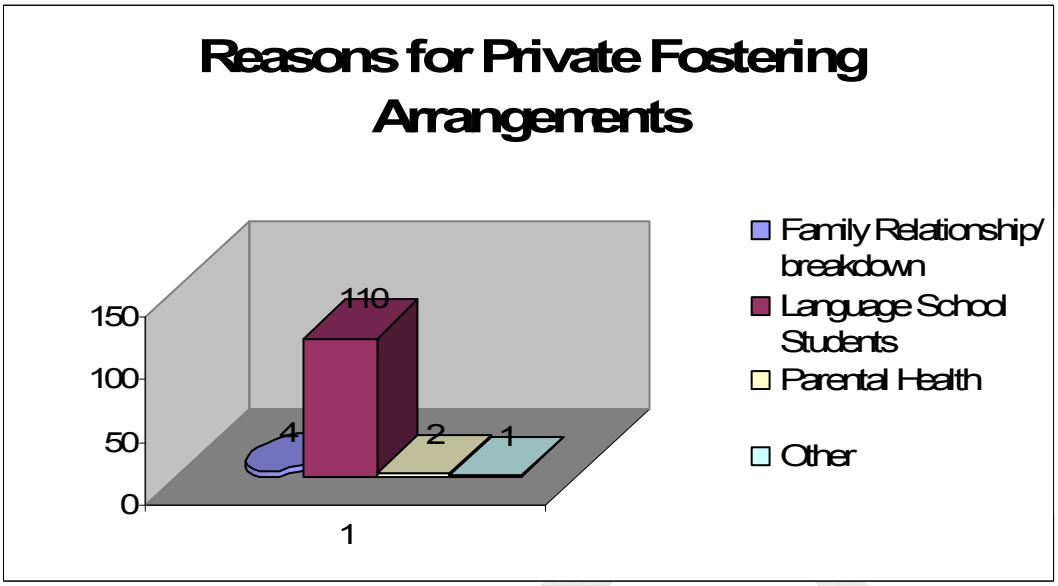
Allegations – what were the outcomes?	2013/14
Substantiated	41%
Unsubstantiated	43%
Unfounded	4%
Malicious	0%
Ongoing	12%

Private Fostering – Annual Report 2013-4

6.11 Again, the LSCB has a statutory duty to monitor the work with private fostering cases. These are arrangements made between those with parental responsibility and another individual to take care of their child for a period of longer than 28 days. This arrangement should be reported to the Local Authority for assessment and monitoring. The Local Authority has a dedicated senior social worker for the task, and this function sits in the Kinship Section of the Fostering team. There is an annual report presented to the LSCB – the key messages are presented below:

6.12

- Within the year there have been 117 new notifications of private fostering arrangements. This figure does not include enquires regarding possible arrangements, of which there were many. This is a notification increase of 120.75% compared with 2012/13
- 7 existing private fostering arrangements carried over from the previous year (2012/13) so in total there have been 124 arrangements requiring assessment and monitoring.
- 87 placements have ended within the year and there are 37 placements continuing into the new business year (2014/2015).



6.13 As can be seen the figures in the graph reveal a very low number of private fostering arrangements reported to the local authority where the reason is family breakdown. Children's Social Care have clarified that all children and young people in private fostering arrangements must be regarded as children in need – all of the processes are in place to support these potentially very vulnerable children, however the figures for identification (language schools aside) continue to suggest that there must be a cohort for children and young people out there who are not being identified.

6.14 The low numbers are a national issue, not just confined to Cambridgeshire. Both the LSCB and the service itself have continued to promote the need for private fostering arrangements to be reported by the parents and or carers when children are placed.

Learning from Multi-agency Audits

6.15 Here, the learning from multi-agency audits – a key tool in the LSCB's monitoring and evaluation functions are described.

6.16 **Child Sexual Exploitation Audit**

An audit regarding the response by agencies to Child Sexual Exploitation in Cambridgeshire was carried out using the established multi-agency audit tool. The audit was reported in March 2014, and reviewed the involvement of all agencies in twelve cases where the young person was thought to be at risk of Child Sexual Exploitation. The cohort included girls and boys, some of whom were Looked After by the Local Authority. The audit tool used asks auditors for a grading around the effectiveness of the response by each agency – whilst overall in all of the themes there was an average of 'effective' (3 out of 5), there were some variations in the effectiveness of practice within each of the themes that the audit has in scope

6.17 Most cases in the cohort showed that professionals understood their roles in relation to

these cases, thus making the appropriate decisions around thresholds – i.e. making referrals or continuing or ending involvement, although there were some examples in the histories of the cases (i.e. prior to the 12 months under scrutiny (Nov 2012-Nov 2013) where it appears that the risk to the young person were not fully understood or escalated or where staff were not sufficiently curious about what the young person was presenting with. The majority of cases also demonstrated that information sharing and communication within and between agencies was appropriate and timely in most cases.

6.18 In the audit there were some useful learning points around the concept of 'risk' from CSE – the report highlighted the need for staff to understand the signs and symptoms but also to understand some of the underlying vulnerabilities of the young people at risk – including the context that some of the cohort came from family background which had been adverse from early childhood and were not protective at the time of agency involvement. This meant that to apply the concept of "Fraser competence' to a vulnerable young person who was not emotionally equipped to make choices or understand the risk to themselves appeared as a failing by the agency to make the right assessment of risk. The audit also identified further learning about what good intervention looks like where a child or young person is at risk of CSE, and how agencies needed to work more effectively with families to help them to prevent and protect their children from the risk of CSE. The need for child-centred, relationship-based work is key where workers know and understand the young person and are able to work with them over a sustained period of time.

6.19 Clear recommendations for action were made to agencies involved and multi-agency recommendations for action ion have been included in the CSE strategy and action plan

6.20 **Multi-agency participation in core groups audit and follow-up activity**

The LSCB led on developing a better understanding of what helped and what hindered participation of staff from agencies across the multi-agency partnership in multiagency meetings. Alongside a monitoring exercise that the LSCB agree to undertake on behalf of the Local Authority 's Improvement Board, the LSCB and Children Social Care audit team sought the views of practitioners and their managers and evidence from case files re practice in core groups. The initial findings regarding the participation of multi-agency staff were that there were:

- Inconsistencies around invitations to core groups
- Variability in levels of attendance
- Variation in the understanding of the purpose of core groups and the CP plan
- Lack of clarity about who should chair and the quality of chairing
- Evidence about the lack of communication and distribution of minutes
- Challenges to participation due to the location and timing of the meeting

6.21 The LSCB then took these findings to a wider group of practitioners through the Local Practice Groups to in a series of workshops to inform them about what good practice in core groups might look like and also to refine the findings from the audit so that new practice guidance could be produced and circulated. This can be found on the LSCB

website at www.cambslscb.org.uk

6.22 Alongside this work the LSCB also lead on a monitoring exercise of the figures of attendance at CP conferences and core group – the data was gathered manually which meant that its accuracy was not always exact. However what the exercise did demonstrate was that despite the significant increase in numbers of children subject to child protection plans as reported at section [xxx] the numbers of staff from agencies increased with the number of plans so that they attended at the same rates despite the double of conferences. This exercise also led to effective challenge by the LSCB regarding attendance and participation at Child Protection Conference which are documented at section [xxx]

The Use of Historical Information in Practice

6.23 This audit arose from the Learning and Improvement action plan following the review in to LO where the finding was that some key agencies working with families, including those undertaking key specialist assessments had not used historical information about the family that was known in agency or across the multi-agency network to inform their assessment of the child or a family member. Therefore the LSCB challenged the statutory agencies to demonstrate through internal audit processes that practice had improved. The findings from the 8 agencies that took part evidenced how historical information was used in all 8 agencies and that there were procedures in place to support tat. The most significant impact of this audit was that it ensured that agencies would in the future regularly audit cases to demonstrate that practitioners took historical information in to account.

6.24 **The Use of the Protocol around Bruising to Non-mobile Babies**

This audit was designed to measure the use in practice of the agreed process following the identification of bruising on a non-mobile baby. This protocol had been agreed in 2012 across Cambridgeshire and Peterborough LSCBs and it was agreed at its launch that the LSCB would audit its utilisation in practice across the key agencies involved – universal health services, acute services and children's social care. The audit found a difference in practice in Cambridgeshire and Peterborough around which staff referred for a paediatric assessment, but found that in the majority of cases the protocol was being followed appropriately in practice. Some re-adjustments were made to the protocol following the audit.

6.25 Single agency audits also form part of the activity of the Quality and Effectiveness group – known as the 'audit of audits' – where agencies tell the LSCG what audits they have completed and their impact on practice. Examples on this were a threshold audit within Children's Services and an audit of safeguarding supervision within Cambridgeshire Community Services as well as regular updates regarding the audit activity within Children Social Care as part of the Improvement plan

7.0 Key data regarding the safeguarding system

LSCB Dataset

7.1 The LSCB dataset for 2013-4 was developed in the previous year with support from regional colleagues around the LSCB priorities. Despite challenge from the LSCB chair to partner agencies it has been difficult to create a relevant dataset that supports the LSCB functions of co-ordination and monitoring and evaluation. Therefore the dataset here describes multi-agency activity around identification and referral and around the effectiveness of the Child Protection system in meeting key targets. What is doesn't do so well is to provide an insight in to the effectiveness of individual agencies in performing their role in safeguarding. This is an area for development for the LSCB in the forthcoming year

7.2 What the dataset was able to show was that there were significant increases in referral activity by some agencies, for example, by schools during the year and this was thought to be due to the impact of some of the high profile cases that have been reported during the year, such as the Daniel Pelka SCR in Coventry. There were also increases in referral and intervention around specific safeguarding concerns, for example, sexual abuse. This could be due to a range of local factors such as awareness raising by the LSCB, national focus on Jimmy Saville and other celebrities who were alleged to have offended.

Child Protection trends

7.3 At Appendix 4, there is an annual report regarding Child Protection trends prepared by the Local Authority's Head Of Service for Safeguarding and Standards. The period 2013-4 saw an unprecedented rise in the number of child Protection plans from 180 plans in March 2013 to 395 in March 2014. The report gives some analysis of what has happened in the Child Protection system which may explain this rise, including record levels of demand for preventative and statutory services.

7.4 The LSCB has seen a response to the challenges it has made about the fluctuation in the system and has been assured by the action that the Local Authority has taken to manage the difficulties

8.0 Learning and Improvement

8.1 In May 2013 the LSCB agreed a Learning and Improvement Framework. This can be found on the LSCB website in the multi-agency procedures section. The Framework describes the approach that the LSCB has developed over the past two years in terms of the generating and embedding the learning from activity including SCRs, multi-agency audits, and from feedback from children, families and practitioners in order.

8.2 During 2013-4, two SCRs were initiated, one in October 2013 and one in December 2013, the first ones for this LSCB under Working Together 2013. A decision on a further case was deferred during January 2014. The full findings of these Serious Case Reviews will be reported in the next Annual Report for 2014-5, however it is worth noting that the 'new world' of Serious Case Reviews has not been without significant challenge to implementing the processes required for example balancing the involvement of practitioners where there are parallel proceedings. This led to delay in the case.

8.3 The Serious Case Review sub-group and the LSCB signed off a combined Learning and Improvement Action plan in March 2014 regarding the actions arising from the SCR and

two other case reviews completed at the beginning of 2013. The actions were completed, however more significant is the need to understand what the impact of this work has been.

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8.4 Any LSCB operates in a complex world and so seeing a clear link between the outcome of what the LSCB does (i.e. challenges and supports) and to a child being made safe from abuse and neglect is not simple. It may well be that other trends, media attention or national scandal may also influence the safety of children. However the LSCB can constantly challenge and support improvements strategically which are should improve outcomes for children.

8.5 The following are areas of activity arising from the combined Learning and Improvement action plan that may have an impact on outcomes for children.

- The DAAT have recently re-commissioned the alcohol treatment services for Cambs and the LSCB were included in the tender evaluation. The new protocol will be finalised when the service starts to deliver.
- The LSCB supported the focus on improvement on attendance and participation in multiagency meetings (impact to be measured in audit work) has led to practitioner development.
- The LSCB developed and launched cultural competence guidance and training – audit continues to monitor this and there are some case specific examples of good practice in this area which suggest impact.
- The LSCB identified a focus on changing the behaviour of practitioners i.e. around the concepts of professional curiosity, escalation and challenge and put this in to training and other activity
- In the 2013 SCR case, where the subsequent practice with siblings was of a high standard, the SCR report informed the consultant social worker's assessment of the family, leading to a positive outcome for the children in terms of their safety
- The overview report writer in the 2013 SCR recommended that high quality assessment relied upon a variety of sources and the evidence from single and multiagency audit work is that assessment work is improving (e.g. the CSC monthly audit programme). Whilst the LSCB is only one of many factors in this improvement, the support from LSCB training and the focus on quality assessments that include historical information are relevant as influencing factors in change and improvement.

8.6 During 2013-4, the LSCB agreed to join a pilot project about Embedding the Learning from Serious Case Reviews that the NSPCC and Tavistock clinic are leading on. The project seeks to offer a methodology for practitioners to take the learning from reviews and actually practice in a different way in order to make the changes to practice that the findings from local reviews have identified. The impact of this will be reported on in the next annual report 2014-5. This complements the LSCB aspiration to have practitioners involved in the case reviewing process as early as possible.

9.0 **Developing the safeguarding workforce**

Attendance at LSCB training opportunities

9.1 LSCB training attendance remains strong and the need for LSCB training places and safeguarding topics increases year on year. 2013 – 2014 has seen a continued increase in attendance and the training opportunities offered to multi- agencies through Cambridgeshire LSCB. Training opportunities available reflect the identified need from serious case reviews, section 11 findings, national direction and local priority safeguarding issues. The following headlines concern the attendance at different

LSCB Training Courses

9.2 57 training courses have been provided covering 37 safeguarding topic areas; a 22% increase of the topics available in the previous year. Out of 829 places offered 764 (92%) people attended the LSCB training; which was a 3% increase in training opportunities as compared to last year. Of those attending 12 % were male and 88% female (which is representational for the majority of the children's workforce) with 80% reported to be white British, 4% other white background 6% other ethnic minorities and 10 % of people preferring not to say

9.3 Most attendees were from Health (Cambridgeshire Community Services), Social Care and the Enhanced and Preventative Service. There has been a significant increase in EPS attendees with Social Care attendees remaining static. There has been a slight increase in Police numbers and a significant increase in Probation Trust attendees and the Acute Trust (hospital staff in Cambridge) (though this figure is almost certainly attributed to the change in data collection). There has also been a significant increase from the Voluntary and Faith sectors.

9.4 There continues to be a spread across the 'Working Together Groups' of attendees at LSCB training with the majority located in Group 3 (those who work predominantly with children). There are no representatives from Group 5 (lead Professionals/ Named Advisors) and Group 7 (Strategic Managers) which is disappointing given that there have been courses available for Lead Professionals / Managers (e.g. Risk and Analysis).

Evaluation of the Impact of LSCB training.

9.5 Courses continue to be recorded as 'Excellent' or 'Good' in terms of:- achievement of the aims and learning outcomes, incorporating equality and diversity issues, delivery and materials; with a noticeable positive increase on satisfaction in comparison to last year's training. Evaluation of the courses would suggest that; participants enjoy the courses, feel that it has helped learning and confidence and are generally rated as something to recommend to other professionals. It is reassuring to see that the messages and lessons learned, which are presented within all of the LSCB training, are reflected in participants learning and within how they feel it will improve their practice. Consistent comments received across all of the training (Appendix 1), on how the course has improved practice, are not dissimilar to previous evaluations and include comments such as:-

- *More awareness / more in-depth knowledge inform practice*

- *Not believe all that's presented/ Ask certain questions / make me challenge re curiosity/ Trust my concerns my judgement/ professional curiosity I will take back to my*
- *Feel more confident / able to recognise / more aware of risks*
- *Not to assume/ more knowledge of impact of parents/ resources to refer too*
- *Understanding of impact on children and families/ offer older children time to speak on their own/ give strength to empower the voice of children / make me more aware of how the child is feeling / listen to the child / awareness of the normal child and child development*
- *Understanding my role / who and where to refer too / professional contacts/importance of talking to each other / effective information sharing / joined up working*

9.6 Comments regarding the need for improvement on courses were about practicalities such as venues (heat / accessibility / space) and no lunch being provided which was consistent as compared to previous years. Certain individual trainer styles were not agreeable to a couple of participants but this was generally around them being challenged in their own views, different ways of working within different agencies or random comments which have been feedback to line managers.

9.7 The majority of attendees felt that the training was applicable to their role and that they would be putting their learning into practice and cascading back to their teams. Some mentioned about: providing the training materials to their teams, raising at team meetings, using resources with families, utilising in supervision of staff and students, reflecting on their own practice and challenging other teams of professionals to make changes to policies and information available to families.

9.8 A positive point to mention is that fewer attendees commented, this year, on safeguarding children not being a part of their role or remit (two participants) as they worked with adults which would suggest that more participants see themselves as working more with families.

Attendance at Local Practice Groups

9.9 515 people have attended the Four LSCB Local Practice Groups across; Fenland, Huntingdon, Cambridgeshire City and South and East Cambridgeshire, which is an 18 % increase on last year. The majority of attendees were from Preventative and Enhanced (P & E), Cambridgeshire Community Services (CCS -health) and Social Care, this is an increase of P & E of 73% as compared to last year, a similar figure for CCS and a 11%decrease in Social Care. There has been a decrease in Education (by 5 people – 90 %) with a slight increase in Early Years remaining constant (4 people30% – but low figures of 14 attendees); an increase in Police (3 people) and Probation Trust (50% - extra 5 people).

9.10 The spread of Target Groups (members of the children's workforce taken from Working Together 2010 / 2013) have most people coming from Group Three (those who work predominantly with children and young people) and Two (those in regular contact with

children and young people) which is the same as previous years. These are the 'identified groups' which the LPGs are aimed at.

Evaluation of the Impact of Local Practice Groups

9.11 All participants who attend the four Local Practice Groups are asked for their comments at the end of the two hour workshops (Appendix2). Some of the themes from the groups included:

- *Lots of relevant information / Clarity of definitions*
- *Good Networking / interesting to find out others views / different agencies*
- *Seeing the child in different settings from different professional perspectives*
- *Left me thinking about ways to improve safeguarding / thought provoking / frightening (in relation to welfare benefits and housing session on safeguarding)*
- *Good to hear about local cases and case examples / good explanation of policy/protocol*
- *Key messages / now have confidence to make a referral*
- *Having time to play and experiment (in relation to the Play workshop)*

9.12 Varied comments for improvement were round venue and parking; have more social workers at these meetings/ longer sessions and more time for discussion. Other points included: - needing a list of recommended resources and more diversity.

9.13 Some sessions created much debate and discussion particularly those on the Bruising in Non Mobile Babies Protocol, Lessons Learned from Cambridgeshire Serious Case Reviews, Welfare Benefits Legislation and Core Groups. The Core Groups sessions held discussions regarding 'what worked well' and 'how core groups could be improved' from partner agency perspectives. This information is being included within the findings from the core group audit and will assist future recommendations for core groups across Cambridgeshire.

LSCB Conference :Effective Multi-agency Safeguarding: Engaging Children and Families' – 26th June 2013

9.14 There were 97 delegates at this event with around 37 additional participants. This is consistent with the previous years' attendance with an increase (9%) in overall attendance of those at 97 %. The Conference was aimed at practitioners and the majority of those who attended were either working with children, young people and their families (80% were practitioners) or managers (14%). 89% of attendees were recorded as women and 87 % White British.

9.15 Attendance for Children's Social Care had improved slightly (by 3 people + 6 Unit members facilitating a workshop) and the Preventative and Enhanced Services significantly improved (12 people) and the Voluntary Sector (4 people) as compared to last year. Police representation slightly improved this year (2 people) with Education and Early Years remaining constant, with 4 members from a' special school' holding a

workshop at the event. There were no attendees from the Youth Offending Service though a workshop was facilitated by 4 YOS workers on the day There was a wide spread of applicants accepted from across the sectors and the working groups as outlined in Working Together 2010

9.16 The participants were all asked to complete an evaluation form. Participants rated the organisation of the day as excellent to good (76%); this was a decrease from last year and participants report this as being due to the change of venue (within Wyboston lakes) and the lack of signage. 91% rated the overall day as 'excellent to good'.

99% of respondents rated Joanne Early as an 'excellent to good' speaker with 77% of participants rating Peter Jordan in the same category. Comments included ' Joanne's exposition of her personal experience was very powerful', 'made me think about my own practice'…'how to have a conversation with parents 'and 'Peter..[provided] useful key tips in improving communication [with children and young people]. A few salient comments about the event included:-

- *Has helped me to remember young people's and families perspectives.*
- *I will use this when meeting with them/children's views at the forefront of all procedures whilst remaining mindful of the safeguarding issues*
- *Really interesting and informative, feel re-energised!*

The six workshops received varied responses with the majority of people rating them as 'excellent to good'. The workshops focused on how to engage with children, young people and their families and the Rape Crisis and Women's Aid workshop was rated the highest followed by the Social Work Unit. Comments included; 'Unit 22 – workshop – an excellent insight into the Unit 22' and 'The workshop on the Cambs Rape Crisis Centre was inspirational'. For further analysis and information please see the 2013 Conference Report.

9.17 **Training attendees: 'Hard to reach' groups**

From the Attendance Report May 2014, it can be ascertained that the 'hard to reach' groups, identified in previous reports as; Police, District Councils, Education, Faith, Early Years and GPs, have been encouraged to attend and engage in a number of different learning and development activities within the LSCB (i.e. training, LPG's, specialist training and priority topics) which is increasing their awareness of safeguarding children and their involvement within the LSCB. However there is still some work to do to encourage more representatives from the Police and from the Early years sector.

9.18 **Life Experience – Voice of the Child**

Many found the training days / sessions, which included service users as being particularly helpful – to give a real lived experience of their experiences and how best for professionals to work and support them. (i.e. Psychosis / Dads Training and Missing Children). Positive comments were made about the case studies used, of which all are 'real life' cases submitted by the agencies from the LSCB partners and training pool.

Particularly impactive has been the input of a young person who had been looked after who had been regularly reported as missing when in a residential unit

9.19 **Bespoke LSCB Training**

It is recognised that for some single agencies the messages on safeguarding need to be taken to them. A number of bespoke training opportunities have been provided to; hospital staff, council members, conference attendees, locality teams, contact centre call takers, foster care social workers and general practitioners.

- On 7 September 2013, the LSCB E learning platform on 'basic safeguarding' was launched to encourage hard to reach groups (those groups who have limited representation on the LSCB multi-agency training) to access LSCB safeguarding training. To date we have had many enquiries but only eight people signed up to undertake the course of which three have successfully completed a number of modules. Although, this is still very early days, it is a little disappointing but is an identified area which needs to be promoted more vigorously. The LSCB Has commissioned the E Learning package until September 2015

- Over the year there have been a number of safeguarding priorities for Cambridgeshire LSCB including; Partner agency participation in core groups, Learning from and improving multi-agency safeguarding practice, Missing children, Parental alcohol behaviours and Child Sexual Exploitation

- The Designated Doctor and Cambridgeshire and Peterborough LSCB Training Managers facilitated four workshops aimed at engaging General Practitioners with the latest national and local safeguarding messages, with a number of guest speakers from partner agencies. In total of 177 General Practitioners and Senior Practitioner staff, from Doctors Surgery's, attended the half day courses.

- Chelsea's Choice is a drama production, on Child Sexual Exploitation, performed by AlterEgo which was commissioned by the LSCB to perform to professionals and to all secondary school year 9 students, across Cambridgeshire, during February and March 2014. A significant number of District Council members and Education representatives attended the professional days, which were specifically aimed at; gaining the schools engagement with the tour for their students and to promote awareness amongst council staff. Police, Social Care and Health were also significantly represented (it should be noted that health commissioned their own session of the play at a conference as part of the tour). It is also interesting to note that 781 professionals also attended the Chelsea's Choice tour within all of the schools to support the young people during and after the play, of which included:- Localities, Police, Integrated Access Team, School staff and CASUS (Substance misuse team for young people).

10.0 Child Death Overview Panel (CDOP)

10.1 **The process and purpose of CDOP**

The primary function of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) is to review all child deaths in the area, which it does through two interrelated multi-agency processes; a paper based review of all deaths of children under the age of 18 years by the Child Death Overview Panel and a rapid response service, led jointly by health and police personnel, which looks in greater detail at the deaths of all children who die unexpectedly. This is a statutory process, the requirements of which are set out in chapter 5 of 'Working Together to Safeguard Children 2013.' The CDOP is chaired by the independent chair of the LSCB. The CDOP annual report can be found on LSCB website.

10.2 **Numbers of child deaths reported and reviewed**

Over the last year, thirty children have died in Cambridgeshire, which is a similar number to previous years. Of those children who died, 43% died from a known life limiting condition, with a significant proportion being babies born with a congenital condition who died in the neonatal period.

10.3 Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of 47 children (some of whom had died the previous year or even earlier). There is often a gap of several months between a death and that death being reviewed, whilst all relevant information is gathered.

10.4 Of the child deaths which were reviewed, the pattern of deaths was similar to that noted above with the majority (74%) being babies under a year old. Similar to the last two years, the next largest group was teenagers aged 15- 17 years old. However, the actual numbers were small with varied reasons for the young people's deaths, none of which were identified as being preventable.

10.5 **Modifiable factors & Safer Sleeping**

It is the purpose of the child death overview panel to identify any 'modifiable' factors for each death, that is, any factor which, with hindsight, might have prevented that death and might prevent future deaths.

10.6 There were six cases across Peterborough and Cambridgeshire where a modifiable factor was identified, five of whom were babies under twelve months old. Three of the babies were in unsafe sleeping arrangements. In all these cases, the mothers had been given advice about safe sleeping although it was less clear whether fathers had been given the same advice. These deaths reinforced the concerns identified in 12/13 about the importance of raising awareness of safe sleeping. In the final quarter of the year, four workshops were held for professionals focussing on how to engage parents in safer sleeping.

10.7 Following a number of drownings both locally and in neighbouring areas over the past

year, the CDOP also created a water safety flier 'Keeping Kids Safe in Water in Summer' which has been widely distributed in order to raise the awareness of both parents and children with regard to the dangers associated with swimming in open water.

11.0 Conclusion

It is hoped that this report described the ongoing progress of the LSCB in adding value to the efforts of all agencies involved in the safeguarding of children across Cambridgeshire. The LSCB has continued to develop approaches to particular areas of work in response to national guidance and expectation of its influence. Its multi-agency auditing approach is well embedded and provides learning for practice which is implemented by agencies; the multi-agency training programme is well regarded and has an impact on practice, and the partnership works in a way that supports reflection and ambition to improve effectiveness so that children in Cambridgeshire are safe.

Comments are welcome – please send any comments regarding the content of the report to lscb@cambridgeshire.gov.uk

Josie Collier, LSCB Business Manager – September 2014.

Appendix 1 - Completed LSCB Business Plan 2013-4

This plan outlines the key priorities for Cambridgeshire LSCB over the next year years. There are four priority areas for 2012-4, each with clear outcomes for the LSCB and for children and families in Cambridgeshire. Each of the sub-groups of the LSCB will draw up their work plans based upon the outcomes and milestones in this plan. The plan will be reviewed every six months and in March 2014 new outcomes for each priority area will be considered, although Priority 3: Communication will maintain its outcome for 2 years.

PRIORITY AREA ONE: EFFECTIVE RESPONSES TO SPECIFIC SAFEGUARDING CONCERNS

OUTCOME FOR 2013-2014	MILESTONES AND MEASURING IMPACT	LEAD SUBGROUP/ AGENCY/	Date for review/ completion	RAG	Comments
That children and young people in Cambridgeshire are protected effectively from Child Sexual Exploitation	For details milestones and outcomes re CSE please refer to the CSE strategy/ action plan Impact to be measured through plan, monitored via performance monitoring dataset	CSE/ Missing Implementation group.	Ongoing with regular review. To be carried over to the new LSCB Business Plan 2014-6		Benchmarking exercise and strategy refresh took place autumn 2014 New joint LSCB strategy and action plan for CSE and Missing approved at LSCB at Jan 2014. Priority areas for development – pathways through services and dataset.
That children and young people in Cambridgeshire are protected effectively from sexual abuse	For details, milestones and outcomes see Sexual Abuse action plan Impact to be measured through plan, monitored via performance monitoring dataset	Business Committee SCR and QEG	Complete March 2014		Significant improvement rate in number of children subject to a plan approximately 8-10%. The training and focus will continue as normal business and some strands will sit in the CSE strategy

When parental alcohol use becomes a risk to children and young people, that children and young people are protected effectively from its impact.	For details, milestones and outcomes see LSCB SCR re Learning and Improvement Action plan Impact to be measured through plan, monitored via performance monitoring dataset	SCR Workforce Development Sub-group for training	Learning and improvement action plan to be signed off at 18th March SCR meeting		L and I plan Of 8 recommendations 7 complete. DAAT protocol has been held up to allow for new provider of adult alcohol treatment services to become established post April 2014.
That the response to the impact of domestic abuse on children and families is responded to effectively across the safeguarding system	For details, milestones and outcomes see Domestic Abuse implementation Board Action plan (section 4 re CYP) Impact to be measured through plan, monitored via performance monitoring dataset	Domestic Abuse Implementation Board: CYP t and f group	To carry over to the LSCB plan 2014-6		Mapping report completed and informing development of county offer for domestic abuse. Domestic governance Board established. New strategy developing. More work to continue from strategy and report.

PRIORITY AREA TWO: EFFECTIVE EARLY HELP AND SAFEGUARDING					
OUTCOME FOR 2013-4	**MILESTONES**	**LEAD SUBGROUP/ AGENCY/**	**Date for completion/ review**	**RAG**	**Comments**
The LSCB can demonstrate that children and young people in Cambridgeshire receive effective early help that meets a range of needs in different communities.	LSCB activities promote consistent application of agreed thresholds and adherence to policies and procedures that are compliant with national policy and statutory guidance, across the safeguarding system, measured through reviewing activities	ALL	Complete and ongoing .		S11 audit identified compliance with MOSI. New referral form reference to MOSI; two audits confirm good application of thresholds. Ongoing audit focus confirms this, with regular monitoring of CP data also reflecting that the 'right' cases receive services
	The LSCB ensures that the MARU is developed so referrals and responses for children with all types of need at level 2/ 3 /4 of MOSI are effective and consistent.	MARU Board chair / Partner agencies	MARU report July 2013 and Jan 2014 Complete and ongoing		The governance of the MARU via the LSCB is established and regular monitoring will continue as well as input in to the MARU buy LSCB activity, eg MARU LPG.
	The LSCB ensures that both safeguarding practice and the processes supporting this manages the risks at the point where work is in transition between agencies and during periods of step-down and escalation and that this is reflected in procedures and protocols arising from Working Together 2013	ALL / Business Committee/ Working Together task and finish/ Area Working Together groups	Review March 2014		Multi-agency audit work will evidence some of this, as will Evidence from E&PS Local Protocol due at LSCB in March 2014

That where identified, demonstrable improvements are made to practice across the safeguarding system	LSCB performance management framework encompasses information about early help, thresholds, specific concerns and evidences effectiveness of intervention.	QEG/ Performance manager	March 2014 Reports to QEG bi-monthly; to LSCB 6 monthly		Performance management framework in place – to October 2013 Business Committee Work underway to develop early help evidence and inclusion on the LSCB agendas
	That the LSCB received regular reports from agencies regarding practice improvement or improvements in the approach to safeguarding	LSCB	Bi-monthly - underway		**In place**
	That the LSCB understands issues of diversity and difference and supports practitioners in developing their safeguarding practice in this area through guidance and training	Business committee:Cultural competence group Workforce Development	Oct-13		**Cultural competence launched end October 2013. training is planned.**
	The LSCB understands where the gaps are in service provision at all levels of need, manages them as a risk and challenges those agencies involved (see learning and improvement framework)	LSCB Board / Chair/ Business Manager	Review March 2014 –		Risk register approach in place – next review due March 2014
	The LSCB responds to identified gaps and challenges partners in early help regarding specific safeguarding concerns which are strategic priorities for LSCB partners e.g. domestic violence, CSE.	LSCB Board / Chair/ Business Manager	Ongoing review March 2014		Address in business plan – LSCB involved in Domestic abuse mapping and analysis; leading on CSE missing.

	That LSCB considers on a regular basis the impact of current resource constraints on provision of services and of organisational change.	LSCB Board / Chair/ Business Manager	Every other Board – ongoing		In place – ongoing, prompted buy risk register discussion and by arising need.

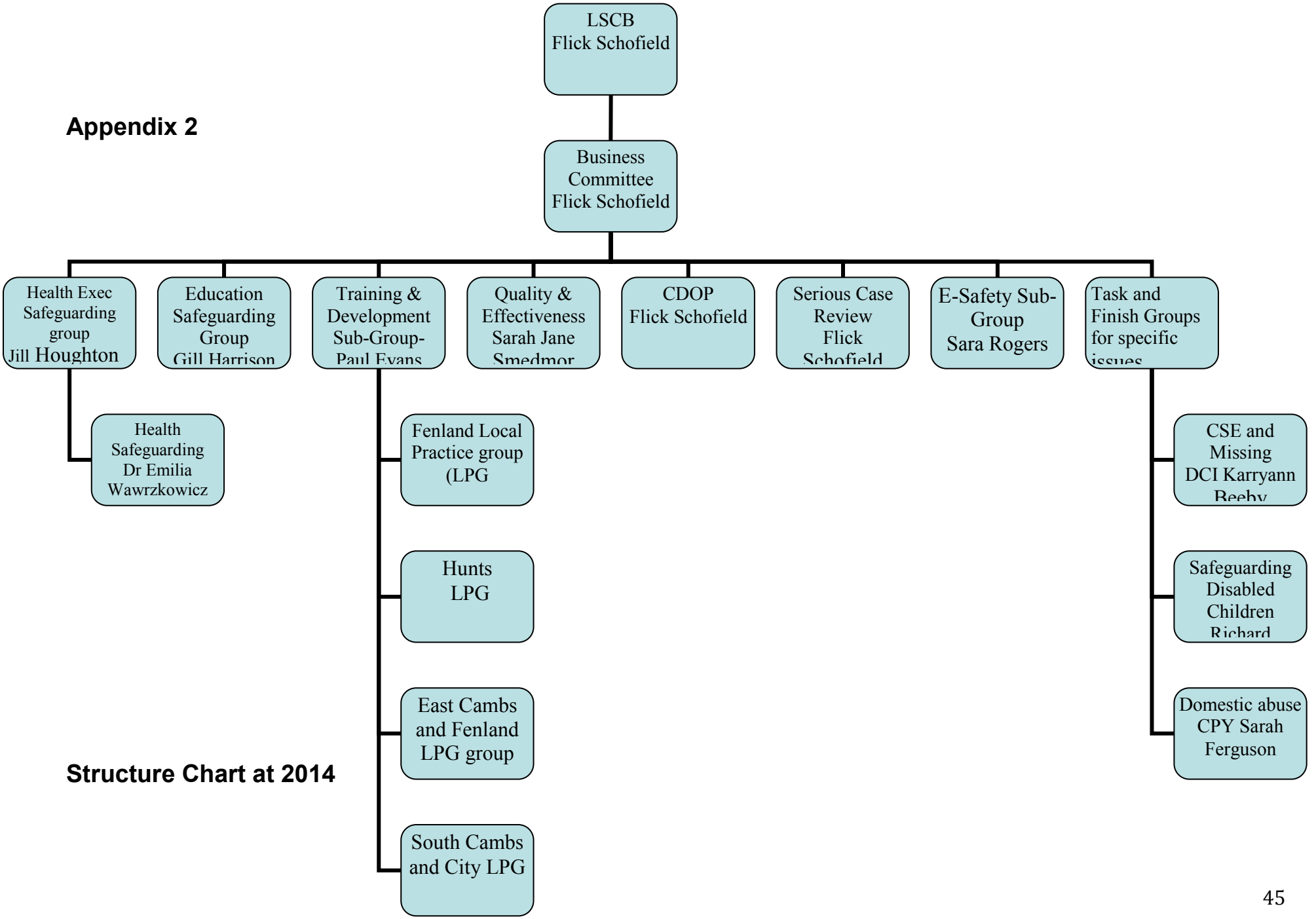
PRIORITY AREA THREE: COMMUNICATION AND ENGAGEMENT					
OUTCOME FOR 2012-2014	**MILESTONES**	**LEAD SUBGROUP/ AGENCY/**	**Date for completion**	**RAG**	**Comments**
The LSCB and partner agencies communicate effectively with children and young people; their families; the community (including different sections of the community); and staff at all levels from partners agencies.	A communication sub-group/ task group continues with an action plan to meet which with the following as key milestones:	Business committee. Business Manager	March 2014 – not complete and ongoing – alternative approach suggested		As before – difficult to get engagement – LSCB to consider different approach eg ensuring it is part of other work-streams etc eg CSE/ missing. This is proving a more successful approach. Participation work continuing at county level
	Ongoing engagement with children and young people with different levels and types of need; their inclusion in different LSCB activities; LSCB takes advantage of different opportunities to communicate.	Comm. group	Complete and Ongoing		Poss alternative approach – using Youthoria online survey – 1st survey regarding CSE complete reported to LSCB in March 2014 Chelsea's Choice underway Work on Participation strategy taking place with CFAS strategy manager and CSC participation team … Participation strategy coming to LSCB Business Comm 31st March

	Establish clear ongoing, dynamic engagement with practitioners regarding their experiences of safeguarding work and the activities of LSCB (see learning and improvement framework	All	March 2014		Ongoing feedback from practitioners at training and LPG gathered Asking LSCB members re how they know practitioners are ok Core group audit and LPGs gained huge feedback . Working Together groups did not happen, but LPGs thriving.
	Engagement with parents around specific safeguarding issues	QEG Safer Sleeping SCR	Ongoing as part of activities – to review Nov 2013		CSE – Chelsea's choice –offer to parents and media campaign re operation Weston Parents voice in audits still not clear Safer sleeping to be launched in April.
	The LSCB communicates with the community to raise awareness of safeguarding issues, through community partnerships and directly with public.	Comm. group	March 2014		This will be done through specific workstreams eg CSE publicity.
	Systems that allow for effective communication within the LSCB, between sub-groups and with Area Safeguarding Committees	Business Manager	March 2014		To date effective , however risk from capacity issue in CSC with new proposed Working Together groups. This has been mitigated by the LPG as place to share information
	That there is a clear 'map' of strategic and operational governance arrangements	Business Manager / LSCB/ CFAS partnerships manager	Review March 2014 – on to new plan		Awaiting capacity to complete – carry over

PRIORITY AREA FOUR: PERFORMANCE MANAGEMENT					
OUTCOME 2013-2014	**MILESTONES**	**LEAD SUBGROUP/ AGENCY/**	**Date for completion**	**RAG**	**Comments**
The LSCB has a learning and improvement framework which promotes different ways of knowing and learning about the effectiveness of early help for and the safeguarding of children and young people in Cambridgeshire.	An LSCB dataset which supports understanding of the child's 'journey', and including the data required by the national 'Children's Safeguarding Performance Information' and key local data.	QEG/ Performance Manager/ LSCB Business Manager	May 2013		Approved, review at Business Committee October 2013 – to be reviewed April 2014
	That the learning and improvement framework measures the impact of the work done by the LSCB and partner agencies and understands the risks to the effectiveness of this work	QEG/ Business Committee	Ongoing – review with Annual report		Suggested review of this for March 31st Business Committee
	A 'mapped' system of feedback from service users about the effectiveness of intervention.	QEG/ Comm and Engagement	March 2014 – not complete		Participation approach being developed

And that the learning and improvement framework supports improvement in the quality of safeguarding practice.	That the learning from ongoing reviewing activity is disseminated to practitioners in a variety of ways	All	Ongoing – subject to review in SCR and QEG		Evidence on Learning and Improvement plan and on Sexual abuse and Domestic abuse audit plan
	That there is a clear relationship between single and multiagency audits and reviews and where possible they are connected to support wider learning	QEG	Ongoing 2014 in QEG.		QEG hears single agency audit report at each meeting and challenges agencies to evidence impact of their singe agency audit programmes. This informs learning and approach to multi-agency audits.
	A section 11 audit process which raises awareness of safeguarding and promotes learning across different agencies.	QEG	Complete		Stat report to LSCB in May 2013. non-stat agencies s11 coming to LSCB in Nov 2013. Action plan monitoring completed in Nov 2013 at QEG. Next s11 due end 2014-early 2015
The LSCB learning and improvement framework supports and promotes effective challenge by the LSCB	Participation in the activity of the Board and challenge and resultant action is evidenced	LSCB.	March 2014 – review of activity available		Eg Audit programme ongoing and learning in Business Plan DA mapping promoting improvement and change to approach

Appendix 2



Structure Chart at 2014

Appendix 3

LSCB Strategic Business Plan – 2014-5:

This plan refers to the LSCB activity for 2014-5 and will reviewed regularly at the LSCB and Business Committee. There are three task and finish groups for each of the first three themes which will take the lead on delivering the outcomes and understanding the impact of the work. This is a working draft and can be amended as agreed by the LSCB when reviewed.

LSCB Priority Theme One: Effective safeguarding response to Children Sexual Exploitation and Children who go Missing from Home and from Care (link to Child Sexual Exploitation and Missing strategy and action plan 2014)						
How will the LSCB do this?	**What will it do?**	**Responsible lead/ group**	**By when**	**What is desired outcome**	**What will impact be and how measured**	**RAG**
Challenge agencies to respond effectively to CSE	Embed recommendations from LSCB CSE audit	CSE Implementation group	September 2014	Co-ordinated multi-agency response	Evidence of embedding Through monitoring of CSE action plan and its impact measures and Learning and Improvement	
	Implement CSE strategy and action plan	CSE Implementation group	As per strategy and action plan	Co-ordinated multi-agency response	Through monitoring of CSE action plan and its impact measures	
Support agencies and staff to develop an effective response	Continue to deliver and review CSE and missing training as per CSE strategy	CSE Implementation group/ Training and Dev sub.	March 2015 as per training strategy	Confident competent workforce	Through training evaluation and impact methodology	
Commission and communicate with practitioners, families and children and young people re the risk of CSE	Conduct another survey of practitioner knowledge and practice	CSE Implementation group	September 2014 (website permitting)	Better informed LSCB CSE strategy inc W/ F dev	Workforce confidence = improved outcomes for children and young people	
	Gain views of young people and their families subject to LSCB audit on the services they received	QEG.	September 2014	Voice of the child and family in LSCB audit activity	Improved responses – through further learning and improvement work	

	Evaluate impact of Chelsea's Choice on CYP that saw it	Chelsea's Choice T and F group/ LSCB Business Unit	December 2014	Better informed LSCB CSE strategy	Effective protection of children and young people from risk of CSE, thought Learning and Improvement	

LSCB Priority Theme Two; The effective safeguarding of disabled Children at home and in care and educational settings (Link to forthcoming Plan)						
How will the LSCB do this	**What will it do?**	**Responsible lead**	**By when**	**What is desired outcome?**	**What will impact be and how measured**	**RAG**
Challenge agencies to safeguarding disabled children effectively *NB – this is a working draft – the final Safeguarding SEND action plan will take in to account the views of parents and children*	Develop definition of the cohort [– broader SEND] Focus on OOC and those in ISEP	Safeguarding Disabled Task and Finish group	September 2014	Effective multi-agency safeguarding response		
	Carry out multi-agency audit of safeguarding of disabled children and develop actions arising	QEG	December 2014	Improved understanding of safeguarding of disabled children	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
	Ensure that disabled children are represented in LADO data	LADO/ SASU	July 2014	Understanding of the safeguarding risk to disabled children	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
	Challenge all agencies to safeguard disabled children that live away from home	LSCB specific monitoring report	March 2015	Effective multi-agency safeguarding response	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
Support agencies and staff to	Develop and support multi-agency training	LSCB Training and	March 2015	Confident competent	Improved outcomes for children and young people.	

respond effectively to safeguarding concerns re disabled children	for wider workforce re SEND children.	Development sub		safeguarding workforce		
	Review policy and procedure and responses re safeguarding disabled children so that they are effective	Safeguarding Disabled Task and Finish group	March 2015	Effective multi-agency safeguarding response	= Improved outcomes for children and young people.	
	Ensure the voice of the child and family is heard in service planning	Safeguarding Disabled Task and Finish group	March 2015	Better informed LSCB strategy	= Improved outcomes for children and young people.	
	Review neglect guidance and LSCB training and GCP to include SEND cohort	Safeguarding Disabled Task and Finish group	March 2015	Effective multi-agency safeguarding response	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
Commission and communicate with practitioners, families and children and young people	Consultation with parents re their perspective on priorities for safeguarding	Safeguarding Disabled Task and Finish group/ Pinpoint	September 2014	Better informed LSCB strategy	Positive impact for those involved in being heard and views acted on (evidence based) – to be evaluated through Learning and Improvement	
	Consult CYP around safety and safeguarding through survey and audit activity	Safeguarding Disabled Task and Finish group/ Voiceability	September 2014	Better informed LSCB strategy	Positive impact and for those involved in being heard and views acted on – to be evaluated through Learning and Improvement	

LSCB Priority Theme Three: Prevention and Protection of children and young people to the risk of domestic abuse – (Link to New Domestic Abuse strategy)						
How will the LSCB do this	**What will it do?**	**Responsible lead**	**By when**	**What is desired outcome?**	**What will impact be and how measured**	**RAG**
Challenge agencies	Produce data about CYP and families to inform re child's journey and consistency of provision – agreed multi-agency as per JSNA	LSCB Domestic abuse and CYP task and finish group	March 2015	A dataset and map of resources to inform consistency of approach and of commissioning services for CYP at risk	Through Learning and Improvement	
	Embed Barnardos risk matrix in practice across agencies	LSCB Training and Dev / LSCB training manager	March 2015	Competent confident workforce	Effective identification of CYP at risk from domestic abuse – measures through Learning and Improvement	
	Ensure co-ordination interventions for CYP which support protection and recovery within family context (parallel interventions)	LSCB Domestic abuse and CYP task and finish group/ Domestic Implementation partnership	March 2015	Effective prevention, protection and recovery of children and young people	Learning and Improvement – feedback from CYP and their families.	

Support agencies and staff	Roll out Barnardos risk matrix training	LSCB T and D group/ LSCB training manager	First round by October 2014	Confident competent safeguarding workforce	Effective identification of CYP at risk from domestic abuse – measured through Learning and Improvement	
	Provide multi-agency training with DA partnership	Domestic Abuse partnership / LSCB training manager	Ongoing	Confident competent safeguarding workforce	Effective protection of and response to CYP at risk from domestic abuse - measured through Learning and Improvement	
	Support development of evidence based tool kit (HfCF / DViP	LSCB Domestic abuse and CYP task and finish group/ EPS work	March 2015.	Confident competent safeguarding workforce	Effective response to CYP as risk from domestic abuse- measured through Learning and Improvement	
Commission and communicate with practitioners, families and CYP	Conduct YP survey re services for CYP re domestic abuse	LSCB Business Unit / Youthoria	Report to LSCB September 2014	Better informed LSCB / DAIB strategy	Effective response to CYP as risk from domestic abuse- measured through Learning and Improvement	
	Conduct YP survey re relationship violence and follow up messages	LSCB Business Unit / Youthoria	Report to LSCB November 2014	Better informed LSCB / DAIB strategy	Effective response to CYP as risk from relationship violence- measured through Learning and Improvement	
	Ensure messages re domestic abuse are given to CYP and demonstrate impact	LSCB Domestic abuse and CYP task and finish group	March 2015	That young people understand the risks of domestic abuse	Feedback from CYP about the impact of receiving messages - how did it change their experience?	

	Conduct focus groups with victims/ survivors re help for their children	LSCB Domestic abuse and CYP task and finish group	March 2015	Better informed LSCB / DAIB strategy	Effective response to CYP as risk from relationship violence- measured through Learning and Improvement	

LSCB Priority Theme Four: Ensure LSCB fulfils its statutory functions of co-ordination of safeguarding work and the evaluation of this work (Link to all subgroup work plans)						
How will the LSCB do this	**What will it do?**	**Responsible lead**	**By when**	**What is desired outcome**	**What will impact be and how measured**	**RAG**
Challenge agencies	Embed Learning and Improvement framework and audit programme	LSCB Business Committee/ LSCB Business Manager	Ongoing – reporting in annual report	Well informed LSCB developing a learning culture	Better co-ordination and effectiveness of safeguarding system.	
	Challenge agencies regarding data across strategic workstreams	Priority task and finish/ implementation groups to be established as leading	June 2014	Clear annual work plan for each group	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
	Ensure that the LSCB is assured through review of all monitoring reports	LSCB Business Manager	Ongoing	That the LSCB fulfils statutory obligation to monitor safeguarding work	Effective co-ordination of safeguarding work, evidence of challenge and result given to LSCB and improvements reported where need is identified	

Support agencies and staff	Take part in LSCB/ NSPCC/ Tavistock Embedding the Learning pilot	Embedding the Learning group	December 2014	To embed the learning from SCR in the workforce – changing safeguarding practice	Workforce that report working differently and with greater effectiveness in safeguarding	
	Roll out the LSCB multi-agency Training programme	LSCB T and D group/ LSCB training manager	Ongoing – subject to regular review	Confident competent safeguarding workforce	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
Directly Commission	Commission a Website re-design from the CCC Digital Strategy Team	LSCB Business Manager/ Digital strategy team	September 2014	Improved website	Increased usage	
	Gain the view of young people through a variety online surveys.	LSCB Business Manager and Task and Finish groups	Ongoing – reporting as above	Better informed strategy	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
	Launch and run Campaign on Safer Sleeping and other CDOP campaigns	LSCB Business Unit and CDOP	July 2014 for safer sleeping/ May-August for water safety	Clear information given to children, young people and their families.	Reduction in child deaths involving specific modifiable factors	

Appendix 4

SAFEGUARDING AND STANDARDS UNIT (SASU)
CHILD PROTECTION ANNUAL REPORT:
01 April 2013 - 31 March 2014

1.0 Introduction and purpose

1.1 This report provides an overview of Cambridgeshire's children subject to a Child Plan from April 2013 until March 2014.

1.2 Child protection procedures are a key statutory element of the safeguarding framework in all local authorities.

1.3 Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local Authorities undertake assessments of the needs of individual children to determine what services to provide and action to take' (Working Together 2013).

1.4 Professionals are required to assess if a child's needs are such that they are at immediate risk of significant harm. The child protection plan clearly sets out the risks and issues affecting the child or young person and the actions which need to be taken by professionals and all family members in order for that risk to be reduced.

2.0 Organisational developments throughout the year

2.1 Social Work, Working Together for Families SWWFF (the new unit model) has seen social workers and clinicians working with children and their families in a more intensive way. Ensuring the right safeguards are in place for children the approach is strengths based and proactively supports families to stay together wherever possible.

2.2 Social workers are challenged and encouraged to think carefully at the start of their assessment about the following:

- Risks the child is facing;
- The ability of the parents to engage with the changes necessary to meet their child's needs.
- Most importantly, whether these changes can be achieved in a timeframe which is realistic for the child to be able to meet their full potential, in a safe and secure home environment, given the child's age and understanding.

2.3 The Cambridgeshire strengths based model for child protection case conferences has been implemented. This is an approach which builds on family strengths, looking at what is working well, what we are worried about and any areas of concern we need to know more about. Families find the conference process more inclusive which in many cases leads to better engagement from families, and feedback from families supports this view.

2.4 In March 2013 180 of Cambridgeshire's children were subject to child protection plans, significantly less than statistical neighbours and the lowest it had been in Cambridgeshire for some time. The rate was 15.6 per 10,000 of the population, compared to 30.5 per 10,000 for our statistical neighbours and 37.9 per 10,000 for all authorities nationally. At

the time the LSCB challenge for all partners was to consider why the numbers had reduced.
It is imperative to state that whilst CP numbers at the time were the lowest for several years the actual number of cases open to CSC had not reduced and in fact increased over the year, indicating that the work was help in CIN rather than CP.

2.5 A report was taken to the LSCB which outlined a multitude of reasons which ranged from:

- the impact of the implementation of the unit model,
- strength based model for conferencing,
- the impact of early help services

Overall Re-referral rates at the time did not indicate that this was an issue and this has been a consistent feature over this last year

2.6 Children's social care in Cambridgeshire has undergone a change in safeguarding personnel over the last year. This has included three new Heads of Service in Access, CIN and SASU.
New Group Managers and Service Managers have been recruited to support them. At the same time, the authority has been taking a close look at safeguarding practice as an integral part of its improvement journey. Lessons and themes from this, and also from multiple audits have been quickly embedded to speed up improving practice.

2.7 Scrutiny is provided to the whole process by Heads of Service from Access and CIN, who agree all requests made for conference.
This is further supported by Service Managers within SASU undertaking an overview of all information regarding the child, prior to the initial conference. The child's protection plan is worked and monitored by the core group between conferences.
The unit Consultant Social Worker and Group Manager oversee the plan along with the Child Protection Conference Chair and SASU Service Manager.
Children subject to child protection plans are discussed on a weekly basis as part of the unit meeting.

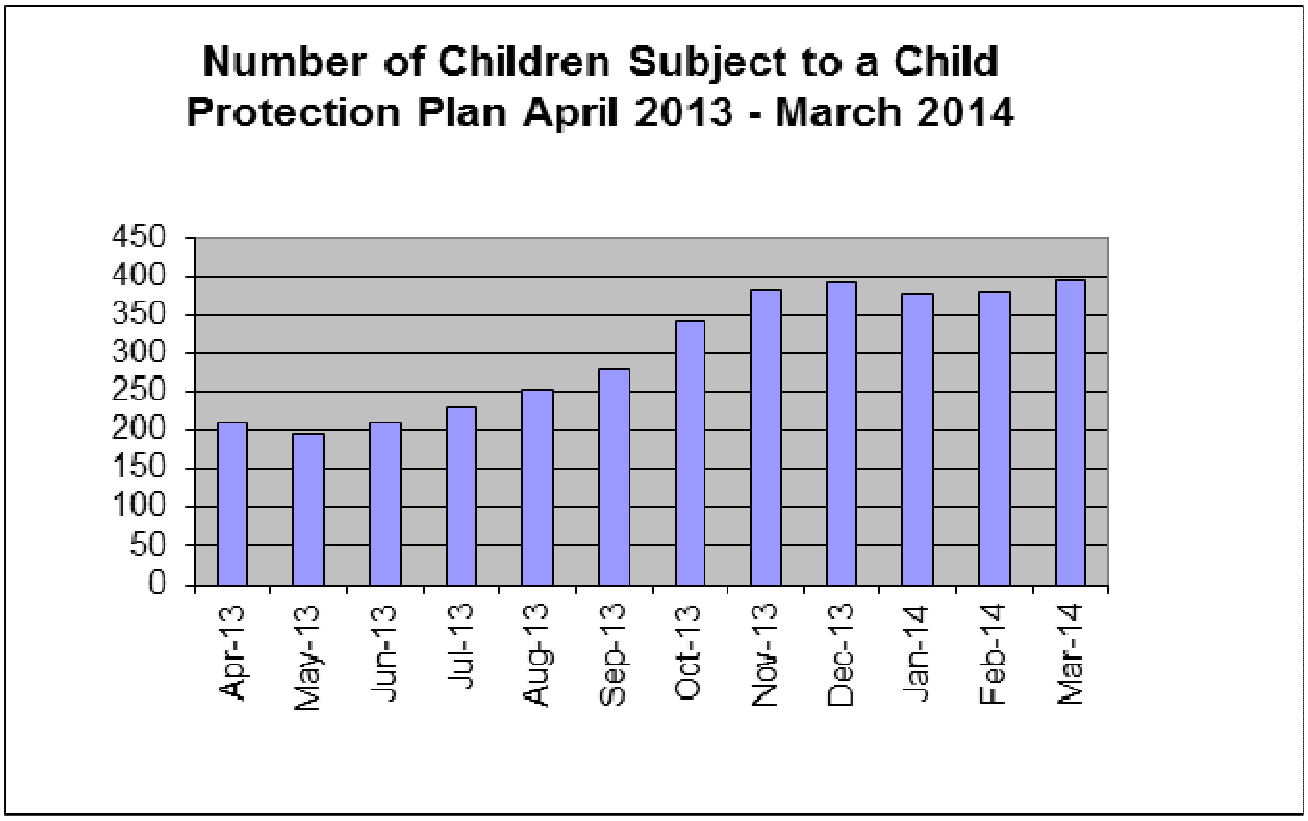
2.8 January and February 2014 started to see a slight decrease in the numbers of children subject to child protection plans, on average 385. However, an increase was noted in March 2014 following the increase in demand of referrals from the police regarding domestic abuse risks to children.

2.8 A Demand Management action plan has been drawn up to address the increased numbers at the front door and SASU service managers are working closely with police colleagues to address the increase in requests for initial conferences.

2.9 It is important to remember that whilst there has been an increase in the numbers of children subject to child protection plans, and the rise in numbers was significant and beyond predictions in the autumn of 2013.
Cambridgeshire is still below statistical neighbours and indeed only Essex have fewer numbers of children subject to plans in the region and our statistical neighbours.

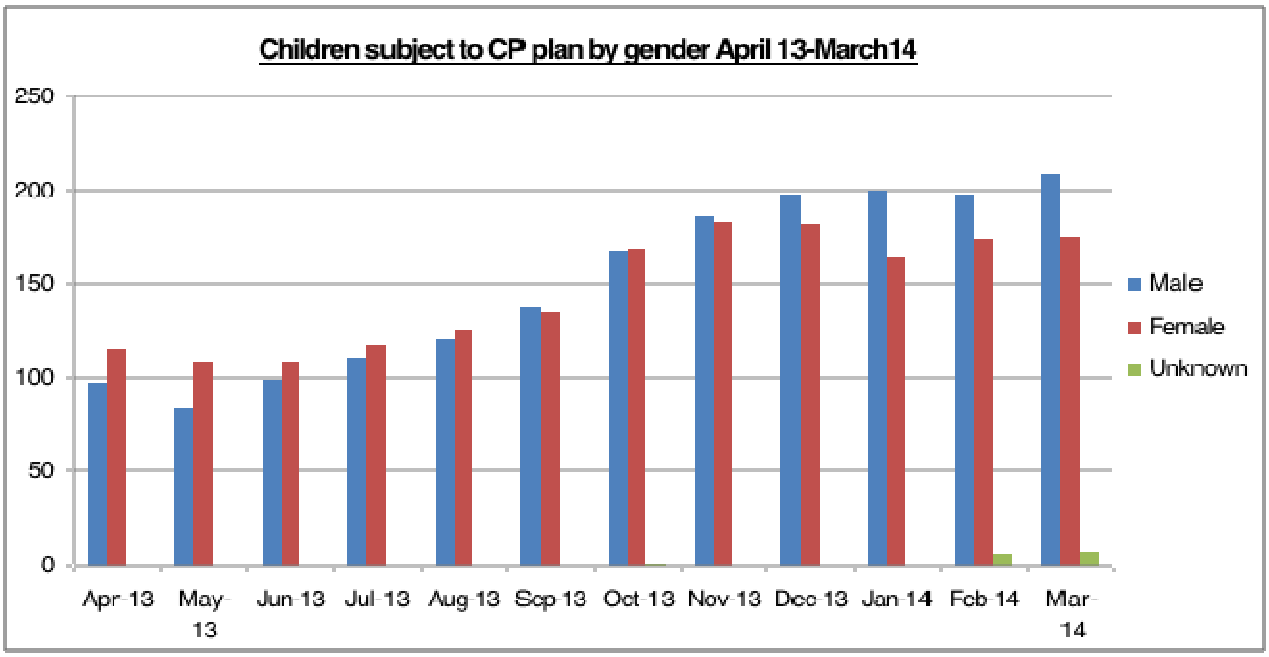
3.0 Number of children subject to Child Protection Plans from April 1st until 2013 until March 31st 2014.

3.1 The graph below shows the numbers of children with a child protection plan in Cambridgeshire from 1st April 2013 until 31st March 2014. The number of children with a child protection plan remained fairly stable between April and June 2013 but increased noticeably during the second half of the year. Given the rise in numbers during this period the County Council alongside of the Safeguarding Children Board decided to undertake further analysis.



4.0 Gender and age profile of children who became subject to Child Protection plans between April 2013- March 2014.

4.1
50.48% were male in comparison to 49.13% females.



Age Range	Number of children	%
0-5	279	52.2%
6-10	134	25.1%
11-15	108	20.2%
16+	13	2.4%

4.2 The largest single group of children who became subject to child protection plans were the unborn baby to 5 year olds, 279 children, and (52.2%). This is as would be expected; given their age, levels of understanding and dependency on their care providers, they are the most vulnerable group. Those aged between 11-15 years represented 108 children (20.2%) with the 16-17 year olds making up 13 (2.4 %) of the total.

5.0 Categories of abuse identified in the children's' Child Protection plans

Most Recent Category of abuse	Number of children	%
Neglect	302	56.6%
Emotional	165	30.9%
Sexual	39	7.3%
Physical	28	5.2%

5.1 It is noticeable that over the year the number of children made subject to plans for risk of sexual abuse has increased from single figures to over 40.
More people are now able to talk about sexual abuse involving children, and the signs and symptoms of sexual abuse being much more readily recognised and acted on.

5.2 The general public and safeguarding practitioners are also made aware on a daily basis (mainly from the media) of sexual abuse allegations made towards 'high profile' celebrities and child sexual exploitation cases and the consequences for children and older victims.

5.3 There has been a considerable focus on safeguarding in families where neglect is of concern, and drift and delay may have occurred for children in multi-agency planning. This is evidenced in the fact that in March 2014, we had, for the first time in two and half years, no children subject to child protection plans for longer than two years.

5.4 This is enhanced by the use of Public Law Outline (PLO) and a swifter journey through public law proceedings for vulnerable children. Training in the recognition and understanding of the symptoms of neglect for all practitioners involved in working with children has supported this work.

5.5 To enhance practice around this time social care staff were also being encouraged to complete the neglect module on the Research in Practice website.

6.0 Ethnicity of children subject to child protection plans

Ethnicity	Number of children	%
White, British	409	76.6%
Any other White background	41	7.7%
Mixed, White / Black African	23	4.3%
Mixed, any other Mixed background	17	3.2%
Mixed, White/Black Caribbean	14	2.6%
Asian/Asian Brit, Bangladeshi	7	1.3%
Black or Black / British African	5	0.9%
Not Obtained	5	0.9%
Asian or Asian British Pakistani	4	0.7%
Mixed White / Asian	4	0.7%
Any Other Ethnic Background	2	0.4%
Chinese	2	0.4%
Any other Asian background	1	0.2%

6.1 Cambridgeshire has become increasingly ethnically diverse over the past few years. The LSCB have worked with the Safeguarding and Standards Unit (SASU) to refresh all written literature in respect the of the Conference process, and make it available in the child and their family's first language.

6.2 The speed with which an increasingly diverse group of children have become subject to child protection plans is informed by very recent demographic changes and will require a discrete piece of work within the overall child care strategy.

7.0 Cohort of children becoming subject of Child Protection plans

Key features:

7.1 The total number of children made subject to child protection plans within Cambridgeshire on 31st March 2013 was 395. This is an increase of 184 children compared to the end of March 2013 when the number was 211.

7.2 During the year there have been 534 instances of children being made subject to child protection plans which marks an 80% increase in comparison to 2012/13 (298).

7.3 Out of the 534 children made subject to child protection plans, 18 had previously been looked after by the local authority at least once.

7.4 82 children (15%) had been subject to child protection plans previously. This is a reduction from the previous year where 19% of children coming to conference had previously been subject to a Child Protection Plan.

7.5 At the time of becoming subject to a plan, 116 children (22%) were already receiving social work services six months prior to being made subject to plans.

7.6 418 children (78%) becoming subject to a child protection plan were not in receipt of a social care (Access/CIN) service in the preceding six months.
7.7 Through monthly reporting to the Social Care Performance Board and quarterly reports to the LSCB, analysis is on-going of their cases to understand their stories and the practice implications. The analysis is looking at previous involvement with social care and intervention by early help providers.

8.0 Understanding some of the issues behind the increase in children subject to child protection plans

8.1 Three particular areas of interest stood out when taking an initial overview if the information available:

- Older children subject to child protection plans
- The significant increase in children made subject to child protection plans in October 2013
- Referrals from schools July –November 2013

8.2 The LSCB and Children's' social care agreed to look further at these three areas to understand the trends in relation to child protection plans.

8.3 Older children subject to Child Protection Plans

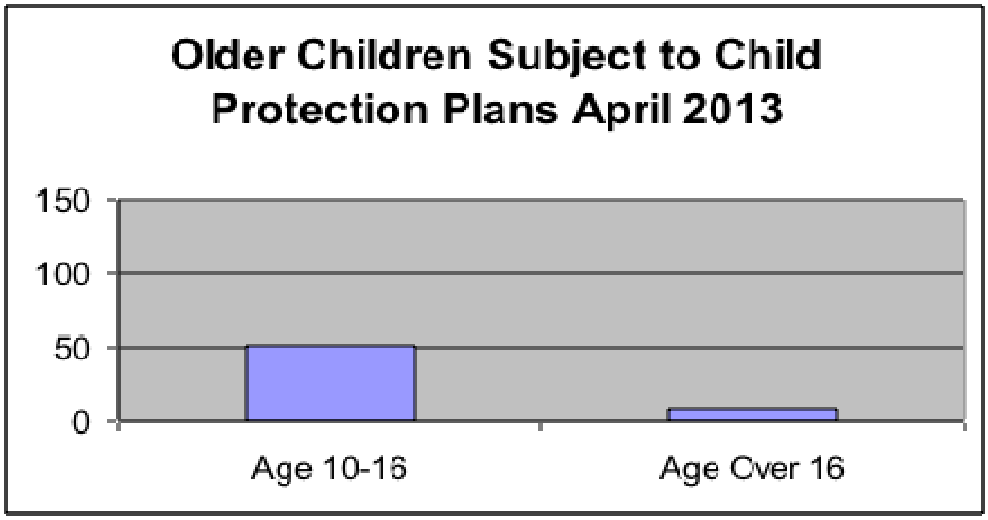
8.4 A particular focus of the analysis will be on the 108 children (20%) aged 11-15 and the 13 (2.5%) of children aged 16 & 17.

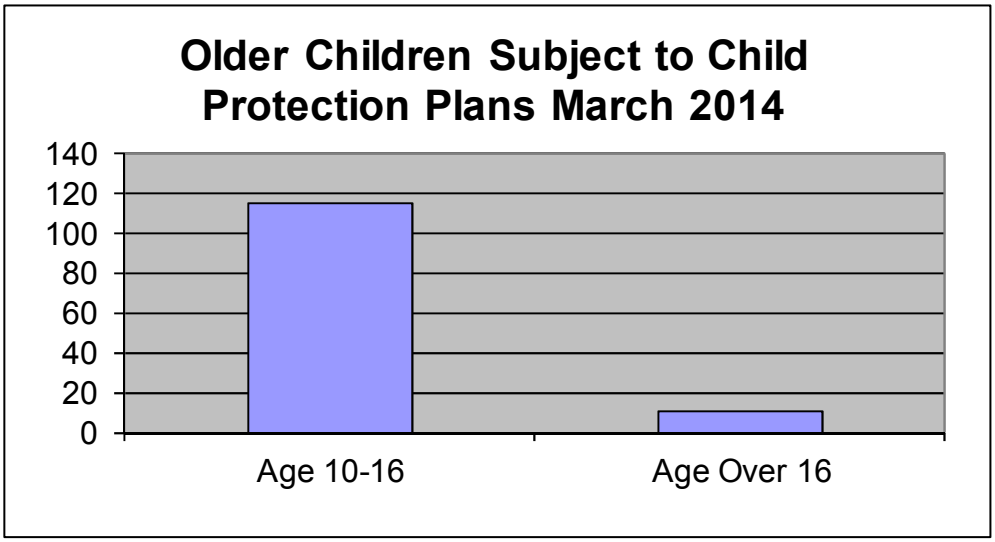
8.5 There will always be cases for older children where a child protection plan is appropriate and Child Protection Conference chairs are clear about these circumstances. This includes immediate risk from the child's parent or care provider, and should be understood in line with the child's own level of comprehension of the risk they are experiencing and needs to be clearly evidenced.

8.6 However, for many older children, there are universal and community services which could provide support for them and it is very likely that these young people would be more willing to engage with these services than 'pure' safeguarding services. Many young people feel there is a stigma attached to receiving services from social care, making them less willing to engage whereas services, specially set up for this age group, tend to be viewed by them as more acceptable.

8.7 Initial analysis of this 13 included children who were at risk of CSE. This is an issue being considered by the CSE sub group as some partners believe this is an appropriate use of the CP planning process

8.8 The charts below clearly show the doubling of children aged 10-17 in 2013/2014 compared to the previous year.





8.9 Initial analysis indicates that notwithstanding the strengths based methodology, the impact of the improvement notice has adversely affected use of the resilience matrix which has just been identified. This is now being applied where appropriate.

9.0 Cohort of children made subject to Child Protection Plans in October 2013

9.1 SASU have taken a closer look at the 91 children made subject to plans in October 2013 and following their journey through the child protection process and then looked at the outcomes for them.

9.2 This is understandably a longer term piece of work, but may be one of the only real measures for us to comprehend why these children were made subject to plans, and how successful multi-agency interventions through the safeguarding process have been.

9.3 Early highlights from this work indicate:

91 children from 47 families had an Initial Child Protection Plan (ICPCC) in October 2013. This was a very steep and unexpected upturn in numbers and had impact across the service.

We gathered some initial information regarding outcomes for the children involved, and will continue to identify where further analysis could be done and completed.

9.4 **Prior to ICPCC- referrals**

- 18 children from 9 families (18%) had previously been the subject of a child protection plan (CP plan).
- Referral sources have been looked at and given the numbers as first steer referrals from school considered.
- Two were transfer-ins (4 children - 4%), leaving 87 children from 43 families.

9.5 **Initial Child Protection Case Conference (ICPCC)**

Children not listed at ICPCC

- 6 children from 5 families (10%) were not listed at ICPCC, leaving 85 from 42 families. For comparison's sake, in April 2014 16% of families were delisted at ICPCC.
- 2 of these children were from a family of three, with the other child becoming listed for sexual abuse. This was a transfer-in conference with a young person (YP) who continued to be at risk of sexual exploitation, but whose younger siblings were exposed to less risk and conflict within the family and for whom a Child in Need (CIN) plan was felt to be sufficient.
- One child (aged 1y 10m) from one family was not listed for neglect as despite there being periods of concern about weight loss and home conditions, as parents were co-operative and keen to work with support. Family.
- One family (5 children, aged 15; 13; 12; 9 and 7) brought to ICPCC for domestic violence and neglect, following periods of CIN in the past. Split plan agreed, with the 15 year old being CIN as less at risk. Two conference members dissented with the decision for CIN for this YP.
- One family (one YP aged 15) came to ICPCC with concerns about sexual exploitation and risk-taking behaviour. Conference split over category and CIN vs CP; Chair chose CIN as child could be supported appropriately with this plan.
- Final family (one aged 2, one aged 5 days) came to ICPCC for risk of neglect and emotional harm from DV. Eldest child was made CIN as he was going to live with father and was secured. Youngest child had a CP plan for neglect.

9.6 **Category of child protection plan**

30 families (61children - 67 %) were listed under Neglect. Work outstanding includes challenging how many of these children were known to preventative services, or who had CAFs before referral to social care*.

2 families (4 children – 4.4%) for Physical

5 families (10 children – 11%) for Emotional – a quick check is required to see how many of these related to DV*.
5 families (10 children – 11%) for Sexual

9.7 **Period between ICPCC and first Review Child Protection Conference (RCPCC)**

- 5 children (5.5%) from 5 families were paper delisted by time of RCPCC. In April 2014, there were 9 children paper delisted (almost twice as many proportionately).
- 6 children (6.6%) from 2 families were transferred out. In April 2014 there was one family transferred out – proportionally the same.

9.8 **First RCPCC**

- By RCPCC in Dec '13/Jan'14, there were 58 children from 28 families still with a CP plan, representing 63% of the initial number.
- 17 children from 8 families were delisted at first RCPCC.

9.9 **Second RCPCC**

- There have been some early second RCPCC outcomes (5) with:
- 3 children from 2 families deregistered at Conference. This requires further exploration*.
- 7 children from 3 families have been paper delisted. This requires further exploration*.
- The remainder of the second RCPCCs are in June 2014, with 48 children in 23 families still subject to CP. This represents 53% of children still with a CP plan.

9.10 **Category**: Neglect 21 families; Emotional 2 families; Sexual 5 families. No physical.

9.11 What is evident from this first overview of these children's plans supports the view that the right children are being made subject to child protection plans in Cambridgeshire

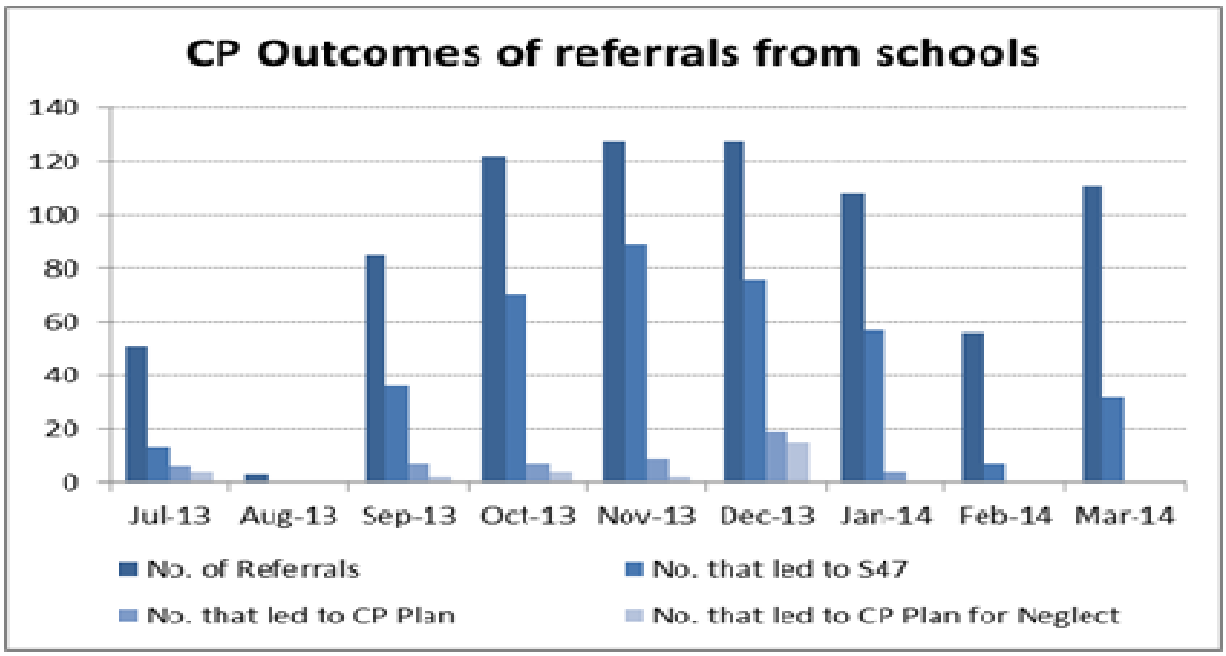
10.0 Referrals from schools

10.1 Since September 2013 there has been a significant increase in the number of referrals received from schools in respect of child protections concerns.

10.2 The numbers rose from an average of 200 contacts per month to over 369 in November 2013, and it is of note that March 2014 saw 457 contacts.

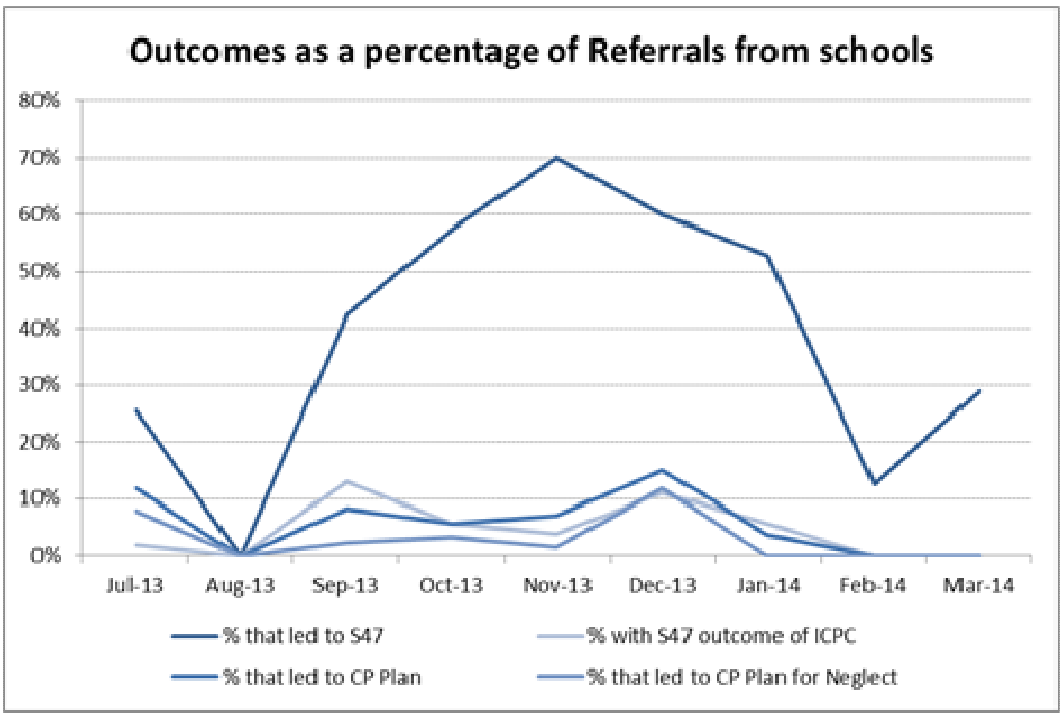
10.3 Given this information, it seems to be a good starting point to take a closer look at the impact this may have had on the numbers of children being made subject to a plan in the latter part of the year.

10.4 The chart below highlights the increased number of referrals from schools between July 2013 and March 2014.



10.5 This analysis tracked all referrals from schools and Education sources between July 2013 and March 2014 to see how many of them went through to CP Plans and, specifically, CP Plans for Neglect.

10.6 There was a significant increase in the number of referrals from schools from October to December 2013. This in turn led to an increase in the number of S47 enquiries across the period. However, only those referrals in December led to a noticeable increase in the number of CP Plans and of CP Plans for Neglect specifically.



10.7 Rates of S47 enquiries increased to a peak in November when 70% of referrals from schools led to a S47 enquiry, with 7.1% of those resulting in a CP Plan. However, though the S47 rate had decreased by December (to 60%) the rate of CP Plans resulting from these referrals had doubled from the previous month to 15% with most of those (12% of all referrals from schools) being for Neglect. Similarly high rates are seen in July, though the numbers are lower) suggesting a possible link to the end

10.8 The publication of the serious case review for Daniel Pelka in September 2013 appears to have impacted on the awareness of child protection concerns in schools, particularly regarding long term neglect.

10.9 The Education Child Protection team and the LSCB have embedded the recommendations from the serious case review and Daniel's story into all training offered to schools and multi-agency safeguarding practitioners.

11.0 Summary and latest position

11.1 This analysis suggests that the increase in the number of children with a child protection plan is due to a combination of factors, specifically

- Proactive work to raise awareness across the children's sector of key issues such as sexual abuse and domestic violence leading to an increase in the numbers
- A general rise in the number of cases being referred to social care services(mirrored nationally) and linked to a national focus on child protection and sexual abuse
- Changes to the approach and ways of working within Children's Social Care and the unit model; leading to more frequent use of child protection procedures to manage risk and effect change.

11.2 Capacity has been increased within SASU to provide extra Service Manager hours, allowing a Service Manager to support the Child Protection Chairs and conference process and a Service Manager to support the Independent Reviewing Officers and their work with Looked After Children. As of 1st May 2014 the Service has been refocused to provide Child Protection Chairs and Independent Reviewing Officers. This has already had a positive impact on the availability of the Service Manager to meet with partners and support the Child Protection Chairs with the important task of case tracking between conferences.

11.3 At the time of writing, June 2014, the numbers of children subject to child protections plans is 369.

11.4 We are confident that all children who come to conference have their needs fully considered and a balanced, multi-agency approach is taken to deciding if they are in need of a child protection plan or if parental engagement is such that an child in need plan would be appropriate.

Child Protection Trends 2013-4

Appendix 5 – LSCB Budget 2013-4

	2013-14 Proposed Budget £	Actual to End January 2014 £	Budget Remaining £
LSCB Board			
Staffing	142,899.00	123,765.41	19,133.59
Consultancy & Hired Services	14,000.00	7,053.54	6,946.46
Office Costs	4,604.00	8,436.25	-3,832.25
	161,503.00	**139,255.20**	**22,247.80**
Chair Person			
Consultancy & Hired Services	42,500.00	31,751.30	10,748.70
	42,500.00	**31,751.30**	**10,748.70**
Training Budget			
Staffing	50,924.00	42,941.76	7,982.24
Consultancy & Hired Services	1,500.00	15,623.30	-14,123.30
Venue Hire	8,500.00	8,316.62	183.38
Office Costs	500.00	2,657.50	-2,157.50
Income	0.00	-1,675.00	1,675.00
	61,424.00	**67,864.18**	**-6,440.18**
Serious Case Review			
Consultancy & Hired Services			0.00
Other			0.00
	0.00	**0.00**	**0.00**
2013-14 Financial Position at 31/01/2014	**265,427.00**	**238,870.68**	**26,556.32**
Unallocated 2013 -14 Budget	**21,439.00**		
Carryforward Unallocated from 2012-13	**72,997.00**		
CDOP			
Staffing		5,414.27	5,414.27
Consultancy & Hired Services			0.00
Other Expenses			0.00
Unallocated Budget - C/F 2012-13	10,155.00		-10,155.00
	10,155.00	**5,414.27**	**-4,740.73**

LSCB Budget Summary - The LSCB c/f was £72,997. Proposals for this will include placing funds in the SCR budget - see below. Also, we wiill be spending on the next years conference, the new disabled children's consultation project, and commissioning external audit review activity At budget preparation there were unallocated funds of £21,439 which remain as at 31 January 2014. Training budget has generated £1,675 income. **Serious Case Review** - At the current end of year, there are two SCRs pending - there is another anticipated and othre reviewing activity. We will be allowing for an anticipated spend of £40000 in this budget
CDOP - CDOP c/f from 2012-13 was £10,155. This is currently unallocated in 2013-14. Spend to date £5,414.27