CAMBRIDGESHIRE LSCB ANNUAL REPORT 2015-16

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1. CHAIR'S INTRODUCTION

Introduction

1. 1 It is my pleasure to introduce the Cambridgeshire Local Safeguarding Children Board's 2015 - 16 Annual report.

1. 2 This annual report sets out how, over the last 12 months, 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.

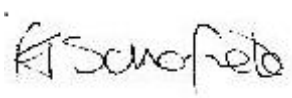
1. 3 I think we have made particularly good progress in the area of child sexual exploitation and children who go missing. This work has been led for the partnership by Dave Sargent, who joined the Board team last summer and whose expertise and commitment has enabled us to increase the pace of change in this challenging area of work.

1. 4 We have also benefited from an Innovations Grant from Central Government which enabled us to work with Peterborough and Norfolk LSCBs to improve our safeguarding services to migrant families and especially families from Eastern Europe.

1. 5 In December 2015 the Government commissioned Alan Wood to undertake a national review of LSCBs, serious case reviews and child death overview panels. This review, together with the Government's response to it, was published in June 2016. It has wide ranging implications for LSCBs and all agencies who work in the field of children's safeguarding. This review will shape our planning and development over the coming year.

1. 6 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.

1. 7 Finally, this will be my last annual report because from September 2016, I shall step down as Chair. Having never even visited Cambridgeshire before September 2009 when I became Chair, I have become strongly attached to both the area and the fantastic staff who work across all the different agencies. I shall miss you.



Felicity Schofield
Chair
August 2015

2. LAY MEMBERS' STATEMENT

2. 1 There are two Lay Members who, together with the Chair, represent the independent element of the LSCB and serve on the main Board. Our role is to provide a different prospective to the professional Board members, to challenge when required and to act as a critical friend.

2. 2 We have regularly attended Board meetings and have played a full and active part in the work of the Board. We both have a wide experience of local government and the voluntary sector giving us some insight into the difficulties and challenges faced by the statutory services. This is a time of ever tightening budgets and of significant change to the way that services are delivered. It is very important, in the face of these pressures, that the safety of our children remains our top priority. To make sure this is the case is our key role.

2. 3 The Board represents one of the few, possibly the only place where all the most senior officers with responsibilities for the safeguarding of our children come together around a table. If for that reason alone the LSCB plays a key role in making sure that all partner agencies communicate with each other and share experiences.

2. 4 We have been impressed by the commitment and determination of all the partner agencies to learn from shared good practice and to take on the lessons learned from past poor practice. To our mind the LSCB has, and continues to have, an important contribution to make towards protecting our children from harm. We are pleased to have the opportunity to play a small role in this important work.

Anne Kent and John Batchelor
Lay Members
July 2016

3 PURPOSE OF THIS REPORT

3.1 *Working Together* (2015) states:
"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. 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 well-being board.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…"

3.2 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.

3.3 In preparing this report, contributions were sought from Board members and the chairs of all sub-groups as well as from other partnerships. It summarises the information contained in reports presented to the LSCB, either on a statutory basis or at the Board's request. A set of data is attached as Appendix 4 summarising the key areas of information about the performance of LSCB partners.

4 EXECUTIVE SUMMARY

4.1 This Report is published in line with the guidance set out in *Working Together* that Local Safeguarding Children's Boards (LSCBs) should provide an account of how they have met their responsibilities in each financial year. *Working Together* was reviewed and republished in 2015, and this report reflects the current requirements as outlined in this Guidance.

4.2 This Report demonstrates that Cambridgeshire has a functioning and effective arrangement in place that meets the needs of the partner agencies but above all meets the need to safeguard children.

4.3 Numbers of children within the Child Protection (CP) system are rising. Feedback from Children Social Care (CSC) is that the complexity and relevance of cases referred has not reduced and that this reflects a genuine increase in demand on the system rather than a change in organisational thresholds. It is an increase that is reflected nationally and regionally.

4.4 Partner agencies have continued to plan for a significant level of resource reduction in line with government requirements. These reductions might be most immediately felt in the Early Help sector, but it is only by having effective Early Help that the numbers of children coming into the CP system will reduce. How to respond effectively to these developments in a way that ensures children remain safeguarded has been central to the work of the Board as it provides a unique forum for partner agencies to consult and develop their strategic approach in the light of the contribution and perspective of their partner agencies.

4.5 **Statutory objectives and functions of LSCBs**

4.6 Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

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

4.7 This Report sets out to demonstrate how the LSCB has carried out these objectives in a way that consistently adds to the quality of safeguarding in Cambridgeshire. It does so by using its position and authority to monitor, audit and assess the effectiveness of services; challenge partner agencies to justify or improve how they work; prioritise and coordinate improvement; develop a trained and aware workforce and act as a catalyst in the development of key areas of practice.

4.8 The report will summarise:

- How proper governance is ensured for the LSCB. This includes the independence of the Chair and her access to the critical senior managers and forums. It also covers the structure of the LSCB and how it is aligned with business needs.
- How it has impacted on its priority areas as reflected in its Business Plan.
- How it has sought to challenge partner agencies to deliver high quality services.
- How it has delivered its functions as laid down in *Working Together*. These functions are:

i Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.

ii Concerns about a child's safety or welfare and thresholds for intervention.

iii The recruitment and supervision of those who work with children.

iv The investigation of allegations concerning persons who work with children.

v The safety and welfare of children who are privately fostered.

vi Cooperate with neighbouring children's services authorities and their Board partners.

vii Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can best be done and encouraging all to do so.

viii Monitor and evaluate the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve. This section includes a summary of the current position in terms of number and thresholds in the Child Protection process.

ix Participate in the planning of services for children in the area of the authority.

- How it has sought to ensure the voice of the child, the perspective of children and young people, is heard in the LSCB and in partner agencies.
- How it has built on the learning it gained to improve and develop the skills and knowledge of professionals and volunteers working with children. The LSCB has delivered at a low cost a comprehensive range of high quality training. Its rigorous validation process supports agencies in ensuring the quality of their training and provides assurance that the training is fit for purpose.
- The work of the CDOP in Peterborough and Cambridgeshire.

5 GOVERNANCE ARRANGEMENTS

5.1 The statutory objectives and functions of Local Safeguarding Children Boards (LSCBs) are laid out in *Working Together* (2015) pages 65 and 66:

a *"Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:*

b *To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area*

c *To ensure the effectiveness of what is done by each such person or body for those purposes."*

5.2 The structure and business planning of the Cambridgeshire LSCB are designed to meet the requirements laid out in this Guidance. They are in place to support it in enabling all agencies to achieve the best possible practice in safeguarding all children across Cambridgeshire.

5.3 The LSCB has the following governance documents:

- Terms of Reference for the LSCB: Approved in November 2013 they lay down the strategic purpose of the partnership and defined the monitoring activity of the LSCB.
- Terms of Reference for the Business Committee: They defined its relationship with the LSCB – the focus being operational and the membership being the chairs of the sub-groups, senior operational managers and safeguarding leads in key partner agencies.
- Terms of Reference and processes for the Serious Case Review (SCR) sub-group: Reviewed this year, they reflect *Working Together* (2015) which defined the purpose of the SCRs but devolved decisions around methodology to the LSCBs.
- Learning and Improvement Framework: A key document that describes how the LSCB generates and embeds learning from its activity. This activity includes SCRs, multi-agency audits, and utilises feedback from children, families and practitioners.
- LSCB Memorandum of Understanding with the Cambridgeshire MAPPA Strategic Management Board.
- Protocol between the Cambridgeshire Health and Well-being Board (HWB), the Cambridgeshire Local Safeguarding Children Board and the Cambridgeshire Safeguarding Adults Board (SAB)

These documents are reviewed as part of the annual reporting/business planning cycle and are available on the LSCB website.

5.4 **Chairing of the LSCB**

5.5 The LSCB is chaired by an independent chair, Felicity Schofield, who has held this role since 2009. Working Together 2015 assigns to the Chief Executive of the Local Authority the responsibility for appointing and holding to account the Chair of the LSCB. The Independent Chair has one to one meetings with Cambridgeshire County Council's (CCC) Chief Executive; the Executive Director for Children, Families and Adults and the Director of Children's Services.

5.6 In Cambridgeshire, the independent chair of the LSCB also chairs the Business Committee, the Serious Case Review Sub Committee, and the Child Death Overview Panel. The latter

also covers Peterborough. This arrangement is designed to bring continuity and consistency to the overall delivery of the Business Plan.

5.7 The chair has the authority and standing to challenge Board members over the performance of their agency, and works to ensure that national policy and strategy has a local response from partner agencies. The independent chair also engages in the national debate and activity around the ever-developing role of LSCBs.

5.8 The independent chair of the LSCB continued her consistent attendance at the Local Authority Next Steps Board and the Domestic Abuse Governance Board. There was also attendance by a member of the LSCB Business Unit at the Children's Trust Area Partnerships.

5.9 The impact of this approach has been to support the spread of significant messages about the quality and importance of safeguarding across the county. There has been a voice of challenge able to enhance the quality and focus of decision making.

Participation of partner agencies in the LSCB

5.10 Partner agencies contribute to the LSCB in many ways. Attendance at meetings and financial support are two key aspects of this, but are far from being the only ones.

5.11 Attendance at the Board, Business Committee and the various sub committees that take forward the work of the LSCB remains strong and shows a continuing commitment to safeguarding. All meetings have been able to function effectively.

5.12 The Business Committee table below includes a number of representatives who were expected to attend only for specific issues or where they have joined or left the Committee over the year.

5.13 The LSCB is grateful for the continued commitment of managers and staff in partner agencies whose time, expertise energy and drive enable it to deliver its statutory responsibilities.

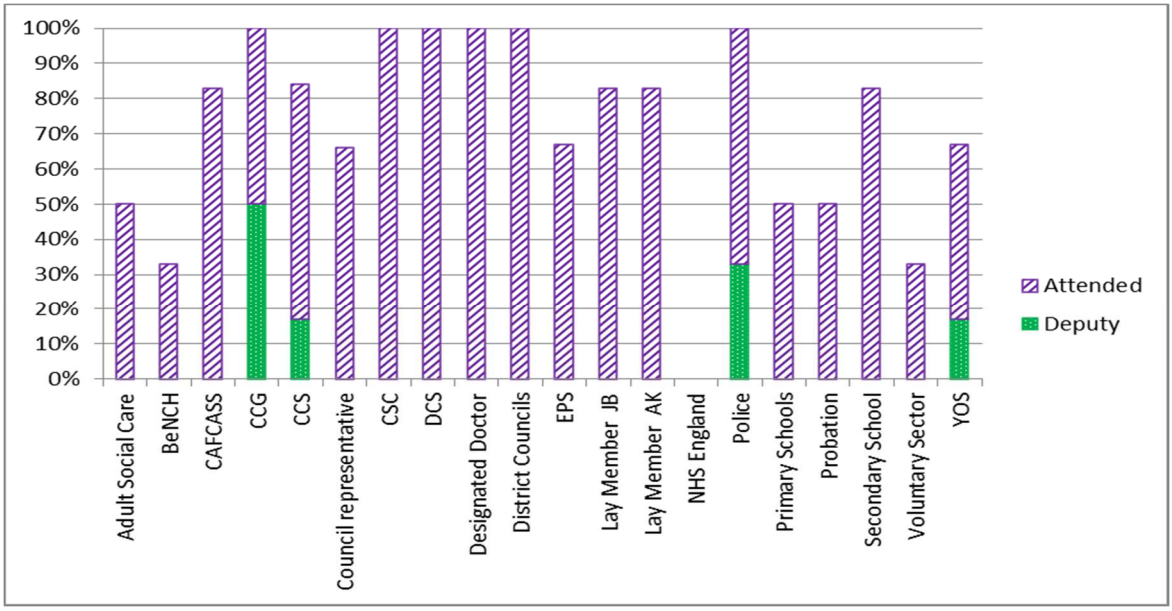


Fig. 1: LSCB Board Attendance 2015-16 (6 meetings)

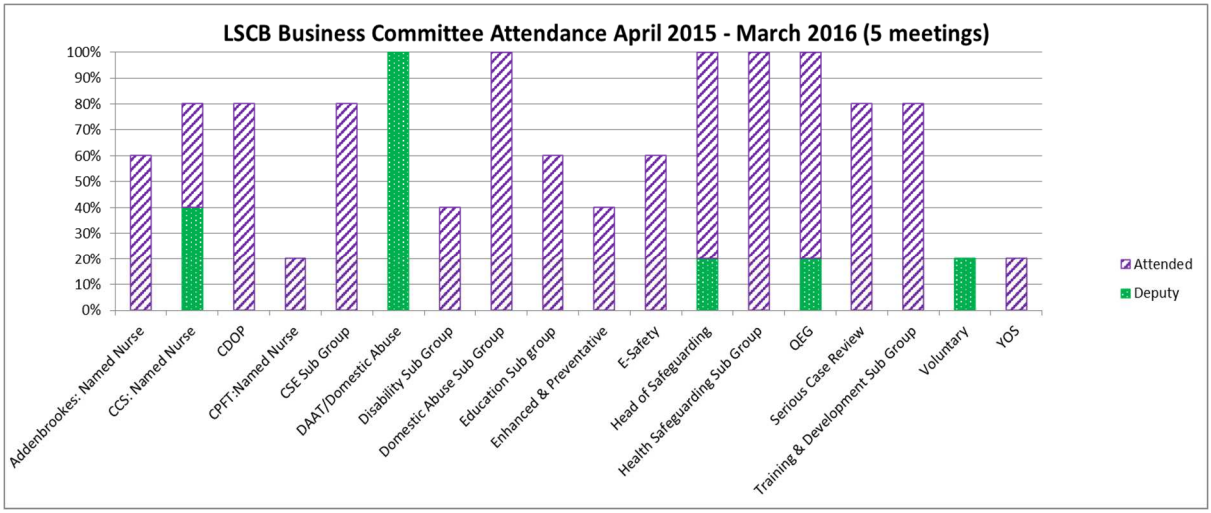


Fig. 2: LSCB Business Committee Attendance 2015-16 (5 Meetings)

5.14 These attendance levels have enabled the meetings to be effective and purposeful. However, there is a constant need to challenge those who don't attend, whilst the Board Unit has reviewed how we work to make the meetings accessible.

5.15 Over the year NHS England has not attended any meetings, citing capacity issues and their national structure as the reason why they are unable to commit to attend. Their role is such that they would have had an important contribution to make on a number of key issues.

5.16 The division of the Probations Service into two agencies, both relatively small in size compared to other Board partners, has made it difficult for them to attend as consistently as they intend. The Voluntary Sector has been represented by a manager from a large national organisation. It had proved difficult for them to attend and representation from a safeguarding manager in another organisation has now been put in place.

5.17 The membership of all meetings is kept under review and amended to meet the needs of effectiveness and efficiency.

Group	Planned	Actual
LSCB Board	6	6
LSCB Business Committee	5	5
SCR Sub Committee	12	5
Training and Workforce Development	6	6
Disability Task and Finishing Group	5	5
Domestic Abuse Task and Finishing Group	4	2
CSE Task and Finishing Group	6	5
QEG	6	6
Joint QEG	1	1
CDOP	4	3
Education Safeguarding Group	4	2
E-Safety	4	2
Health Executive Safeguarding Group	6	6

Fig. 3: LSCB sub-group activity 2015-16.

5.18 The figures above depict the number of LSCB-subgroups that took place during 2015-6. Most groups meet on a bi-monthly basis. The SCR sub-group is scheduled to meet on a monthly basis but will only meet when business requires. Where there were fewer actual meetings than those listed as planned meetings this was due to a proactive decision that a meeting was not required. This approach meets the need of partners without a significant loss of effectiveness. The exception to this was the eSafety Committee which was affected by staff absence due to sickness. The Business Committee is reviewing the most effective way to deliver this workstream.

Coordination with key strategic partnership Boards in Cambridgeshire

5.19 Attention has been given to cooperating with the other key public sector partnerships in Cambridgeshire, including the Health and Well-being Board (HWB), Safeguarding Adults Board and Area Partnership meetings (Children's Trust). To some degree this remains at an early stage and more work is needed to streamline communication and coordinate priorities. However, some work has been undertaken across the Boards, particularly in the area of Transition between children and adult services.

5.20 **The LSCB Budget**

The LSCB has a budget made from multi-agency contributions from the following agencies:

- CCC Children's Services
- Cambridgeshire Constabulary
- National Probation Service
- Cambridgeshire and Peterborough Clinical Commissioning Group
- NHS England
- Cambridgeshire Community Services NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Hinchingbrooke Hospitals NHS Trust
- Papworth Hospital NHS Foundation Trust.

Details of the budget can be found at Appendix 6.

6. LSCB: PRIORITIES 2015-16

Business Plan

6.1.1 Attached as an Appendix is the Business Plan for 2015-16 with updates on actions taken to complete the tasks as required. All commitments in the plan were met. The plan reflects the Boards priorities:

- CSE
- Safeguarding and Disability
- The impact of Domestic Abuse

6.1.2 Diversity and culturally competent practice across all providers is covered in the Report section on the Innovations Project. This summarises advances in information gathering, good practice guidance and training when working with the East European Communities. In addition, the gender, role and ethnicity of the professionals attending LSCB Training is covered in the relevant training section.

6.1.3 The LSCB continues to improve the range and quality of data available to it, seeking additional information on key areas from the relevant agencies.

6.1.4 The LSCB has developed its administrative systems to record and present clearly to meetings the information it uses and the consequent actions it takes to apply that learning. This process is designed to improve our capacity to identify and act on areas of concern and do so consistently across the whole spectrum of safeguarding activities.

Child Sexual Exploitation and Missing

Child Sexual Exploitation

6.2.1 Child Sexual Exploitation (CSE) remains a high priority for the LSCB with key objectives in the Business plans that have been met. The objectives are outlined below and evidenced in the current structure we as a partnership have developed to respond:

a. Increase the capacity and coordination of agencies in safeguarding children from CSE
b. Create a workforce competent to respond to CSE.
c. Increase public awareness of CSE and enhance the ability of children to recognise and reduce the risk they face.
d. Increase the ability of key professionals and members of the public to recognise and respond to risk of CSE.
e. Provide relevant tools and structure for professionals working with CSE
f. Provide evidence of good practice with CSE.

6.2.2 During the last 12 months Cambridgeshire LSCB have appointed a Coordinator to oversee CSE and Missing Children and along with partners have fully reviewed a number of work streams such as training, awareness raising, communications, prevention and partnership activity. The reviews have centred on national guidance and best practice including Ofsted joint targeted inspection guidance.

6.2.3 The structure of meetings has been clarified to ensure that risk and vulnerability are defined for each case we deal with. This has enabled partner agencies to better understand the thresholds for CSE and identify the correct pathway for each one.

6.2.4 The emphasis is on putting the child first and ensures that any intelligence or information coming into our possession is reviewed and dealt with at the appropriate level. As a partnership we currently have 25 children at risk of CSE and 135 children vulnerable to CSE. Each and every case has been risk assessed and proportionate action taken to ensure risk is mitigated and the relevant intervention put in place.

6.2.5 The structures we now have in place clearly define who has what responsibility with regards to safeguarding children and young adults and more importantly provides a platform for scrutiny and audit. The partner agencies have tested agencies by holding a "deep dive" Ofsted style audit to identify strengths and weaknesses in our current processes.

6.2.6 The Audit established that there was evidence of good multi-agency working but a) there were differences in which children were identified as being at the at highest risk by agencies, and this has been rectified by improved communication b) high quality return interviews are critical to all processes but were not being undertaken as robustly as was required, and a new process, using a new provider, is being put in place to rectify this and c) differences in the definition of key concepts (Missing/Absent, Vulnerable/At risk) led to confused communication, and shared definitions have now been agreed and promoted.

The current meeting structure is as follows and is explained further below.

LSCB CSE Implementation Group

6.2.7 This is a Police chaired quarterly meeting attended by all partners and is jointly attended by Peterborough SCB. The meeting will discuss the joint CSE action plan and highlight any activity taking place against the actions. Any matters arising with partners can be dealt with at this meeting and this is the forum where we would discuss national themes and trends.

CFA Strategic CSE and missing meeting

6.2.8 This is a monthly local authority meeting to provide strategic oversight of the arrangements across Children's, Families and Adults (CFA) for CSE and children missing from home, care or education, ensuring that services are working effectively together and barriers to children's well-being are swiftly addressed.

6.2.9 The role of the LSCB Coordinator at this meeting is to provide an interagency perspective to the development of Cambridgeshire County Council policy and process.

Operation Makesafe

6.2.10 This is a police led monthly meeting concentrating specifically on an identified "cohort" of individuals most at risk. Where any intelligence is received concerning the cohort, clearly defined intervention pathways are put in place.

6.2.11 Intelligence concerning suspects and locations is also shared with the CSE Coordinator who can then seek assistance from wider partners such as Housing Providers and taxi Licensing. A recent example of information sharing and assistance highlighted problematic hotels in the Cambridge City area, through partnership intervention and awareness raising we were able to work with the local policing teams to highlight the hotels responsibility and ensure structures were in place for visiting and training.

MASE Meeting

6.2.12 The group comprises a small number of key partners who meet monthly to review all children who are deemed "most at risk" and have been specifically referred to MASE from Operational Missing and CSE meeting. It is expected that the child in question will be discussed by their key worker who will be invited to the meeting. The panel will then undertake a review of risk and ensure that there are appropriate safeguards and a plan in place. The key objectives are:

a. To review all children who have been referred to MASE from the CFA Operation Missing and CSE meetings
b. To share information in relation to the children who have been referred, undertake an assessment of risk and ensure there are appropriate safeguards and a plan in place
c. To review all new information and intelligence which comes to light, police colleagues to share information from Operation Makesafe
d. To ensure information is shared with the Strategic and Operational groups
e. To review information on the dashboard

Training and Communication

6.2.13 The LSCB have managed and delivered 10 training events throughout the year to over 130 partners. The training has been specific to Child Sexual Exploitation and safeguarding with subjects covered:

a. Introduction to CSE
b. Working with CSE
c. Missing Children
d. Disability and CSE
e. CSE involving boys as victims

6.2.14 The feedback received through course evaluation has been incredibly positive with most partners going on to request further, more advanced, training.

6.2.15 The LSCB website is currently under reconstruction to provide resources for children and young adults, professionals and parents and carers. The intention is to give each group a single point of reference for information specific to their need.

Missing from care, home and education

6.2.16 The effectiveness of the procedures in place to safeguard children who are missing from school, home and care has had considerable attention during 2015-16. Running in parallel with the work on CSE, but with a wider range of children and a more complex picture of vulnerability to abuse and serious harm, major multi-agency process changes have been implemented to improve the impact that services have in protecting these children. Whilst much has been done, all acknowledge that this is a work in progress and we are yet to reach a point where we can be satisfied at our arrangements.

6.2.17 Agencies are continuing to work hard to understand why children/young people go missing and what resources are required to support them. Last year has seen an improvement in information sharing between agencies. The next step is to enhance the timeliness of the recording of return interviews to support an effective understanding of themes and trends.

6.2.18 Every child or young person known to the police as missing from care or home in Cambridgeshire is referred to the local authority and a return interview is offered and, where they agree, is completed.

6.2.19 Each child and young person is considered at the CSE Operational Meeting, even if they refuse an interview and knowledge around their missing episode is shared. This leads to safety plans being reviewed.

6.2.20 It is evident from the stories of the children and young people who go missing the reasons they go are very individual to them. The way to respond to each of these children and young people is to provide an individual response and plan for each child and signpost to services where possible.

CSE and Missing Operational Meeting

6.2.21 There is a multi-agency monthly meeting which carefully monitors children and young people who go missing repeatedly. The meeting ensures that an assessment of risk is considered for each child and where risk of exploitation is identified suitable strategies are put in place. If the assessment is such that the child is deemed "high risk" then this can be immediately referred to the Missing and Sexual Exploitation Group (MASE) that meet shortly after this one. The meeting also scrutinises themes and trends with return interviews and quality of submission of the missing exemplar.

6.2.22 Processes have been in place to keep information on children who are missing from education and steps taken to ensure they are safe. During the course of this year the LSCB has worked with the local authority to develop a proactive approach that identifies the children at most risk and ensure that sufficient resources from partner agencies are in place to take action to locate and safeguard them.

Safeguarding Disabled Children

Safeguarding Disabled Children Task and Finishing Group

6.3.1 Achievements:

a. Two consultations were held to establish the understanding of Safeguarding amongst disabled children. This included a survey at significant depth that covered a range of ages, location, disability and ethnic origin. Both surveys show a very limited level of understanding and interest amongst the children about safeguarding. Given their level of vulnerability to abuse this is a finding of significant concern and further work is required.

b. The service user perspective has been included in the meetings to improve relevant and effectiveness of the work undertaken and parents of disabled children have been members of the group.

c. A Disability Multi-Agency audit has been completed and improvement actions identified and carried out. LSCB and CCC Training has been reviewed and amended. Policy, process and data provision have been reviewed and enhanced, including the on-line LSCB processes and information on allegations against those working with disabled children.

Safeguarding and Domestic Abuse

Domestic Violence Task and Finishing Group

6.4.1 There have been significant changes in governance, with the establishment of a Joint Cambridgeshire and Peterborough Domestic Abuse Governance Board. The Cambridgeshire Implementation Board was disbanded. The Joint Board will oversee a series of discrete workstreams rather than have a fixed sub group structure in place to support its objectives. This area of work has been developed at a time of major reductions in available resources within the public sector and the need to ensure we deliver services efficiently and to best effect.

6.4.2 We have seen an increased focus on violence between and by young people and current domestic abuse structures are not tailored to be effective with this group. The understanding of domestic abuse has moved towards a more refined model where "control" is the driver behind some violence but in other situations the violence is part of a more generalised pattern of pressure and inappropriate or ineffective behaviours.

6.4.3 Achievements:

a. Increased awareness amongst schools and young people about domestic abuse through tailored training and awareness raising programmes.
b. A consultation with young people took place and the learning fed back to the Board and the Group to amend practice as required.
c. A shared language and assessment model was achieved through the roll-out of the DVRIM.
d. Complicated Matters, a major intervention toolkit and training resource was made available to all agencies through the LSCB supported by E-Learning.
e. The Domestic Abuse "Offer" was finalised and gives a practice framework for staff working with Domestic Abuse.
f. The dataset includes police information, and in future the focus will be concentrated on repeat victimisation.

6.4.4 In future, the LSCB will receive a Report from the Domestic Abuse and Sexual Violence Partnership Manager to the LSCB Business Committee on a six monthly basis covering the issues relating to Safeguarding and receive feedback from the Committee.

Other LSCB Groups

eSafety

6.5.1 The group continues to be a joint Cambridgeshire and Peterborough group with meetings being held in alternate venues.

6.5.2 E-safety training has been delivered to staff in Localities to enable them to take on the E-safety Champion role. They will support the work of Localities and deliver sessions to parents also.

6.5.3 The E-safety audit tool and Incident flowchart and accompanying guidance have been reviewed and updated.

Education Sub-Group

6.5.4 The Education Sub Committee continues to ensure the education sector remains informed about issues around safeguarding and the LSCB has an overview of the state of safeguarding in Cambridgeshire schools. Recruitment practices continue to have a high level of scrutiny and remain a key element in Ofsted Inspections. Weaknesses in process were identified but evidence is now available that the required changes have been made by schools.

6.5.5 A comprehensive programme to train school staff about Prevent, and their associated legal responsibilities, has been completed and all schools have had a Prevent Lead trained.

6.5.6 The government's initiative on disqualification by association was managed into practice, including updates on changes in guidance as they were issued. The waiver process was successfully followed as required. No staff member was found to be disqualified by association at the end of the process.

6.5.7 The LSCB was provided with an overview Annual Child Protection Monitoring Report. It showed that 98% of responding schools used the model Safeguarding policy and 100% used trained staff for recruitment.

6.5.8 In addition, the LSCB receives a report on the outcome of the audit of recruitment practice within schools. This has been an area of significant interest to Ofsted and schools have worked with the local authority to ensure robust good practice is in place.

Health Executive Safeguarding Group

6.5.9 The aim of the Health Executive Board is to strengthen and provide direction for the health community as well as agree the work plan for the Health Safeguarding Group. This group was established last in 2013 and through 2015/16 has provided two way communication between the Safeguarding Children and Adults Boards in Cambridgeshire and Peterborough: sharing the key messages from the boards to health partners and providing updates on relevant activity.

6.5.10 In addition the group has focused on the following:

a. Child Protection Information System
b. Domestic Violence Review of Providers
c. Complex Case Management Process
d. Learning from the Verita Report into Dr Miles Bradbury at Cambridge University Hospitals
e. Safeguarding within Primary Care
f. Monitoring of the Health Safeguarding Group work plan.

6.5.11 Meetings of the HSG in 2015/16 were used to focus on specific areas of the work plan, as well as encouraging the sharing and good practice and discussion concerning specific issues. Areas covered by the group in the last year have included:

a. Strengthening the reporting from the Health Economy to the LSCB around Safeguarding activity

b. Strengthening the relationship between Primary Care and Community Providers
c. How to support professionals in hearing the voice of the child
d. How to promote professional curiosity and be aware of disguised compliance

7. LSCB: IMPROVEMENT THROUGH CHALLENGE

7.1 Much of the Board's effort is placed in challenging agencies to improve safeguarding where necessary. There have been three significant examples of challenge over the year.

7.2 Following the presentation of the Private Fostering Report the Board was concerned about the statutory framework for safeguarding children at Language Schools. These have a significant presence in Cambridge. In the light of the considerable evidence available the Chair wrote to the Government demonstrating that the current statutory responsibilities placed on providers and agencies have the potential to allow unsafe practice by poor providers. In addition, the Board responded to a Government Consultation to raise the issue and show the systemic weakness in the current arrangements, including the risk of promoting extremism.

7.3 Many children who are educated at home receive a good education tailored to their needs and those of their families. However, there is a group who not only do not attend an educational establishment but also are not in contact with health or any other professional agency. There was grave concern at the Board about the system's ability to safeguard them. The Chair wrote, together with her peer from Peterborough, Executive Directors and lead Counsellors, to express this concern to the Department of Education. The government has responded and thanked them for broadening the evidence available to them on the issue.

7.4 The NHS in Cambridgeshire was subject to a CQC inspection covering safeguarding in August 2015. In addition to the expected set of recommendations and subsequent Action Plan, the inspection drew attention to the difficulties facing children requiring ADHD and ASD assessments and provision. The situation then impacted on the other staff offering them support. This is part of a more general national picture and agencies were well aware of the concern. The LSCB has worked to support the CCG take forward the development of additional services and the redesign of the CAMH pathway. In the future it will continue to request information about the accessibility and effectiveness of this service as the initiatives undertaken come to fruition. This was an issue where the presence of NHS England could have increased the scope of the Board to impact on this issue.

7.5 The Board has a culture of open challenge at the Board, in meetings and its wider relationships. This is supported by the existence of a "Challenge Log" to keep a record of this process and the changes that come from it, at the centre of its work. Four examples of this would be:

- When a survey of children's health and wellbeing was presented the meeting requested information on the process in place to respond to those who identified themselves as being at risk or showing acute concern. This response was shown to be effective
- The Board has made a number of very specific challenges about the health assessments available to Looked After Children and subsequently significant improvements in compliance were demonstrated.
- The Board Unit required confirmation that the local authority Call Centre was aware of the changes in the reporting requirements for FGM. In the event it was not, but the process was amended to ensure compliance.
- The Board requested that the Local Authority evidence its effectiveness in safeguarding children placed out of county and required further reports to demonstrate progress in meeting their needs.

7.6 Following a presentation on national Guidance on the use of medical examination in cases of sexual abuse, the three central agencies working with the LSCB agreed a new process for the Sexual Abuse Referral Centre (SARC). This was supported by a new and much improved contract for delivering these medical services.

8. THE FUNCTIONS OF THE LSCB

Policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.

8.1.1 The LSCB provides a comprehensive set of procedures and guidance on line. These have been reviewed in 2015 and 2016 to ensure they reflect current national and statutory Guidance and local practice. These procedures are managed in close cooperation with the Local Authority CSC procedures to ensure consistency in expectation.

- A number of key sections were rewritten during the year to reflect changes in good practice or legislation:
- Safeguarding Disabled Children Practice Guidance.
- Managing Individuals who Pose a Risk of Harm to Children (including MAPPA)
- Guidance for Professionals Working with Sexually Active Young People Under the Age of 18
- Female Genital Mutilation.
- Managing Allegations or Serious Concerns in Respect of Any Adult who Works or Volunteers with Children.
- Responding to Complaints About a Child Protection Conference.
- Prevent and Radicalisation/Extremism.

8.1.2 The existence of a reliable and up to date reference on process and good practice is highly valued by practitioners and remains much used.

Concerns about a child's safety or welfare and thresholds for intervention;

8.2.1 Cambridgeshire has a well-established framework for the delivery of services according the needs of the child, the Model of Staged Intervention. This Model is well understood and used by staff and agencies to identify the appropriate approach for working with individual children and families. In a number of areas of practice, including Domestic Abuse and Substance Misuse services, a similar Model has been used to structure the "Offer" of services available.

8.2.2 Prevent and Extremism are safeguarding concerns and the business of the Board. In addition to agenda items at meetings, appropriate identification and referral processes are promoted through the LSCB Website and our generic training incorporates key messages about effective safeguarding from political exploitation. Information on the identification of risk to radicalisation, the referral pathway for Prevent and the referral form have been added to the LSCB's "Reporting a Concern" web page. There are relevant resources and links in the LSCB procedures.

8.2.3 The issues facing Young Carers has been of concern and the Board received assurances through an outline of the plans being put into place by the local authority and requested performance data to enable it to track progress.

The recruitment and supervision of those who work with children

8.3.1 During 2015-16 the LSCB have asked statutory and key voluntary sector agencies to report through a structured "Section 11" audit their compliance with their statutory responsibilities. This has included evidence of proper recruitment process and effective supervision. In the set of questions covering recruitment, vetting procedures and allegations against staff 96% of responses were that the agency "Fully Met" requirements. Where there were gaps or partially met requirements follow up action was taken.

8.3.2 The potential for harm to be done by professionals has been a very significant area of concern for Cambridgeshire, reflected in it being the theme for one of the LSCB Conferences this year (covered more fully under Training chapter of this report). 2015-16 saw the publication of the review by Verita into the context of the offending by a senior health professional. The LSCB Chair decided that the quality and thoroughness of this review meant that any further LSCB Case Review would not be likely to provide any significant learning, and as such not necessary. The LSCB supported this review and held a major Learning Event following up on the recommendations contained in the Verita Report. There will need to be continued emphasis on empowering service users to challenge providers through the provision of good information and on fostering a work place culture that supports Safeguarding.

The investigation of allegations concerning persons who work with children (The work of the Local Authority Designated Officer)

8.4.1 *Working Together* (2015) refers to local authorities having a Designated Officer or a team of Designated Officers involved in the management and oversight of allegations against people that work with children (LADO). This guidance states that any such officer should be sufficiently qualified and experienced to be able to fulfil this role effectively, giving an example of social workers being the relevant professionals for this role. The Cambridgeshire LADO unit meet the requirements of *Working Together*.

8.4.2 A total of 497 'referrals' or contacts were received into the LADO Unit during 2015-16. This is a 17% increase in the number of referrals and contacts over the preceding year, when there were 413 referrals. There is a general picture of increased referrals across the region, which may be a response to the level of attention the issue of staff and volunteer abuse of children has received in the media.

8.4.3 296 were logged and closed, but there is often a considerable amount of work undertaken by Cambridgeshire LADO before this conclusion has been reached. Of these, 144 resulted in an internal investigation by the employing agency and 57 moved to the consideration of a multi-agency approach through a Complex Strategy Meeting.

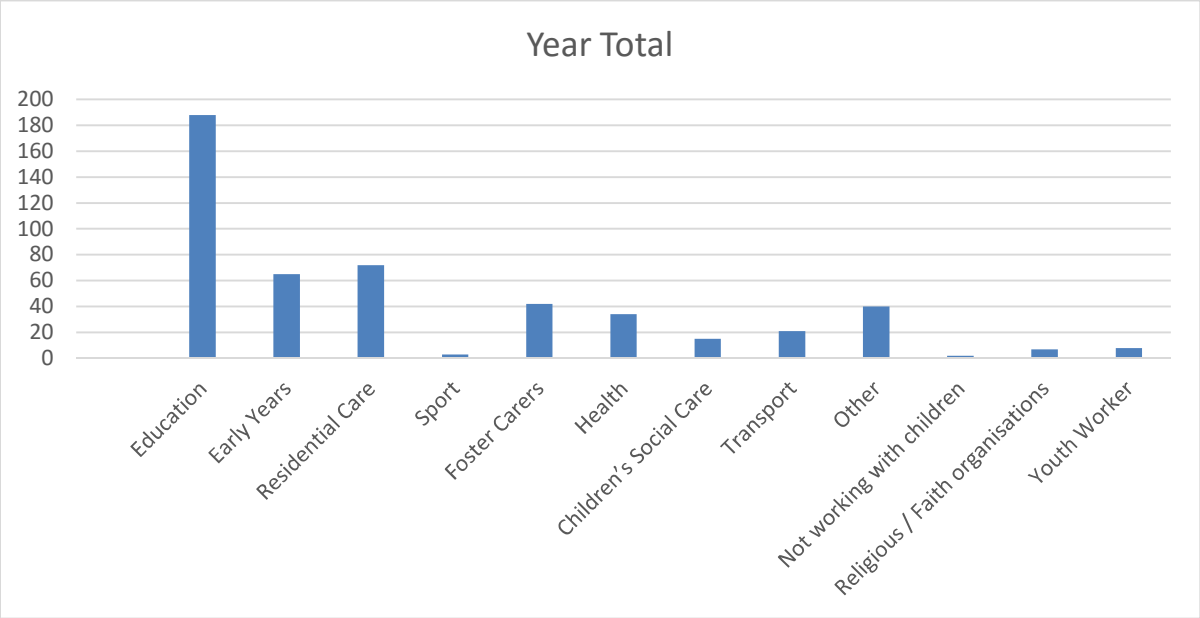


Fig. 4: Staff and volunteers referred by role:

Role	Year Total	15/16	14/15 %
Education	188	38%	36.56
Early Years	65	13%	15.50
Residential Care	72	14%	13.32
Sport	3	1%	3.87
Foster Carers	42	8%	7.51
Health	34	7%	7.51
Children's Social Care	15	3%	2.42
Transport	21	4%	5.08
Other	40	8%	4.85
Not working with children	2	0.40%	0
Religious / Faith organisations	7	1.40%	1.21
Youth Worker	8	2%	1.45

Fig.5: Sources of referrals to the LADO

	Year total	%
Logged and Closed	296	60%
Internal investigation	144	29%
Complex Strategy Meeting held	57	11%

Fig. 6: Outcome of referral

8.4.4 Of the 144 that led to an internal investigation, the outcome was as follows:

	Year total	%
Substantiated	25	27
Unsubstantiated	84	50
Unfounded	4	9
Malicious	2	0
False	10	3
Not concluded/outcome unknown	19	11

Fig. 7: Conclusion from internal investigation.

8.4.5 Disabled children are particularly vulnerable to abuse by carers. In total 21 referrals to LADO were in relation to an adult who worked or volunteered with children with a disability, 4.2% of the total. Of these 21 referrals 10 were in relation to advice and support given and resulted in being logged and closed. 6 resulted in an internal investigation being undertaken by the employer. 5 resulted in a CSM being held. This means that proportionately twice the number of referrals went to Complex Strategy Meetings for disabled children when compared to the total group.

The safety and welfare of children who are privately fostered

8.5.1 There continues to be wide acceptance that many private fostering arrangements are not reported to LA's and therefore cannot be covered in the report.

8.5.2 Cambridgeshire had 110 private fostering cases open between 1 April and 31 March 2016, 33 of which were ongoing arrangements from 2014-2015. Of the 107 new notifications, 29 were determined not to meet the criteria for private fostering or the anticipated arrangement did not commence. The Local Authority was not made aware of any disabled children living in private fostering arrangements over the last year.

8.5.3 Cambridgeshire has considerable numbers of children in private fostering arrangements in comparison to other local authorities. Cambridgeshire's number of cases last year is similar to the whole of the North East region. This is because the Cambridgeshire and national figures are skewed by private fostering arrangements made for educational purposes. There are 453 British Council accredited language colleges in England and 37 in the Eastern region, of which 21 are in Cambridgeshire.

8.5.4 Of the 110 Private Fostering cases requiring statutory monitoring visits at least every 6 weeks, 6 were British children and 104 were foreign national students. Of the 33 ongoing arrangements from 2014-2015, 32 (97%) had monitoring visits completed within the required timescales. The one case when this did not happen was because the carers and child chose to disengage with the service. Of the 77 new arrangements in 2015, 75 (97%) had monitoring visits completed within the required timescales.

8.5.5 Most commonly privately fostered children in Cambridgeshire between April 2015 and March 2016 were aged between 10 and 15 years old, and were from Asia. This number includes two large organised groups who have visited the county regularly.

8.5.6 There are also students from Asia who have come to study in local secondary schools via private arrangements between parents and associated acquaintances who immigrated to the UK. Some of these children have been in placement since 2011 and 2012, they return home regularly during school holiday period and many have regular contact with their families. These arrangements are expected to be long standing with children gaining GCSE's and A-Level's before attending university.

8.5.7 The foreign students generally retain frequent electronic and telephone contact with their families ensuring that they are well supported to maintain a strong sense of cultural identity. Private fostering reports give attention to children's specific needs relating to gender, ability, race, religion and culture.

8.5.8 Seven notifications were received for British children (2 for the same child several months apart). This is similar to 2013-2014. In 2012-2013 and in 2014-2015 there were higher numbers (around 15) of British children.

8.5.9 All mainstream children who are privately fostered continue to be considered to be Children in Need and remain open to Children's Social Care Unit's while they live in private fostering arrangements. This enables a more uniform approach to recognising the vulnerabilities of privately fostered children and ensures that their needs are being identified and appropriate services are sought. After assessment is completed and the arrangements are approved by the Kinship Team, the Unit's undertake the statutory monitoring visits. They work to stabilise and secure their placement or whether the focus is on reunification back home.

8.5.10 Of the 72 private fostering arrangements that ended during the year, 58 children went home directly from the arrangement. This is to be expected given the number of students visiting

temporarily for educational courses. 38 private fostering arrangements continued into the new business year of 2016-2017.

Cooperate with neighbouring children's services authorities and their Board partners; Working with Peterborough LSCB

8.6.1 During 2015-16 the Board has worked with the Norfolk and Peterborough Safeguarding Boards on the development of services with the Eastern European communities. This has been funded by the national Innovations Project. The outcome from this is covered in more detail in the Cultural Competence section of the Report. A number of the initiatives from this project will now be taken forward jointly by the three Boards.

8.6.2 Cambridgeshire and Peterborough have a strong historical link, and many LSCB agencies deliver services to both Local Authority areas. As such, the two Boards have sought to develop the level of co-working across the two areas. The primary purpose has been to reduce duplication of work, have consistent expectations placed on partner agencies and increase the efficiency of meetings. There have been some savings in LSCB resources which have allowed other work to be progressed.

8.6.3 There have been joint sub-groups looking at E-Safety and CSE. The impact of the latter is outlined in the relevant section.

8.6.4 There has for some years been a significant level of cooperation over training and the provision of a number of joint programmes. In February the two LSCBs ran a highly successful joint Neglect Conference, reflecting the importance of Neglect in both areas. Working together on this Conference proved productive, and a fuller account is given in the Training section. It is anticipated that the next step will be a joint Neglect Strategy.

8.6.5 This year has seen the development of more formal ties between the Quality and Effectiveness Groups. The first joint QEG Meeting was held in November. Future Section 11 audits will be jointly delivered, simplifying the process for partner agencies and reducing the resources required from them. However, Cambridgeshire and Peterborough have very different demographics and not all the key agencies cover both areas. For this reason there will always remain differences in some priorities that will need to be reflected in the audit plans.

Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can best be done and encouraging all to do so.

8.7.1 The LSCB has run three Conferences this year:

- When it's one of us: Professionals who abuse
- Learning from the Verita Report
- Neglect: More than just a Grubby Child

8.7.2 Between them these covered two of the most significant issues facing partner agencies, managing the risk from abuse by staff and Neglect. The latter represents far and away the most common category of abuse identified in the Child protection process.

8.7.3 Whilst no Serious Case review has been commenced this year, there has been the publication of Reviews undertaken last year. This has been supported by the distribution of Posters and summary materials, the delivery of specific training programmes and presentations to an Area Partnership and Local Practice Groups (LPGs).

8.7.4 Local Practice Groups provide a less formal forum for practice development and discussion, remain a key part of raising awareness across staff in all agencies, and it is encouraging that numbers of attendees has risen in 2015-16.

8.7.5 The Website has been further developed after its earlier move to a platform within the CCC website. This has involved looking at the overall appearance of the website, making the structure more logical and easy to use, and enhancing the content of individual pages and sections.

8.7.6 In partnership with colleagues in the local authority, the LSCB has reviewed and re-launched its leaflet covering the Child Protection Conference. Designed to ensure families and professionals alike have a good understanding of the purpose and process of the meetings, it was informed by feedback on the experience of members of the public and staff.

8.7.7 In addition to the above, we have also provided materials covering:

- The new requirements to report Female Genital Mutilation
- Expectations over smacking
- Safeguarding and Disabled Children
- A range of CSE leaflets and posters
- Material for professionals who may be involved in a case subject to a SCR.

8.7.8 These have been made available through a variety of media and the majority have been translated into languages other than English.

Monitor and evaluate the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.

8.8.1 The LSCB has a responsibility to monitor and evaluate services and it is ideally placed to do so effectively and efficiently. Within the LSCB structure, agencies gain from a shared approach to audit and monitoring that supports learning about how they work together to meet the shared objective of safeguarding children.

8.8.2 Appendix 5 outlines some of the sources of evidence used to evaluate what is done by local agencies to safeguard children. There is a range of material and approaches which together provide a robust and comprehensive range of evidence covering the whole area of safeguarding.

8.8.3 Much of the collating and analysis of this information is done by the Quality and Effectiveness Sub Group, or QEG.

<u>The Child Protection Process in Cambridgeshire 2015-16</u>

8.8.4 At the end of 2015-2016, Cambridgeshire had 439 children subject to a Child Protection plan living in Cambridgeshire, compared to the end of 2014-2015 when there were 387 children. This is a rise of 13% over the year in comparison with 2014/15. Numbers peaked at 443 in February 2016. There is a “wave” pattern of plans being made, with a consistent low point over the summer.

8.8.5 Cambridgeshire is not alone in seeing an increase in these numbers. It is also being seen across the region and in the local authority areas identified as the comparators for Cambridgeshire. This has been noted and reported nationally, and has an impact on capacity for all services.

8.8.6 At the end of 2015-16, Cambridgeshire had 33.39 children per 10,000 subject to a CP plan. This compares with 35.2 for the comparator group and 42.9 nationally.

8.8.7 Within Children's Social Care (CSC), the First Response and Emergency Duty Team (FREDt) and Contact Centre have been dealing with a higher level of contacts to the service. Their triage process, including signposting and referral to other providers delivered a consistent number of cases to the social work units for assessment. However, the level of risk in the cases coming through to the units is increasing, and this is impacting on the requests for Conference, court proceedings and the need to accommodate children and young people. Referrals are stable but the number of cases meeting threshold for assessment and intervention are rising.

8.8.8 The quality of Child Protection Meetings is being enhanced by the development of a more robust approach to timeliness, use of appropriate venue, effective information sharing and the participation of families. LSCB and CCC audits on levels of attendance and Report writing to improve compliance have been used as a key factor in identifying compliance by partner agencies and improve their response. Continued focus on this issue at QEG will ensure agencies give the appropriate priority to resourcing this process.

Section 11 Audit

8.8.9 Undertaken by the LSCB in 2015, the Audit requires agencies to self-evaluate their policies and procedures and provide evidence that they are meeting their requirements to safeguard children.

8.8.10 Overall, 87% of all answers in every Standard were "Fully met" in June 2015.

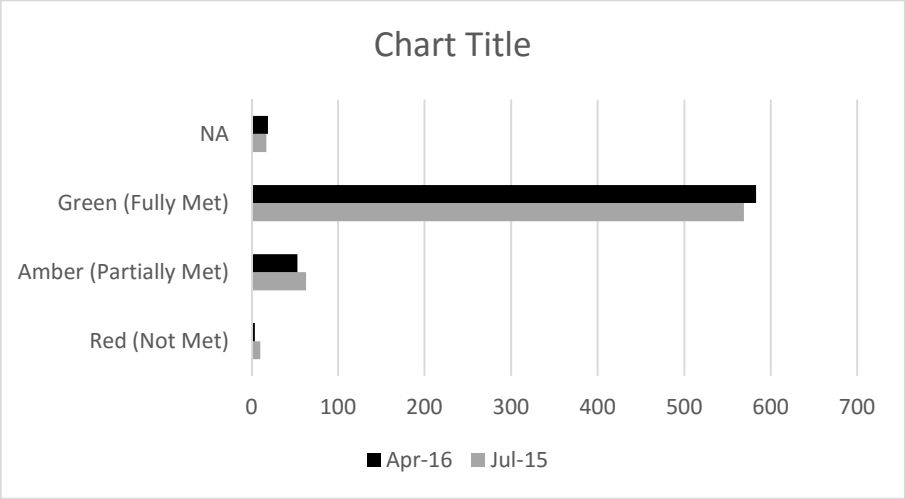


Fig. 8: Summary of self-evaluation judgements in the Section 11 Audit. Initial June 2015 and after improvement action April 2015

8.8.11 Where this was not the case follow up action has been requested and monitored. The audit returns identified which areas required improvement and what actions would be undertaken to achieve it. Update reports were requested and progress measured. Where necessary, failure to respond effectively was escalated to the QEG chair for follow up at a more senior level.

8.8.12 Some areas, such as District Councils, had difficulty in providing the required level of evidence. This may reflect the impact on them of resource reductions and the frequent re-structuring and re-allocation of responsibilities that have gone with it. The issue of reductions in public funding is one that could be faced by a number of LSCB partners and will be monitored by the Board over the forthcoming year.

8.8.13 In addition to monitoring progress on the required improvements, the LSCB has worked with agencies to assist them in making the improvements needed.

8.8.14 Other agencies have a national or regional management structure that makes compliance with local guidance and the provision of local information difficult or impossible. The Board has been made aware of this.

Multi-agency audits.

8.8.15 During 2015-16 Research in Practice published research into the effectiveness of multi- agency audits. The good practice identified by the research was turned into a check list which was used to audit Cambridgeshire's practice.

8.8.16 We were in line with all but three of the good practice criteria, the improvements needed being:

- Including a wider range of front line professionals in the audit process. This is under consideration.
- Obtaining feedback from staff involved in cases covered in the audit. Achieved in subsequent audits.
- Obtaining feedback from families. This has been built into a current audit.

8.8.17 There were three themed Multi Agency Audits:

Disabled Childrens Audit

8.8.18 The Audit Report concluded that "practice is effective" but goes on to comment that there remain areas that could be improved and the summary scores showed a general picture of good work being undertaken. However, there was a need to ensure that risk was assessed on a more consistent basis; that criteria for specific services needed to be understood better; and that work needed to be done on the transition between services, particularly movement between MOSI stages. These findings supported the LSCBs closer involvement in the re-launch and monitoring of the Think Family approach and the effectiveness of the Lead Professional role.

Complex Circumstances Audit.

8.8.19 The overall conclusion was that the audit had found "positive and effective practice" with:

- Evidence of a 'whole-family' approach in some cases and clear demonstration of risk management in trying to keep families together.
- Agencies taking positive and decisive action to safeguarding children – there was clear energy and commitment in practice with the families concerned.
- Impressive examples of agencies working together and the impact of this being evident in the child's or young person's progress.

Recommendations covered:

- A review of practice differences between "Access " and "CIN" social work units, which was undertaken by a CSC Head of Service
- Clarification of the Multisystemic Therapy Service role and communication process

- A focus on ensuring cases are not allowed to "drift" or that complex families generate confused professional practice
- The need for a continued emphasis by the LSCB on cultural competence.

Core Group Meeting Audit

8.8.20 Professionals gave positive responses over attendance, purpose, understanding and effectiveness of the Core Groups.

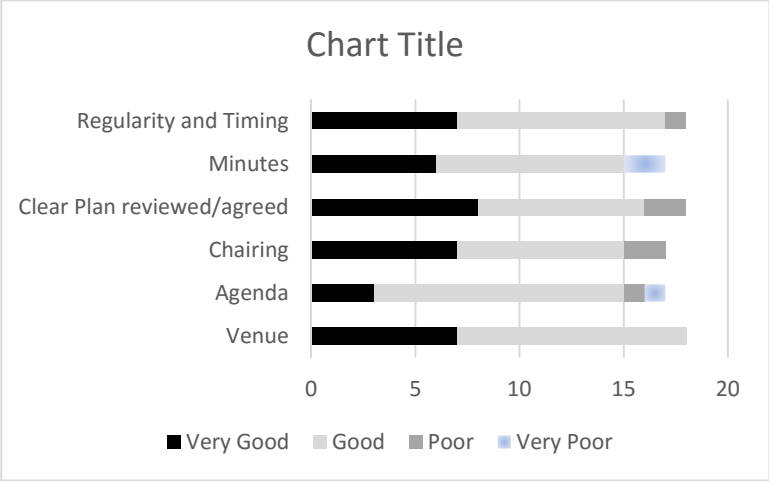


Fig. 1 Judgements on organisation of the meeting.

8.8.21 A high level of attendance by parents was evident, and where the age of the child made it relevant this was mirrored by a good level of attendance by children. They were viewed as participating effectively in the overwhelming majority of cases and this was identified as a real area of strength for CGMs.

8.8.22 There had been improvements in the meeting process but some recording issues remained. CSC therefore added Core Group data into their performance management information, and the impact of this resulted in increased compliance.

8.8.23 By self-report, managers were less confident in their role than front line professionals, and LSCB training has been developed and delivered to address this.

Single Agency Audits

8.8.24 There is now in place a mechanism for agencies to inform the LSCB about the scope of and outcomes from their own internal audits. This enables a level of oversight on issues and progress, but more critically ensures learning is shared and the cross over into the experience of other agencies is not lost.

8.8.25 A range of responses have been received, including:

- Assurance as to the appropriate use of the CP referral process and feedback to specific agencies where improvement was needed through the better use of internal safeguarding leads
- Evidence as to the improvement in the quality of CP Conference reports by CCS staff
- Assurance as to consistent improvement of the quality of work undertaken by CSC in line with Ofsted criteria

- Improvement in the availability and use of the CSE checklist in Enhance and Protective services.
- Learning about effective practice in substance misuse services and in particular use of the CAF

8.8.26 Of note was an internal CCG managed single agency "Section 11" audit of GPs that allowed them to engage with a very busy and relatively hard to reach, but absolutely key, group of professionals on good safeguarding practice. It highlighted with them the need to have up to date policies and procedures in place. The value of the audit was partly to measure compliance but the most significant benefit was to engage GPs in the issue and improve awareness and practice.

Dataset

8.8.27 During the year, work has been undertaken to improve the quality and range of quantitative information available to the Board and partners. Three of the key aspects to this are:

- A dashboard of critical indicators that will be provided to each Board meeting to support their identification of issues arising in safeguarding process and practice
- A set of public health held indicators of the safety of children in the community by geographical area, including level of hospital admissions for injuries and avoidable poor health that could show neglect. This has been developed alongside Peterborough SCB.

8.8.28 At the last inspection, Ofsted felt The Data Set required a broader multi-agency range of information. The Board has been building this up over time. With this data the Board will have a much more informed and accurate picture of safeguarding in Cambridgeshire and where to concentrate its attention to generate required change

Participate in the planning of services for children in the area of the authority

8.9.1 The Board and its Committees have been active in supporting the planning process for the Local Authority and its partners and ensuring that the Board's priorities feature in their planning process and service delivery.

8.9.2 Over 2015-16 two areas of service delivery saw significant strategic developments, Early Help and Looked After Children. Early Help has been challenged by the increasing imperative to prioritise reducing resources by need. There has been an independent assessment of impact and effectiveness, a Strategic review was held, and an enhanced model of working through the Lead Professional role was introduced. The success of the approach in meeting the needs of children and preventing the risk of significant harm depends on the response of all agencies. Given its pivotal role in delivering multi-agency working, the LSCB has actively supported the development and roll-out of the Lead professional role, supporting and challenging agencies to develop their approach. It remains a work in progress to identify performance measures that are timely, robust and outcome centred and this task will need to be completed 2016-17. The LSCB will monitor the effectiveness of the programme and challenge agencies where further progress is required.

8.9.3 The relatively poor outcomes for Looked After Children (LAC) have been known for many years, but making significant inroads in improving the situation has proved to be difficult. Cambridgeshire is no exception, and the Local Authority has initiated a Corporate Parenting Strategy to increase the profile of our responsibilities to these children and the importance of improving their life chances. This has been promoted at the Board and evidence of impact was

requested. There has been significant progress in ensuring they can access medical assessment and intervention but evidence remains needed to establish the impact of the other themes within the Strategy.

8.9.4 The differential impact on LAC who are placed out of County has been a specific concern of the Board, which has challenged the Local Authority to demonstrate progress in ensuring they receive the priority they require. The need to ensure timely health assessments is being pursued via the Regional LSCB Business Managers meeting.

8.9.5 The Local Authority has put resources into developing additional services for families whose child or children are at risk of coming into Care and used the LSCB to increase awareness of this service.

8.9.6 The Health sector was subject to a CQC Safeguarding review and the Police were part of a thematic HMIC Vulnerability Inspection. Whilst the inspections were of single agencies or sectors, the impact of their services was relevant to all and many of the responses to the recommendations were best addressed on a multi-agency basis. By providing a multi-agency forum the Board played a unique role in using the Inspections to improve services. The CQC Inspection featured a number of recommendations around CSE and the LSCB Coordinator was able to work with Trusts to enhance the quality and effectiveness of their capacity to identify, record and report issues.

9. UNDERTAKE REVIEWS OF SERIOUS CASES AND LESSONS TO BE LEARNED.

9.1 There have been no SCRs commissioned in 2015-16, although a SCR completed last year has been published.

- The Action Plans that came from the SCRs in 2014-15 have been implemented and completed.
- The issues include:
- Better understanding of CP process and the use of safeguarding specialists within individual agencies
- A more robust understanding of information sharing requirements
- Ensuring that the Early Help and Lead Professional process supports engagement with families and promotes consistency and good communication across the MOSI "levels"
- That the needs of disabled children and those with complex long term medical conditions are met and the children safeguarded effectively

9.2 Two cases have been subject to a multi-agency review and learning has been identified from both. Both cases originated from the youth offending service and featured vulnerable adolescents. One led to improvements in the guidance on Safety Plans and raised issues about communication and effective intervention across geographical boundaries. The second identified learning about the importance of managing information over time and across agencies, and led to improvements in guidance on communication with hospitals when children who were at risk but also posed a risk required treatment.

9.3 For much of the year the LSCB has been engaged with a local institution which over a number of years has had different staff members investigated for, and charged with, child sex offences. After initially raising awareness as to the significance of the concerns, the LSCB has been able to support the institution in ensuring it now has good safeguarding arrangements in place and can demonstrate effectively that this is the case.

9.4 Following the high profile conviction of a staff member for offences of sexual abuse, a local health provider worked in close liaison with the LSCB, seeking advice or consulting at critical points to ensure that the safeguarding policy response was appropriate

9.5 The terms of reference for the subcommittee and the referral form have been reviewed.

10 INNOVATIONS PROJECT WORKING WITH EASTERN EUROPEAN FAMILIES

10.1 Cambridgeshire, Peterborough and Norfolk Local Safeguarding Children Boards were funded by the Department for Education (DfE) to undertake an innovative project to improve the effectiveness of safeguarding practice with Eastern European migrant families.

Engagement with Service Users.

10.2 Engagement with service users was carried out using three methods: a printed questionnaire (246 responses), one to one discussion and focus groups.

10.3 The main messages:

- There is limited awareness about UK law and legislation
- There is a mistrust of services allied with a common perception that social services will take away their children.
- There is limited awareness about services, what support they can provide and why they are involved. The involvement of services causes anxiety.
- A lack of willingness to engage with services because they do not believe that this will result in positive changes.
- Family problems need to be resolved in the family.
- It is important to keep strong and close relationship between family members and to support each other.
- At the age of seven a child would usually start school. At this age they are expected to have a level of maturity and responsibility for their actions.
- Depending on age and length of time it is OK for older siblings to look after younger ones.
- Parents have strategies to stop a child's behaviour when it is seen to be unsatisfactory, but not to encourage positive behaviour.
- Education is seen as very important.

10.4 Amongst the eastern European community there was limited knowledge about the requirements of UK law regarding the safety and well-being of children. Knowledge was mainly gained through word of mouth from fellow nationals. Despite this nearly all were registered with a GP and the percentage using children's centres were within the range of the UK national average. There is a high level of anxiety and low levels of trust and confidence within eastern European communities about the services that are provided locally. Migrant families are not receiving all the information that they need in order to make informed choices about using services

Engagement with Service Providers

10.5 Engagement with service providers was carried out using an electronic survey, single agency discussion and multi-agency focus groups. There appears to be a lack of confidence amongst some members of staff around engaging with eastern European migrant families. During the consultation there were several individuals and groups who identified that the treatment of eastern Europeans by some service providers was unacceptable ranging from intolerance through to racist comments and behaviours. The range of quality of interpretation and translation services requires greater monitoring and quality assurance.

Analysis of Data

10.6 Key Points:

- Of the Eastern European countries being allocated National Insurance numbers Lithuania, Romania, Poland and Bulgaria have the largest numbers.
- The number of different nationalities is becoming less varied in each of the three authorities but those that remain are less dominated by only one or two nationalities.
- There are no real differences between the three authorities' general pattern of contacts and referrals when compared with those for the Eastern European community.
- Across the three authorities contacts into Social Care are more likely to have come from schools and health visitors.
- Referrals to Social Care in Cambridgeshire and Norfolk are more likely to come from housing or individual acquaintances. In Peterborough referrals are more likely to come from local authority services or health visitors.
- There are more vulnerable children from Lithuania, Latvia and Poland than from other nationalities. In Peterborough there are a large number from Slovakia as well.

Training Programme

Front Line Staff

10.7 A training course was developed using the information and evidence gained from the consultation process and the competencies identified in the LSCBs' practice guidance. Including pilot sessions, 189 staff were trained. Participants were asked to give an overall rating of the course and 89% rated the course as either Excellent or Very Good.

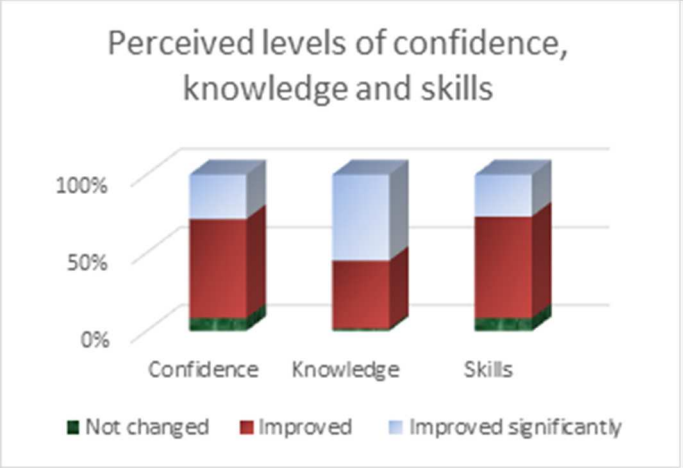


Fig 9. Evaluation Feedback on the impact of the Training to front line staff

Conferences for Managers

10.8 Two events were run aimed at managers and team leaders. They were attended by a total of 120 staff. Alongside the findings from the project, there were presentation of good practice from local voluntary sector providers, video presentations from service users and presentations from teams who had attended the training and made positive changes to their practice as a direct result of this.

Practice Guidance

10.9 Practice guidance across all three local authorities was reviewed and issued. All three authorities are using the same key competencies within their safeguarding procedures and the project and LSCBs have promoted this Guidance.

Outcomes

10.10 Governance and accountability: Through the process of this project Cambridgeshire, Peterborough and Norfolk LSCBs are better informed of the issues and the arrangements in place to meet the needs of this potentially vulnerable cohort. LSCB partners have a greater understanding of the need to incorporate cultural proficiency into all functions and activity from commissioning through to monitoring and evaluation.

10.11 The Boards have greater knowledge and capacity to challenge and hold agencies to account and section 11 self-assessments will be a means to both monitor and evidence cultural appreciation and competence within organisations. All three participating LSCBs are incorporating cultural competence into all their training courses to ensure that this does not appear as a stand-alone subject but acts as a thread throughout all LSCB issues.

Cross boundary working

10.12 Collaboration across the three local authority areas has been seen to be beneficial for all parties. This project has been a successful opportunity for the three Boards to work together. Plans to continue the close relationship have been agreed and the three LSCB business managers will be holding regular meetings to monitor the progress of the legacy of the project and to look for further opportunities for collaboration.

11. VOICE OF THE CHILD

11.1. The LSCB and its partner agencies share a responsibility to use the perspective of service users in their development of services, and in particular the "Voice of the Child". There are challenges in demonstrating where it has had an impact, and improving and developing this work will remain a priority for the foreseeable future.

11.2. In 2015-16 there were six strands to the LSCB's approach:

- The Section 11 Audit showed improvement over time for agencies ensuring service development took into account the need to safeguard children and ensure their perspective is taken into account.
- Commissioned consultation, most specifically with disabled children on their understanding of safeguarding, and young people and domestic abuse
- Reference to the learning generated by specialist consultation professionals, such as Participation (a CSC initiative consulting children and families within the CP system)
- Reference to user feedback in Inspections.
- Awareness of single agency consultation on their own strategies and policy developments, such as by CCC in the development of the Corporate Parenting Strategy and CCG/CPFT around the new CAMH pathway and a survey of school pupils which was wide in scope but covered specific issues including domestic abuse, E-Safety and vulnerability.
- Innovations project for Eastern European communities

11.3. There are major differences between the language and idioms used by professionals and those used by children and young people. The Domestic Abuse consultation showed this up starkly and agencies communicating with young people need to be able to demonstrate they use relevant and effective language as well as appropriate media for communication.

11.4. Attending CP meetings can be alienating and painful for the children concerned. In response, the Board has requested evidence on the effective use of advocates for children.

11.5. The LSCB training continues to invite the voice of the child within its training events to give a real lived understanding of their experiences and how best for professionals to work and support them. Young people's comments and videos are included within the training and for some events there are young people and parents who help to facilitate the day. Out of all the training these are the events which are rated most highly by practitioners in terms of understanding what service users think and need in terms of practice to safeguard them and their families.

11.6. The Board also receives and reviews the CCC Children Services Complaints Report and other agencies have agreed to make the LSCB aware if there is significant learning coming from any Complaint received. The number of complaints remains low and they do not evidence a picture of significant concern about how the system is experienced. Equity of treatment, clear communication and realistic expectations lie at the centre of many complaints. In response, we have reviewed how information and the process is given to families, including what they should expect at key points. In addition, emphasis being given to the timely sharing of Reports with families.

12. LEARNING AND IMPROVEMENT FRAMEWORK

12.1 The LSCB has a Learning and Improvement Framework, the dynamic process within which is shown in Fig 10

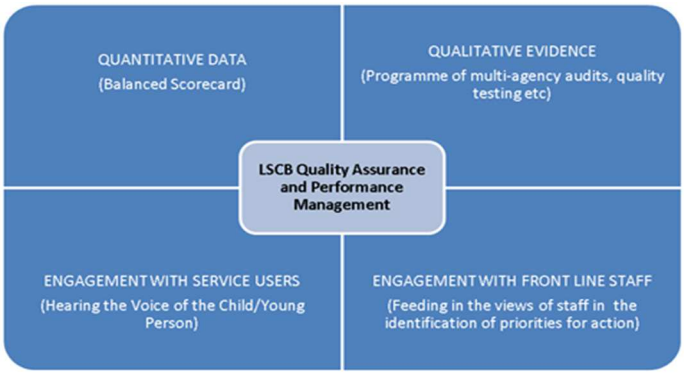


Fig. 10: LSCB Learning and Improvement Framework

Cambridgeshire LSCB Training 2015 - 2016

12.2 Gail Herbert, a valued member of the LSCB team, has successfully supported the LSCB training whilst the Training Manager has been away on sick leave; ensuring that the safeguarding training programme has run smoothly and that many opportunities have continued to be available for professionals.

Attendance

12.3 LSCB training attendance remains strong and the demand for LSCB training places increases year on year. 2015 – 2016 has seen a continued increase in attendance and the training opportunities offered to agencies through Cambridgeshire LSCB.

12.4 61 training courses were provided to practitioners covering 51 safeguarding topics with 931 attendees (96% attendance), which included 6 additional courses as compared to last year. Additionally, there has been a reduction in the number of courses which had to be cancelled, due to improved administrative processes of advertisement and booking.

12.5 Cambridgeshire LSCB continues to offer high quality safeguarding multi-agency training covering a range of topics and priority learning points for professionals which is extremely well attended.

Impact and Evaluation

12.6 93% of attendees completed and returned evaluation forms on the training day and continue to rate the training as 'good', criticisms include; room temperature and parking. Two courses have been identified as needing changes and those specialist trainers are developing the training to accommodate the concerns raised. Comments on how the training will impact on practitioners practice remain positive with themes including;

- *Confidence / More awareness of social media and technology that children and YP are accessing which will enable me to support them/guidance on accessing certain sites and make parents aware.*
- *Make sure the child's voice is head and question views of other professionals to check that they have also talked to the child.*

- *I am more aware of how CSE can affect any gender, age and race which isn't often how it is reported in the media.*
- *Through the exploration of local SCR with other people on the course it was clear that sometimes culture influences professionals practices and sometimes the child gets lost.*

It is extremely difficult to measure the impact on children and families in terms of safeguarding, from practitioners attending the LSCB training events. Indicators currently used are self - reflection and practice observation from managers. Within this area professionals continue to report that attendance at LSCB events and what they have learned has impacted on practice and contributed towards improved safeguarding outcomes for children and their families.

Local Practice Groups

12.7 The LSCB continues to support the 5 regional areas, including the MASH, who organise and facilitate safeguarding workshops throughout the year for sharing information and practice learning. In total there were 31 groups facilitated with a recorded 633 attendees, this is a 39% increase on last year's figures indicating the continued need for these and the valued contribution of these learning events.

12.8 The two hour workshop sessions are a valuable resource for getting safeguarding messages out to a wide range of professional people and are highly regarded by practitioners. Overall sessions evaluate as interesting, well presented with clear presentations and speakers, a good opportunity to network and supporting changes to practice.

12.9 Some salient feedback points from the practitioners who attended the groups were:

- *Informative – good level of appropriate info – helped to support working knowledge*
- *It was useful to unpick some of the more complex issues within the protocol with very experienced practitioners from a range of agencies*
- *Hearing views of other agencies working with YP/ All really useful – just good to see issues being discussed and not hidden*

LSCB Conferences

12.10 The LSCB has provided and joint facilitated three conferences over the year.

<u>'When it's one of us: Professionals who abuse' – 2 July 2015</u>

12.11 There were 174 attendees at the conference (10% increase on last year's figures from the annual conference) and of those 61% worked directly with children, young people and their families. There was an increase in attendance from both the Health sector and Enhanced and Preventative sector but disappointingly there was a drop in attendance from the Education sector.

12.12 Of the 66% of participants who completed evaluations forms (an improvement on last year), over 90% rated the presentations of the speakers as 'excellent'. The five agency workshops at the event were overall received well and noted as 'good to excellent'. Some of the comments to support the success of the event include:

- *Remain vigilant and know who to talk to in regard to safeguarding concerns with children*
- *Overall delivery was very informative but also humorous. Food for thought, well done!*

12.13 Professionals reported that this day lead to a 'lot of self-reflection' in practice terms when working with team members and other professionals ('thinking the unthinkable' and not being complacent with the practice of professionals who 'you think you know'). Many managers were very clear that they would be looking at their own policies, procedures and recruitment processes as a result of attending this event.

'Addenbrookes & Cambridgeshire LSCB Joint Learning Event' – 8 December 2015

12.14 Following the publication of the Verita report in October 2015, an event was run in conjunction with Addenbrookes hospital to enable the learning from both the report and the experience of the staff involved to be shared. 82 professionals attended, with the majority (74%) from the Health sector and other sectors including; Children's Social Care, the Enhanced and Preventative sector, Early Years, Police, District Councils and the Voluntary sector.

12.15 Of the 52% of evaluations forms returned 96% thought that the organisation of the event was 'excellent to good'. The afternoon event consisted of 4 speakers, with over 80% of participants rating speakers 'excellent to good'.

'NEGLECT: So much more than just a grubby child', - 11 February 2016

12.16 194 attendees attended the joint Cambridgeshire and Peterborough LSCB event (63% of Cambridgeshire delegates). There was good representation across all sectors and working groups, the majority of attendees represented practitioners predominately working with children, young people and their families (84%). 74% of participants returned evaluation forms. All presentations were well received with over 80 'excellent to good'. Eight workshops were facilitated and the Cultural Competence workshop and the Evidence Led Practice workshop were the most highly rated.

GP training

12.17 Three courses were facilitated with 177 attendees in total; this is a 72% increase on last year with the same number of courses facilitated.

E Learning

12.18 The LSCB commissioned an e learning platform on 'basic safeguarding', though few practitioners signed up or completed the training. The contract has not been renewed given the training was not reaching targeted groups, 'value for money' and therefore not impacting positively on safeguarding practice.

Serious Case Reviews and Child Death Overview Panel

12.19 To improve knowledge and safeguarding practice leaflets summarising the SCR cases have been published by the LSCB.

Single Agency Training – Validation

12.20 As part of Working Together 2015 the LSCB has a duty to make sure that single agencies provide safeguarding training to staff and facilitate training which is 'fit for purpose'. Part of that process entails members of the LSCB workforce group 'validating' the training. Figures of staff needing the training and being trained are being collected by partners, however, of those courses provided for validation, the LSCB have validated 5 courses, for this training year (similar to previous years). There are also a number of courses, which with the LSCB support, are being rewritten and resubmitted in order to meet the criteria of validation process and thereby improving outcomes for safeguarding children in terms of professionally trained staff.

Training Reviews

12.21 The number of training review forms completed continues to be low though delegates are now sent an electronic Smart Survey to complete, to encourage an increase in returns by making the completion of the training review quicker and simpler. Salient points which show how the learning has improved practice to safeguard children and families are listed below.

Practitioner Comments:

12.22 I have used the training notes given to feed into our supervisor training and also help in how we record incidents and concerns on our report forms

12.23 I am interacting more with the carers of the children with disabilities and letting them talk while I give my full attention

Managers Comments:

*12.24 Since attending the training **** has working with two cases where the children are self-harming. **** was able to identify the self-harming behaviours and offer strategies to both children and parents.*

*12.25 **** has discussed with me how we can use some of the course resources to support our parents especially those with learning difficulties. We will be looking at building a portfolio of information that all our colleagues can use.*

*12.26 This course has given **** the confidence to discuss Parental Mental Health and liaise with the multi-disciplinary team that looks after the child*

13. CHILD DEATH OVERVIEW PANEL

The process

13.1 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.

13.2 This is a statutory process, the requirements of which are set out in chapter 5 of *Working Together* (2015). The CDOP is chaired by the independent chair of the LSCB. The CDOP annual report can be found on the LSCB website. There are two versions of the annual report, one for professionals and one for general publication. This second version summarises some information in order to prevent individual children from being identified.

13.3 The information in this summary relates only to Cambridgeshire children.

Numbers of child deaths reported and reviewed

13.4 Over the last year, 29 children's deaths were reported in Cambridgeshire, which is one death less than last year and a similar number to previous years. Of those children who died, 62% were less than a year old, the majority of whom never left hospital.

13.5 Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of 20 Cambridgeshire 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.

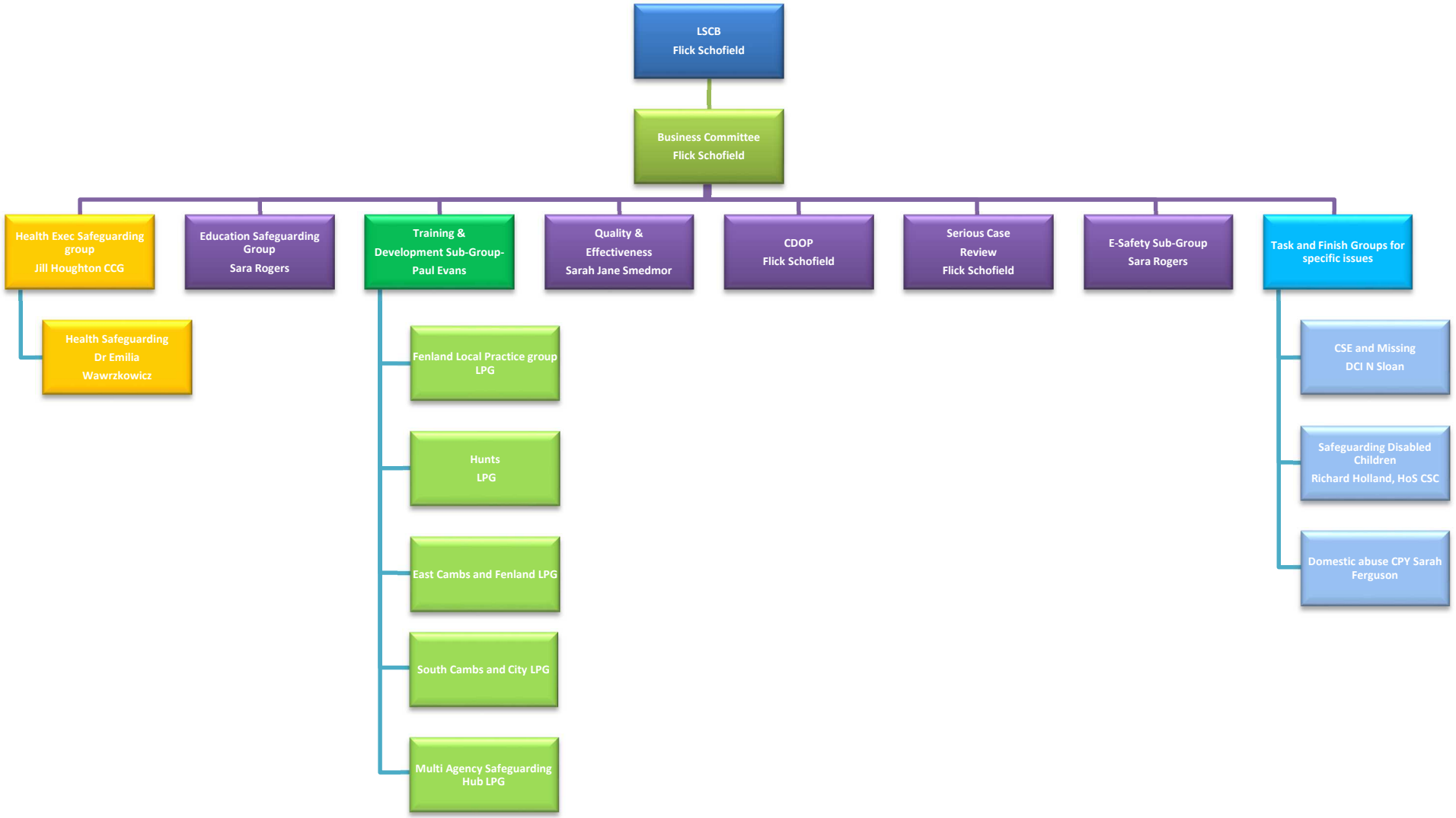
Modifiable factors & Safe Sleeping

13.6 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.

13.7 There were six cases in Cambridgeshire where a modifiable factor was identified. Whilst the modifiable factors for two deaths were linked to different medical interventions, the other four deaths were linked to unsafe sleeping arrangements. The excessive use of alcohol in the parents was identified as an additional factor in three of those four deaths.

13.8 The Safer Sleeping Campaign was launched in April 2014 with a programme of workshops across the County. It has been a success in terms of promoting awareness and the safeguarding messages to practitioners working with families about safer sleeping, combined with highlighting other impacting factors on infant death such as parental alcohol behaviours. The safe sleeping campaign was re-launched for 2015 and a further two workshops were held for early help workers, early years, locality teams and children's centres.

Appendix 1. LSCB MEETING STRUCTURE APRIL 2016



Appendix 2

2. LSCB STRATEGIC BUSINESS PLAN (2015-6) START DATE 1 APRIL 2015

End of Year Summary

This plan sets out the planned LSCB activity for 2015-6 and will be 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. Each group has its own more detailed plan. It is planned that these groups will complete their work by the end of 2015-6. This is a working draft and can be amended as agreed by the LSCB when reviewed. The RAG rating reflects the progress being made against actions, more details is provided in the embedded action plans from each task group leading on priorities.

RAG Rating

	Action Plan Completed
	a delay but the action is still planned
	no implementation plan in place

ACCRONYMS

CSE	Child Sexual Exploitation	GCP	Graded Care Profile (structured assessment for neglect)
CYP	Children and Young People	JSNA	Joint Strategic Needs Assessment
QEG	Quality and Effectiveness Group (LSCB audit committee)	HRB	Health Related Behaviours
CSP	Community Safety Partnership	DVRIM	Domestic Violence Risk Identification Matrix
SCR	Serious Case Review	TDWSG	Training and Development Workforce Strategic Group (LSCB Training committee)
OOC	Out of County (placement for a Looked After Child)	CCS	Cambridgeshire Community Services (NHS Trust)
ISEP	Independent Specialist Educational Placement.	EandP	Enhanced and Preventative – Council services for children
SEND	Special Educational Need and Disability	CSC	Children Social Care
MASE	Missing and Sexual Exploitation (victim protection and perpetrator prevention meeting)	CP	Child Protection
HMIC	Her Majesties Inspectorate of Constabulary	CFA	Children, Families and Adults – Council Department
CQC	Care Quality Commission	LPG	Local Practice Group – briefing for professionals
HMIP	Her Majesties Inspectorate of Probation	CIN	Child in Need
NWG	National Working Group for Sexual Exploitation		

LSCB Priority Theme One: Effective safeguarding response to Children Sexual Exploitation and Children who go Missing from Home and from Care						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Progress and Measure**	**RAG**
Increase the capacity and coordination of agencies in Safeguarding children from CSE.	Implement CSE strategy and action plan	CSE Implementation group	March 2016. Strategy and action plan implemented and reviewed bi-monthly.	Co-ordinated multi-agency response	Through monitoring of CSE action plan and its impact measures • CSE coordinator in post Oct 15 • Strategy Reviewed Oct 15 • MASE meetings established • Multi-agency Intelligence process enhanced • Missing processes, specifically the proactive use of information to reduce risk, enhanced • Multi-Agency "health check" against Ofsted, HMIC, CQC and HMPI criteria currently in process completion by end of Feb • CSE featured as an explicit criterion in the Section 11 audit including structure/lead senior manager, policy and training. • Creation of CFA Missing and CSE Operational Group to review all high risk missing or those at risk of exploitation every month	
Create a workforce competent to respond to CSE	Continue to deliver and review CSE and missing training as per CSE strategy – ensuring that individual teams and agencies are training operational staff	CSE Implementation group/ Training and Dev sub groups.	March 2016 as per training strategy. April 2015 both LSCB's report to	Confident competent workforce	Through training evaluation • Single agency training programmes delivered in Health and other partner agencies • Core LSCB training delivered with positive evaluation	

			have provided training.		• LPG sessions on CSE and a) boys and b) disability delivered with positive evaluation • CSE incorporated into expectations for mainstream safeguarding training • NWG membership reactivated to ensure that current national themes are available to all partners in a timely manner	
Increase public awareness of CSE and enhance the ability of children to recognise and reduce the risk they face.	Ensure children and young people continue to be made aware of risk of CSE through publicity and awareness raising and partnership work	CSE Implementation group/ Business Unit/ Area partnerships QEG audit with young people views on CSE + practitioner survey.	March 2015 CSE leaflets available for young people and children. Resource pack provided to schools. Further productions of Chelsea's Choice arranged for autumn 2015	CYP avoid the risk Of CSE	Direct feedback from children and the public • Chelsea's choice delivery reviewed and to continue within Area Partnership/CSP • Tailored leaflets produced in a range of languages and made available on LSCB website • LSCB website reviewed to include a portal specifically for parent/carers	
Increase the ability of key professionals and members of the public to recognise and respond to risk of CSE	Ensure wider workforce (e.g. taxi drivers, district councils, housing, GP's, hotels and bus drivers) are aware of risk of CSE and missing through awareness raising and partnership work.	CSE implementation group / LSCB training & development manager.	September 2015	Improved awareness of CSE and vulnerability of children and young people	Direct feedback from the identified groups • Work to identify vulnerable locations undertaken and response initiated • Work to raise awareness with taxi drivers and include in their training and licencing processes undertaken • Included as an issue in core single agency training and LSCB training	

Provide relevant tools and structure for professionals working with CSE	Ensure referral process in place for child abuse and child sexual exploitation. Creation of multi-agency forums to discuss children at risk.	CSE implementation group. Operation Shade + multi-agency group to be set up (Business Manager)	New joint referral form implemented April 2015. Op shade ongoing 2015. November 2015	Effective tool to assess CSE risks and support referrals to multi-agencies.	Evidence of use • Police and CSC databases support the identification of CSE victims and perpetrators • Joint CSE management tool provided for staff and made available on LSCB website • Resources for specific agencies e.g. schools on LSCB website	
Provide evidence of good practice with CSE	Ensure children and young people are safeguarded.	CSE implementation group QEG	Audit of selected cases of multi-agencies by November 2015	Young people and children safeguarded in terms of CSE.	CSE recorded on case files, children and young people supported in a timely fashion accessing appropriate inter agency intervention. • Police and CSC databases support the identification of CSE victims and perpetrators • MASE and Missing processes reviewed and good practice identified and built on in future structure • Multi-agency audit completed March 2016.	
LSCB Priority Theme Two; The effective safeguarding of disabled Children at home and in care and educational						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Support the Action Plan through ensuring clarity as to scope of its remit	Develop definition of the cohort [– broader SEND] Focus on OOC and those in ISEP	Safeguarding Disabled Task and Finish group	Feb 2015 May 2015 to include sick children.	Effective multi-agency safeguarding response	Agreed definition on record	
Review and improve services to disabled children	Embed the learning from the multi-agency audit of safeguarding of disabled children and develop actions arising	QEG	November 2015	Improved understanding of safeguarding of disabled children	Review of impact from Audit Recommendations • Lead Professional strategy supported by LSCB and reporting process agreed to allow for monitoring and analysis of	

					evidence as to the effectiveness of the role in coordinating the need and safeguarding of children including disabled children.	
Monitor incidents of abuse by professionals	Ensure that disabled children are represented in LADO data	LADO/ SASU	Sept 2015	Understanding of the safeguarding risk to disabled children	Data to be reported regularly within LADO report to Board • Data now being collected and will appear in future LADO reports	
Establish quality of current practice in Safeguarding disabled children living away from home.	Challenge all agencies to safeguard disabled children that live away from home	LSCB specific monitoring report	September 2015	Effective multi-agency safeguarding response	Inclusion of data regarding the safeguarding of disabled/SEND children to be included within LAC Report to LSCB. • Included as a specific group in LAC report to the LSCB Jan 2016 covering a)type of placement b) voice of disabled children in their own planning and c) issues over communication and safeguarding	
Increased workforce competence to deliver high quality services	Develop and support multi-agency training for wider workforce re SEND children.	LSCB Training and Developmen t sub	September 2015	Confident competent safeguarding workforce	Attendance levels and evaluation of relevant training • Issue of link between SEND and CIN/CP plans was raised by LSCB • CCC and LSCB training reviewed to cover issues over SEND • Disabled children's safeguarding needs included in single and multi-agency training expectations • Neglect Conference covered the needs of Disabled children	
Establish a supportive policy	Review policy and procedure and	Safeguarding Disabled	June 2015	Effective multi-agency	From the report on what young people and their families tell us.	

and procedure working context for professionals, informed by the voice of service users	responses re safeguarding disabled children so that they are effective	Task and Finish group		safeguarding response	• Procedures and policies reviewed end 2015 • Further review to follow completion of consultation with children and families May 16 Report on the findings from the consultation delayed until May 2016.	
High quality of provision through professionals use of effective and consistent assessment framework	Review neglect guidance and LSCB training and GCP to include SEND cohort	Safeguarding Disabled Task and Finish group	November 2015 launch of Graded Care Profile – NSPCC/LSCB	Effective multi-agency safeguarding response	Use of GCP tool and measurement of impact. • "Cambridgeshire" GCP tool developed • To be launched Feb 2016 • Neglect Strategy to be adopted 2016/17 following Neglect Conference • GCP workshop at Neglect Conference A training programme is in place for the first half of 2016-17 to support roll-out of GCP. A Neglect Strategy is a priority for the LSCB 2016-17. On this basis this action for 2015-16 is closed.	
Policies, processes and practice informed by the service user perspective (parents)	Consultation with parents re their perspective on priorities for safeguarding. Parent representative on Disability Task and Finish group.	Safeguarding Disabled Task and Finish group/ Pinpoint	June 2015	Better informed LSCB strategy	Report on what young people and their families tell us. • March 16 is the end date for a major consultation exercise with a range of disabled children over their perception of safeguarding and own needs • Voiceability survey undertaken Report on the findings from the consultation with service users has been delayed until May 2016. A further consultation with the parents of service users will follow.	
Policies, processes and practice informed by the	Consult CYP around safety and safeguarding through survey and audit activity and	Safeguarding Disabled Task and Finish group	May 2015	Better informed LSCB strategy	Report on what young people and their families tell us. • Information for parents/carers provided	

service user perspective (children)	ensure the voice of the child and family is heard in service planning				• Consultation to follow outcome from consulting children • Parents represented on T and F Boar Report on the findings from the consultation with service users has been delayed until May 2016.	
LSCB Priority Theme Three: Prevention and Protection of children and young people to the risk of domestic abuse						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Improve agency capacity to monitor and evaluate the impact of services	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	June 2015	A dataset and map of resources to inform consistency of approach and of commissioning services for CYP at risk	Board approval of dataset • Additional police information now included • Focus in DV services is now on repeat incidence • Feedback from HRB survey on related issues analysed	
Increased effectiveness of services to safeguard children through coordination of agency planning and implementation	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	June 2015	Effective prevention, protection and recovery of children and young people	Feedback from CYP and their families on the impact of services. • Programmes developed, delivered and reviewed. However, evidence of impact was disappointing and programmes now discontinued • DV "Offer" and guidance agreed	
Voice of the service user informs policy and practice	Ensure learning from YP consultation is embedded in practice	LSCB Domestic abuse and CYP task and finish group/ Domestic Implementation partnership	Sept 2015	Effective prevention, protection and recovery of children and young people	Feedback from CYP and their families. • Report from consultation given to Board and used by T and F group	

Increase the competence and confidence of the workforce	Provide multi-agency training with DA partnership	Domestic Abuse partnership / LSCB training manager	Ongoing	Confident competent safeguarding workforce	Training numbers and feedback on impact • Multi-agency assessment tools and referral process agreed and on LSCB website • Major programme of training for use of DVRIM delivered	
Support good practice through the use of effective tools	Support development of evidence based tool kit (HfCF/ DViP)	LSCB Domestic abuse and CYP task and finish group/ EPS work	June 2016	Confident competent safeguarding workforce	Evidence from audits of the effective use of tools • Complicated Matters toolkit endorsed, made available on LSCB website and promoted • Supporting eLearning package promoted	
Voice of the service user informs policy and practice	Report and embed learning from Domestic Abuse consultation including considering the communication with CYP	LSCB Domestic abuse and CYP task and finish group	Report to DA T and F group on 29.04.15	Better informed LSCB / DAIB strategy	Feedback from CYP and their families. • Audit of agency communication to confirm compliance planned for May 16	
Voice of the service user informs policy and practice	Conduct focus groups with victims/ survivors re help for their children	LSCB Domestic abuse and CYP task and finish group	New approach required. Focus groups arranged July 2015	Better informed LSCB / DAIB strategy	Feedback from CYP and their families. • Changes in the governance of DV across Cambridgeshire and Peterborough, together with major resource reductions has made it necessary to delay consultation until its focus is clearer.	
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)						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Better co-ordination and effectiveness of	Embed Learning and Improvement	LSCB Business Committee/	March 2016	Well informed LSCB developing a	Evidence available in Annual Report • Principles of Learning and Improvement framework agreed at	

safeguarding system.	framework and audit programme	LSCB Business Manager/ QEG		learning culture	Business Committee after review of current processes • Supporting processes ready to be put in place prior to end Mar • TDWSG discussion about effective support for improvement and agreed process for ensuring messages become embedded • Training validation process reviewed to ensure all key themes included in training • SCR learning disseminated through leaflets, website, LPG sessions and training programme	
Improve LSCB capacity to monitor and evaluate the impact of services	Challenge agencies regarding data across strategic workstreams	Task and finish groups	To end work and complete plans March 2016	Clear annual work plan for each group	Evidence available in Annual Report that Action Plans have been reviewed and completed • Action plans in place and monitored • "Needs" dimension to dataset under development with public health • Use of HRB survey and other sources of data to compliment dataset • Joint dataset under development with Peterborough SCB	
Increase the impact of cultural competence on service delivery	Challenge agencies around cultural competent safeguarding practice	All subgroups and task and finish groups	To include in sub-group work plans	Each work plan will ensure that culturally competently safeguarding practice is in place	Evidence of relevant outcomes in Action Plans • Inclusion Project has included Cultural Competence training for front line staff • Cultural Competence for managers conferences to be held in March • Model for future delivery in place supported by Train the Trainers session • Innovations Project included consultation with service users over	

					experience of services and with staff over “blocks” to good practice	
Improve LSCB capacity to monitor and evaluate the impact of services	Ensure that the LSCB is assured through review of all monitoring reports, with a focus this year on the Impact of Savings	LSCB Business Manager	Ongoing	That the LSCB fulfils statutory obligation to monitor safeguarding work	Use of dataset to review and set priorities and challenge inadequate services in Board Minutes • Key strategic documents brought to Board for discussion by agencies • Increased use of single agency audits to reinforce evidence of agency practice • Section 11 audit followed up to request information on impact of action plans • Increased provision of evidence from Health in Report format	
Improve impact of learning from SCRs	Application to take part in next phase of ELA LSCB/ NSPCC/ ILCA Embedding the Learning pilot	Embedding the Learning group	March 2016	To embed the learning from SCR in the workforce – changing safeguarding practice	Feedback from the Overview Authors and professionals involved in Serious Case reviews • No further SCRs • Application not successful • Regional and national review of SCR practice will be used to inform future process • Participation in consultation for national review of SCR process	
Increase agency capacity to deliver effective safeguarding services.	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	Training numbers and feedback on impact • Training delivered in line with plan despite absence of Training Manager • LPGs have increased attendance 2015-16	
Increase agency capacity to deliver effective safeguarding services.	Review the LSCB training on neglect and risk as per the LSCB SCR recommendation from EB	LSCB T and D group/ LSCB training manager	September 2015	Confident competent safeguarding workforce	Training numbers and feedback on impact • GCP to be rolled out through the LSCB across Cambridgeshire. (Delay caused by absence of Training Manager but now in hand)	

					• Training to support GCP to be in training offer for CCC, CCS and LSCB	
Voice of the service user informs policy and practice	The LSCB will support a planned consultation by the CSC Participation service with the cohort of YP subject	LSCB training and development manager / CSC Participation manager	March 2016 (12 month project)	Improved understanding of experience of children and young people subject to a CP plan	Feedback from CYP and their families. • Participation group now in place and developing its effectiveness • Communication in place with consultation lead in E and P • Participation Group lead reported to the LSCB on key learning and a further Report is scheduled	
Increase agency capacity to deliver effective safeguarding services.	Norfolk, Cambridgeshire and Peterborough LSCB's working together on Innovation bid.	Provide project worker to research and summarise existing local learning and development Multi-agency training. Practice standards development	Start April 2015 – 2016	To improve safeguarding arrangements for the children and families of Eastern European migrant backgrounds within the Wisbech area.	Effective safeguarding for children and young people of Eastern European migrant backgrounds measured through positive outcomes. To be audited six months following the project completion. • Project Plan on track. Final Report being completed	

Appendix 3. BUSINESS PLAN 2016-18

BACKGROUND INFORMATION

Purpose of the Plan

The Business Plan is the way that the Board records how it views its current context and the key areas of work that it should concentrate on during the forthcoming year or years. These areas reflect local needs and national priorities. It is supported by information from partner agencies and the wider Cambridgeshire community. To ensure transparency and accountability to the wider community the Plan is published, and in due course so is a closing report on its implementation and impact.

Its Priorities are:

1. **Ensure effective safeguarding of children against Neglect.**
2. **Child Sexual Exploitation & Missing**
3. **The Voice of the Child**
4. **Enhancement of LSCB effectiveness in discharging its responsibilities**
5. **Developing and Supporting an Effective Workforce**

Having decided on the key areas to be covered, the plan summarises what needs doing, who will make sure it happens and by when. During the life of the plan it is regularly reviewed to ensure that what needs to be done is being done. The final review of the Plan is published as part of the LSCB Annual Report.

The Government has published its proposals for the future of multi-agency coordination and oversight for child safeguarding. LSCBs are likely to change significantly and may cease to exist in some areas. Instead there will be more scope for alternative local arrangements tailored to meet local need. The timescale for these changes is likely to be between one and two years. To prevent any loss of momentum in working on the Board's agreed priorities, this Plan has been designed to be delivered over an eighteen month period. Inevitably the current Plan includes work that prepares for a transition into any new arrangement that is put into place.

Board Objectives*

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Board Functions*

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) Training of persons who work with children or in services affecting the safety and welfare of children;

(iii) Recruitment and supervision of persons who work with children;

(iv) Investigation of allegations concerning persons who work with children;

(v) Safety and welfare of children who are privately fostered;

(vi) Cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) Participating in the planning of services for children in the area of the authority; and

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

*Working Together 2015

WHAT DID THE BOARD USE WHEN SETTING OBJECTIVES?

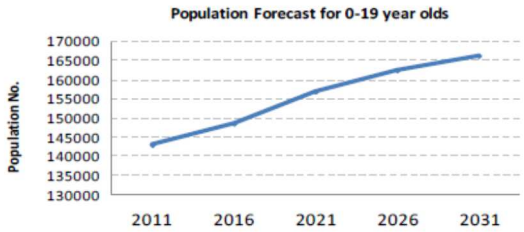
CHILDREN IN CAMBRIDGESHIRE

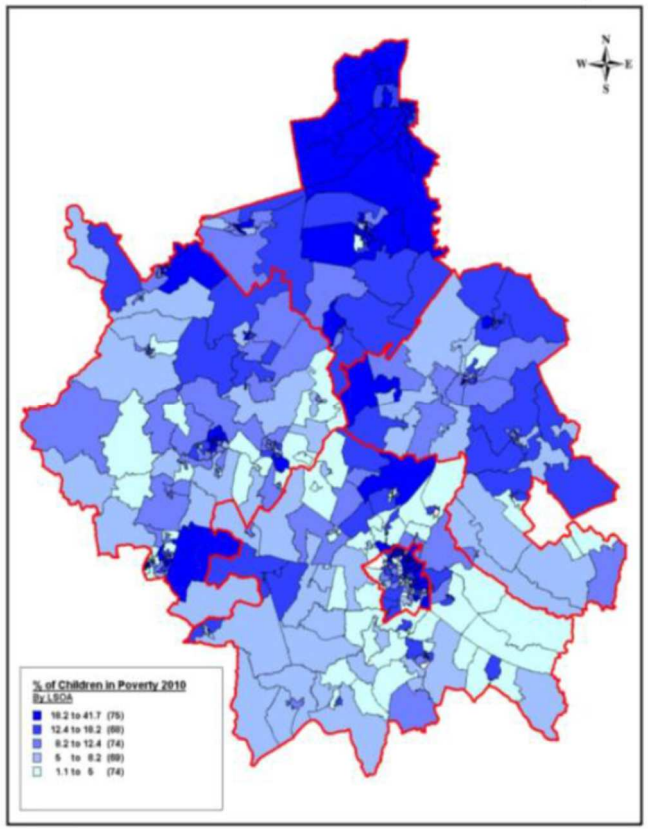
2011 census returns show 621,200 people living in Cambridgeshire, 144,785 (23%) of whom are under 20 years of age. The population of the county grew by 68,500 (12%) in the 10 years since the last census in 2001, rising from 552,700. This was the largest growth in the population in any county council authority in England. The number of children and young people increased by 9,700 to 144,785; a 7% rise compared with a 3% rise nationally.

Looking ahead, current and planned housing developments in Cambridgeshire are expected to create a further major influx of young families. By 2031 the number of children and young people is forecast to grow 16.8% compared to 2011. This equates to an increase of 23,900 more 0-19 year olds over 20 years.

The population growth between now and 2031 will not be spread evenly across the county. The largest increases are expected in Cambridge (39.8%) and South Cambridgeshire (24.1%) whereas in Huntingdonshire we are anticipating a decrease.

The percentage of children in poverty here is lower than the national average of 21.6%. But 13.3% of children are living in poverty in Cambridgeshire - 16455 children. There are pockets of concentrated deprivation including in the Wisbech Waterlees ward where 38.7% of all children are living in poverty.





Distribution of Child Poverty

BUSINESS PLAN 2016-18

1. Ensure effective safeguarding of children against Neglect.

LSCB Function

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(d) participating in the planning of services for children in the area of the authority

Neglect is the category of abuse identified in about 70% of Child Protection (CP) Plans. It is known to have a major impact on children, but enabling families to make and maintain the long term changes needed to reduce neglect is a significant challenge for practitioners and services. Neglect is associated with a number of issues facing families, including poverty, parental mental illness, domestic abuse and substance abuse. As such tackling neglect crosses the boundaries between adult and child focussed services.

Objective	Accountability	Success Criteria	Progress
To reduce the impact of neglect on children by coordinating and enhancing services.	LSCB Board	A coordinated approach across services to maximise impact. The Board to have in place a Neglect Strategy in a joint approach with the Peterborough SCB **Sept 2016.**	
	Business Committee	Demonstrate the successful Implementation of the Neglect Strategy by: Providing evidence within the LSCB dataset of change in the prevalence and impact of neglect in the wider community. **Nov and July Boards**	

		b) Providing evidence within the Dataset and CP six monthly and annual Reports about change in the prevalence of Neglect as a CP criteria **July and Nov Boards**	
	Business Committee	Staff are equipped to make informed, consistent assessments of families where neglect is an issue. The Graded Care Profile (GCP) in practice by a) providing a Cambridgeshire model assessment tool b) Issuing Guidance on its use c) training staff in its use and d) providing evidence of use in practice through a survey of trained staff a) July 16 b) Sept 16 c) Mar 17 d) Apr 17	

2. Child Sexual Exploitation & Missing

LSCB Function

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority

There is a major national focus on ensuring that children who are vulnerable to exploitation are Safeguarded.

Objective	Accountability	Success Criteria	Progress
Develop an model of staged intervention or "Offer" for the victims and potential victims of CSE	CSE Task and finishing Group	Adoption of the Model by the Board by Sept 16 Model on Website, publicised by Newsletter and incorporated into Training by Nov 16 Survey of staff as to familiarity with and usefulness of the model Jan 17	
Ensure the risk and vulnerability of children Missing from Care, Home and Education has been effectively managed	CSE Task and Finishing Group	That evidence is provided to the Board in Reports as to a) levels of referral into Operational Group and MASE b) the outcomes for children identified as Missing, vulnerable to exploitation and at Risk. Nov and July Meetings	
Safeguard children from the risk of exploitation by Gangs.	Business Committee	That by Oct 2016 the Business Committee is able to show that children are Safeguarded: a) That Guidance is in place and accessible b) B) that the level of gang activity has been measured c) That a proportionate response to coordinate services is in place	
Safeguard children from the risk of exploitation by extremism and radicalisation.	LSCB Board	That the Board is assured appropriate and proportionate arrangements are in place by Jan 2017	

3. The Voice of the Child Relevant to all LSCB Functions			
Objective	Accountability	Success Criteria	Progress
Ensure that examples of good practice in consulting children and service users, including evidence of impact on service design and provision, are available to the Board.	LSCB Board	Two reports to be collated by the LSCB Business Unit that summarise the submissions of good practice from Agencies to the Jan and July Boards and are included in the LSCB Annual report. All LSCB Committees to include demonstrating their use of the Voice of the Child in Business Plans or provide the Board with the evidence as to why this is not appropriate.	
Improve the experience of case conferences for children & the parents/carers	LSCB Board	Provide practical and strategic support to the Participation Project and enable it's continuation in line with learning from the current pilot. A plan for support of the Project to be discussed at the Sept 16 Board. When agreed the Business Unit and Project will be responsible for delivering the Plan and reporting on progress to the July 2017 Board.	

4. Enhancement of LSCB effectiveness in discharging its responsibilities

Relevant to all Functions including 1a (vi) cooperation with neighbouring children's services authorities and their Board partners;

Objective	Accountability	Success Criteria	Progress
Improve effective coordination with strategic partnerships in Cambridgeshire.	Chair of LSCB and Business Unit	Review Communication Strategy. To enable Partnership Chairs to meet with the intention to agree a protocol for coordination across Partnerships and a high level plan covering Cambridgeshire priorities and accountability. LSCB SAB HWB CJC By March 2016	
Maximise opportunity to increase efficiency and effectiveness through closer working with Peterborough SCB	Unit Business Manager/Head of Service	To hold joint Cambridgeshire and Peterborough Committee meetings twice a year to coordinate activity of shared need and identify areas of difference that require local management. This will include, but not be limited to: QEG • Dataset • Joint Multi Agency Audits • Section 11 Audit	

	Staff Development and Training Managers	• Sharing of learning from audits and monitoring Workforce development • Joint Training courses • Shared Training materials • Staff access to training across the Local Authority/LSCB area boundaries • Joint validation process • Joint development of new courses and commissioning CSE • Overarching Strategy CSE strategy • CSE Training and awareness raising materials • Operational activities as relevant To review potential for joint training with SAB Units in Peterborough and Cambridgeshire by April 17 • DoLs, • Safeguarding children for services to adults • Children and adults open to sexual, gang and extremist exploitation,	

	Business Manager/Head of Service Business Manager/Head of Service	• NICE Guidance on transition to adult services within Health and Social Care. To support the implementation of the NICE Guidance on Transition from Child to Adult Services in Health and Social Care Services To request information on the effectiveness of the implementation from the Health Safeguarding Executive and Local Authority is provided to the Boards by Mar 17 To provide both Board with a joint Report on lessons learnt about efficient and effective joint working, Nov 16	
Complete review of Learning and Improvement processes and recording	Business Unit Business Unit and agencies holding data.	By November 2016 to demonstrate an administrative process that supports and records effective learning being used to improve practice and provides transparency around the implementation of actions, recommendations and initiatives identified as required to enhance safeguarding. Performance Information made available through a "Dashboard" for Board by Sept. 2016	

Enhance the capacity of the Voluntary Sector to safeguard children	LSCB Business Unit J Hansen, Cambs City Council	Engage and consult with key providers to increase awareness of safeguarding in July 2016. With key providers and representatives in the sector, to identify priority actions for 16/17 to enhance the capacity of the sector to be self-sufficient in supporting good safeguarding practice, including recruitment, training and policy. To draft and provide a Plan for the implementation of these actions to the LSCB for approval in Sept 2016. To Report on progress to the Board and demonstrate increased capacity and resilience within the voluntary sector in Cambridgeshire, July 2017	

5. Developing and Supporting an Effective Workforce

Function 1a (ii) training of persons who work with children or in services affecting the safety and welfare of children;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

Objective	Accountability	Success Criteria	Progress
Adequate resources and capacity to deliver or commission training;	LSCB	Training delivered within budget and to plan	
Policies, procedures and practice guidelines to inform and support training delivery in line with the	TDWSG	Agencies to provide evidence of compliance with Validation process by March 2017	

Learning and Implementation Framework		Monitor individual agency delivery of training in line with LSCB policy and Standards by March 17	
Identification and periodic review of local training needs, taking into account research, national developments, learning from SCRs and child death reviews(not only those carried out locally), followed by decisions about priorities;	TDWSG	Deliver required training programmes and communicate mandatory content for training programmes identified by the LSCB Learning process. Undertake an annual brief overview of multi and single agency training needs for the medium to long term. Support required content with resources on web-site	

Appendix 4. LSCB DATASET 2015-16.

This dataset is part of the Learning and Improvement Framework. Quantitative data is one of a range of measures of understanding the safeguarding system. These indicators focus on what we are concerned about as stated in the priorities. It is not complete in that there are some pieces of information which are not available at the current time.

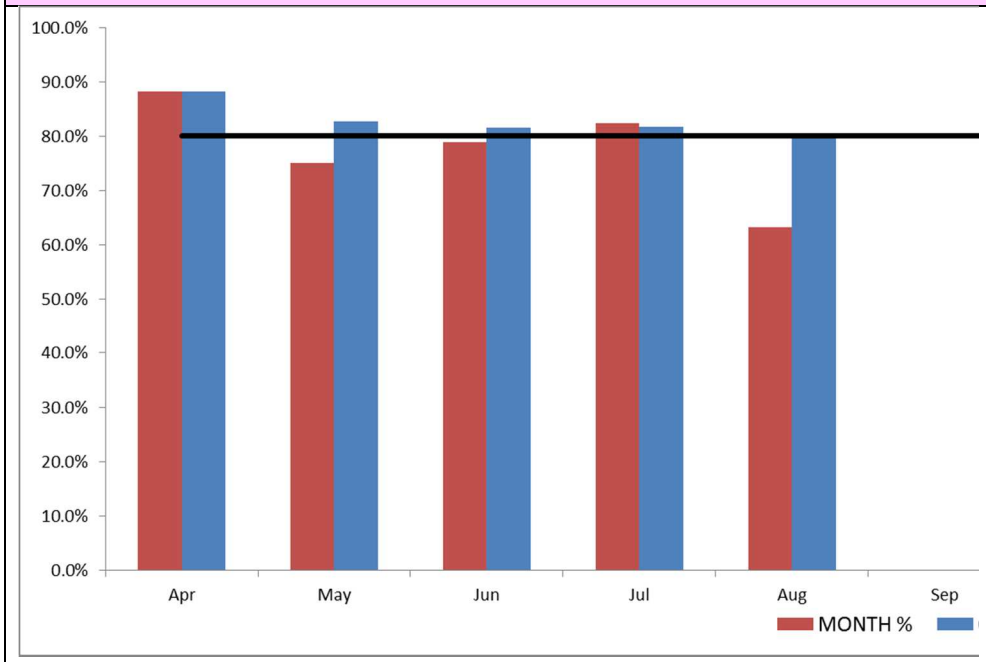
Key Points

- Workload has increased in the CP processes with increased levels of contact and open cases.
- The recorded number of children reported as missing to the police has increased
- There have been changes in reporting mechanisms that have made some comparisons over time difficult. Early Help data has been temporarily unavailable for the last six months of the year whilst new indicators have been developed that are relevant as measures of effectiveness in current practice. The rationale has been to improve the significance of the data and increase the meaningfulness of the exercise.
- We anticipate providing a re-designed dataset next year including:

1. Data on broad indicators of abuse within geographical areas
2. More detailed Early Help data
3. Information on the use of police cells for children
4. Information on outcomes for looked after children, including those placed out of county.

- Improved agency compliance with safeguarding standards following the Section 11 Audit can be demonstrated.

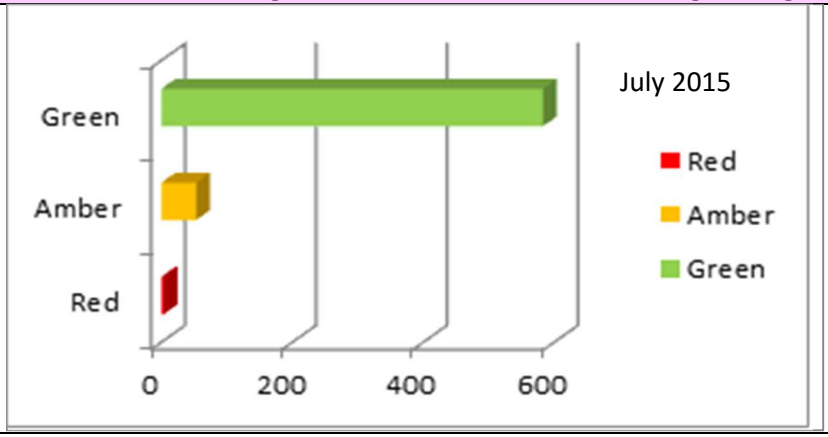
EARLY HELP
How do we know that the early intervention and safeguarding offered to children and families make a difference?
% CAF which achieve the intended outcomes

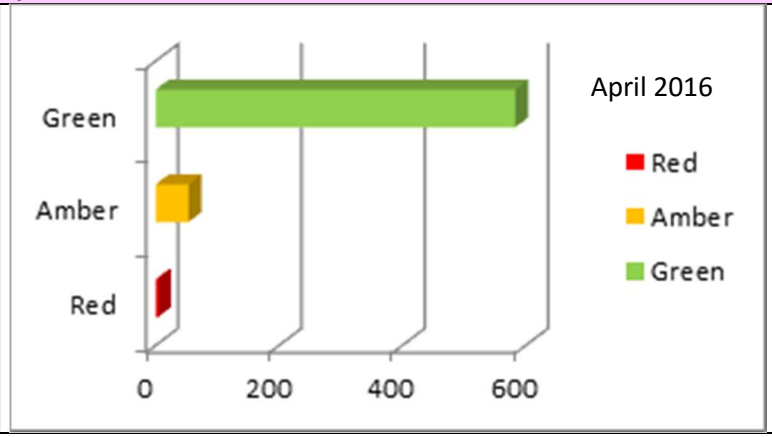


Data on CAFs achieving outcomes has not been made available for the period from September onwards. There has been a major initiative to review the CAF data and improve its relevance as an assessment of effective practice. New indices for effectiveness in Early Help will be available for 2016-17.

Commentary:
Over the last six months Together for Families and Enhanced and Preventative services have consulted with the Board on the meaningful measurement of effectiveness in Early Help. There has been concern that this current measure is not the most reliable basis for a judgment available and as such this data is no longer available. A new set of outcome focused measures is anticipated for 2016-17.

ORGANISATIONAL CAPACITY TO SAFEGUARD: The Findings from the Section 11 Audit 2015.
How do we know that agencies are able to meet their safeguarding responsibilities?





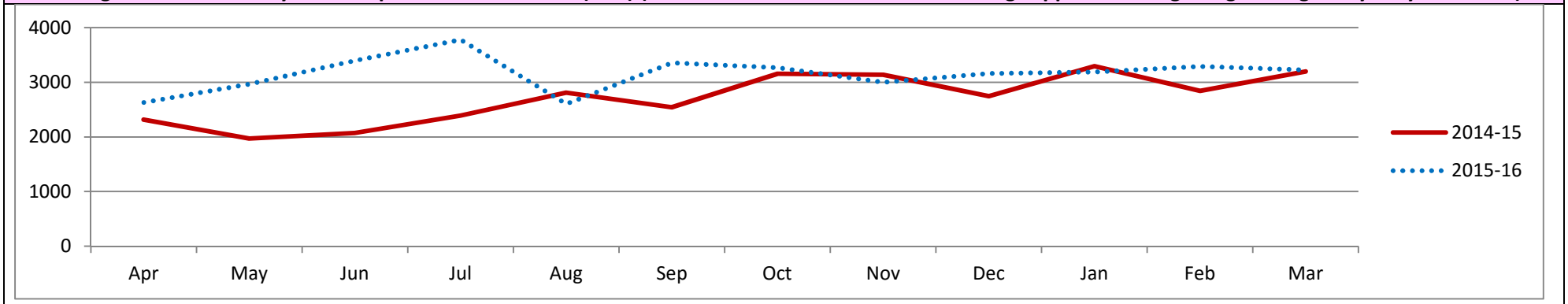
	Jul-15		Apr-16	
	Number	%	Number	%
Red (Not Met)	10	2%	4	0.6%
Amber (Partially Met)	63	10%	53	8%
Green (Fully Met)	569	86%	583	88%
None	17	3%	19	3%
Total	659		659	

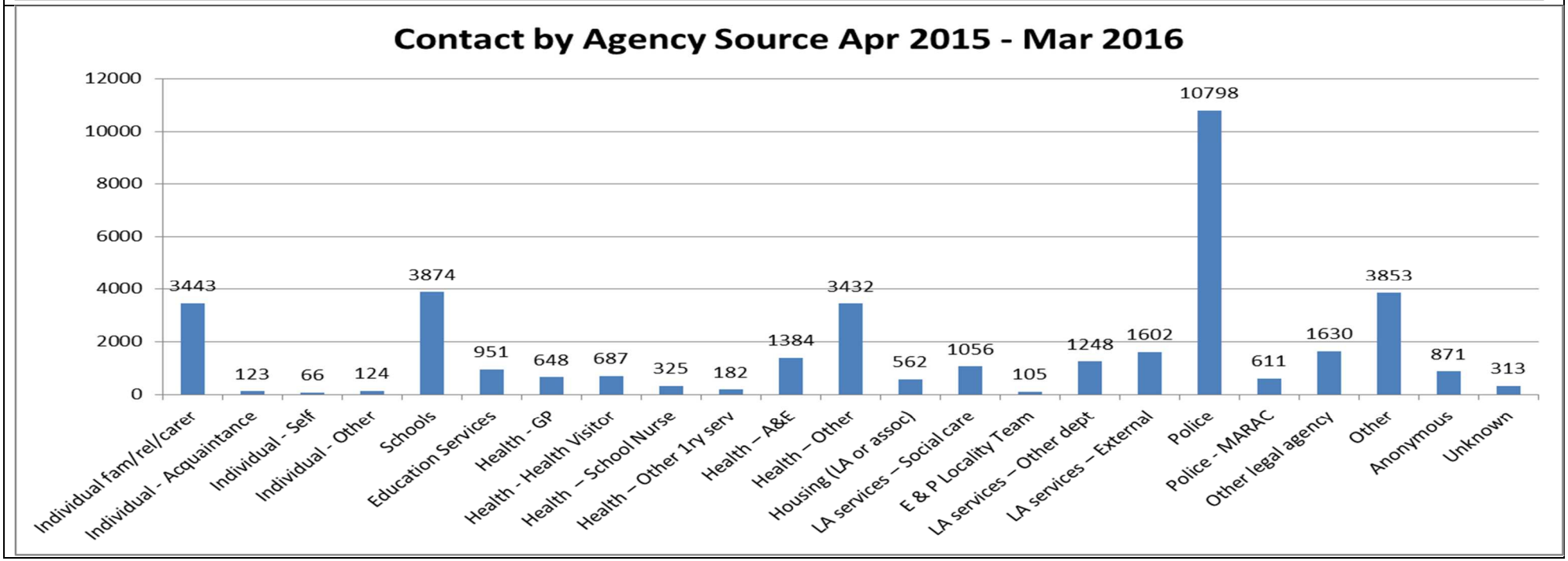
Current Section 11 returns after action plan reports are included.

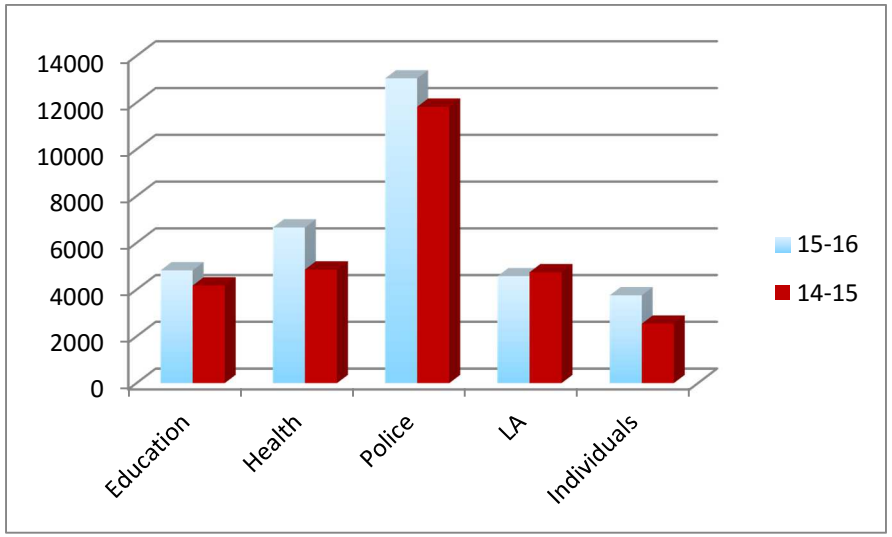
Commentary: Of the remaining "Reds", two relate to issues not readily addressed on an individual county level and apply wider than Cambridgeshire. One relates to an agency that has not reported on progress to date and the other where further re-organisation has delayed implementation. Follow up action is being undertaken on these and "ambers".

DEMAND ON THE CHILD PROTECTION PROCESSES

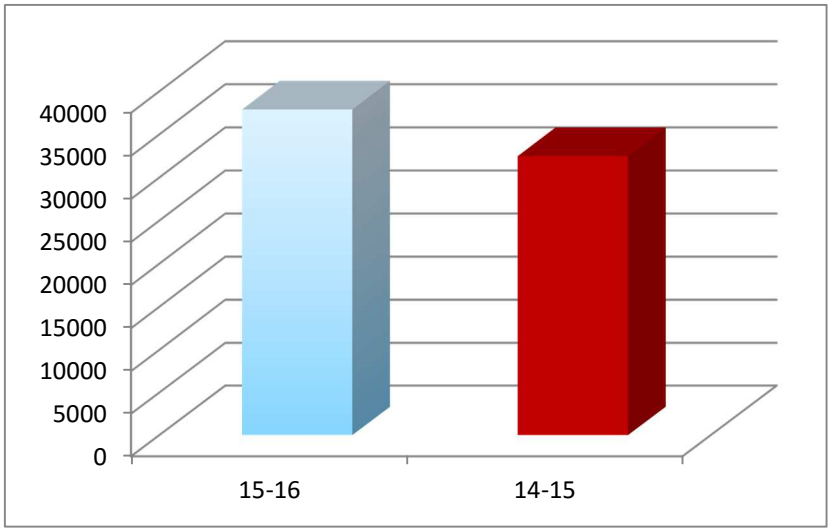
Percentage of all contacts by source April 2015 – Mar 2016 (N10) (How do we know if what we are doing supports making safeguarding everybody business?)







Total contacts by agency groupings 2015-16 compared with 2014-15.



Total Contacts received 2015-16 and 2014-15

Comment: Overall contacts have risen from 32477 in 2014-15 to 37888 in 2015-16. This represents an increase of 17%. Whilst not out of line with the national trend, it does represent a significant challenge for the Child Protection processes to absorb this level of increase. Contacts have increased from Education, Health agencies, the Police, and most noticeably from individual members of the community. The only area where there has been a reduction in referral is from other Local Authorities.

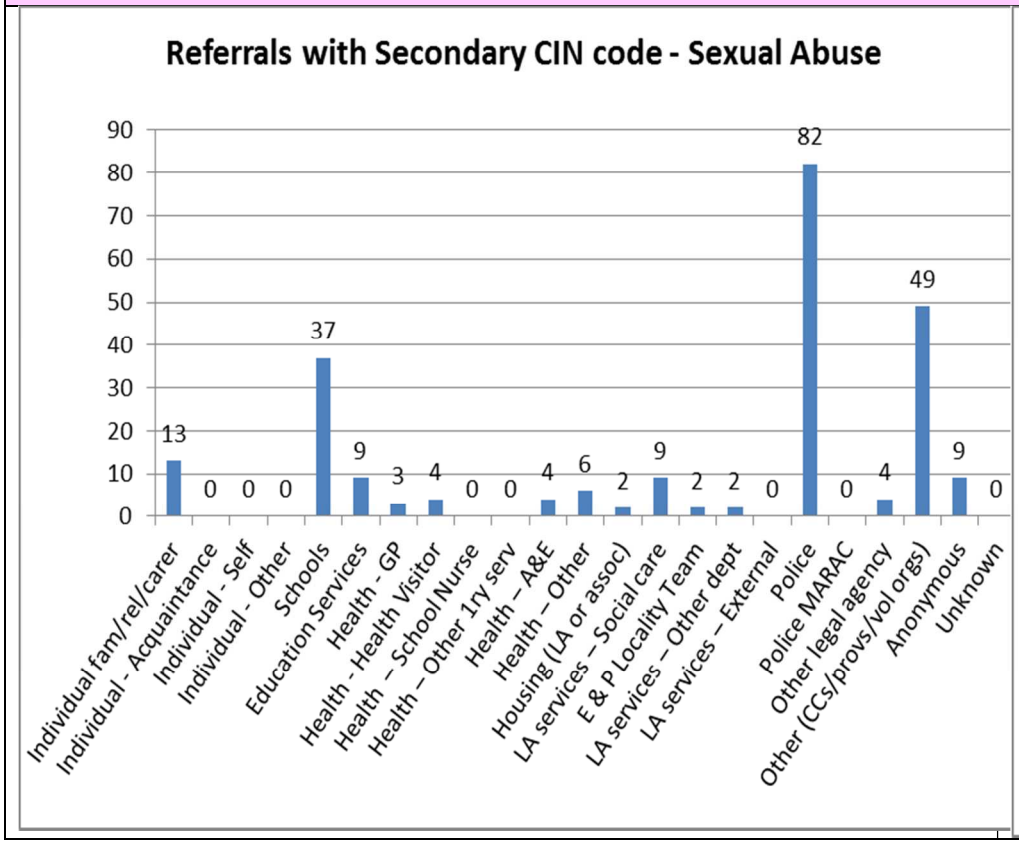
Children's Social Care (CSC), have shown that whilst the First Response and Emergency Duty Team (FREDt) and Contact Centre have been dealing with a higher level of contacts to the service, their triage process that directs contacts to the most appropriate service for the child has referred on to CSC a relatively stable number of cases. However, the risk and complexity of the work coming to CSC is increasing, and this is leading to higher demand on requests for Conference, court proceedings and the accommodation of children and young people.

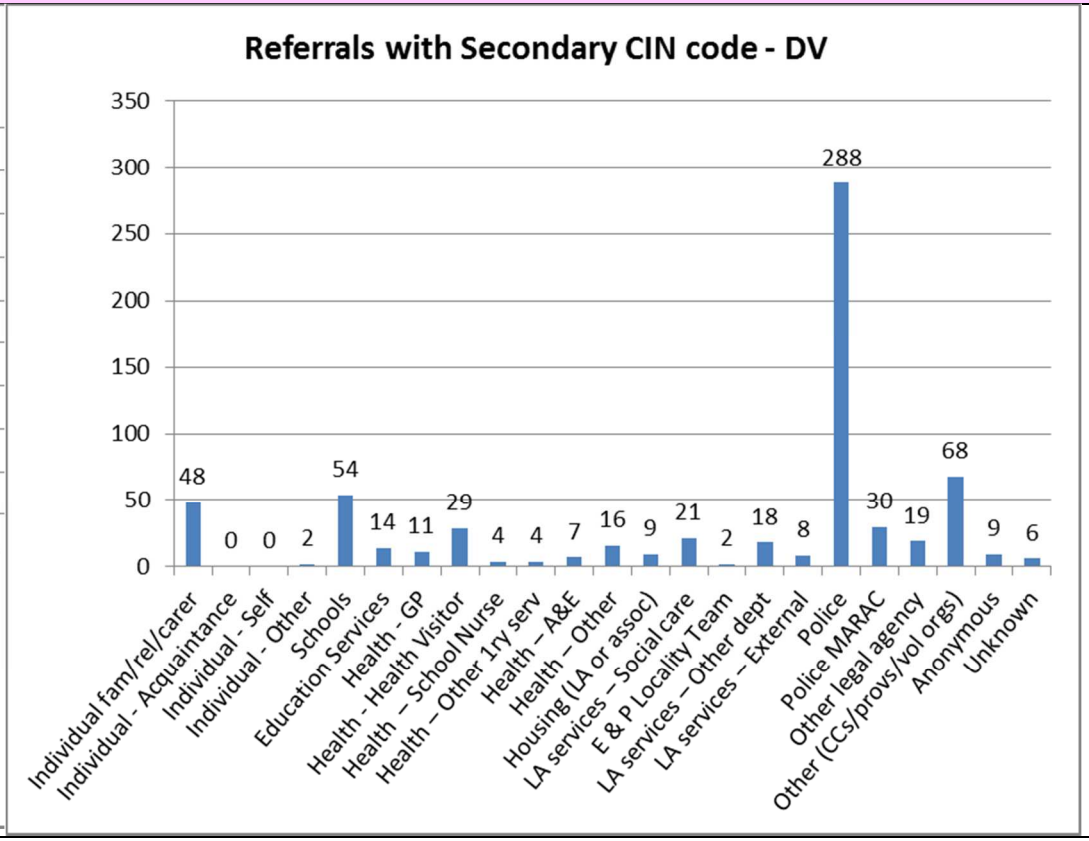
LSCB PRIORITY AREAS

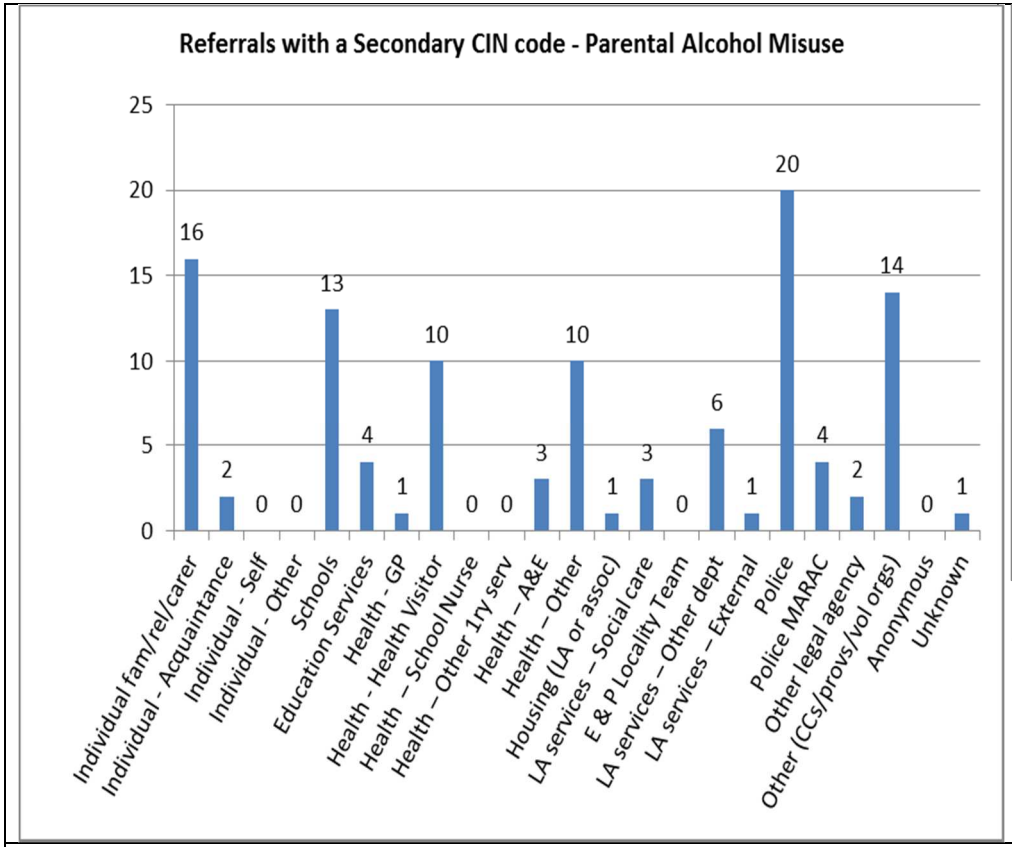
Priority One: Sexual Abuse; Parental Alcohol Misuse; Domestic Abuse; CSE and Missing April 2015 – March 2016 inclusive

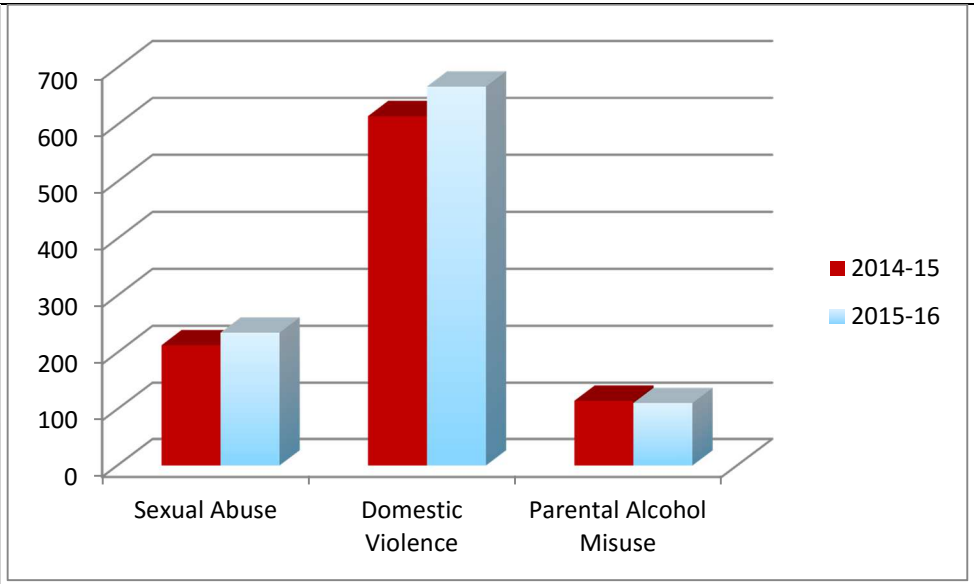
How do we know that our responses to specific safeguarding concerns make a difference to children and young people?

Reporting of concerns is the first stage of an effective response – knowing that agencies are referring concerns is important.









Change in use of secondary CIN codes 2014-5 to 2015-6

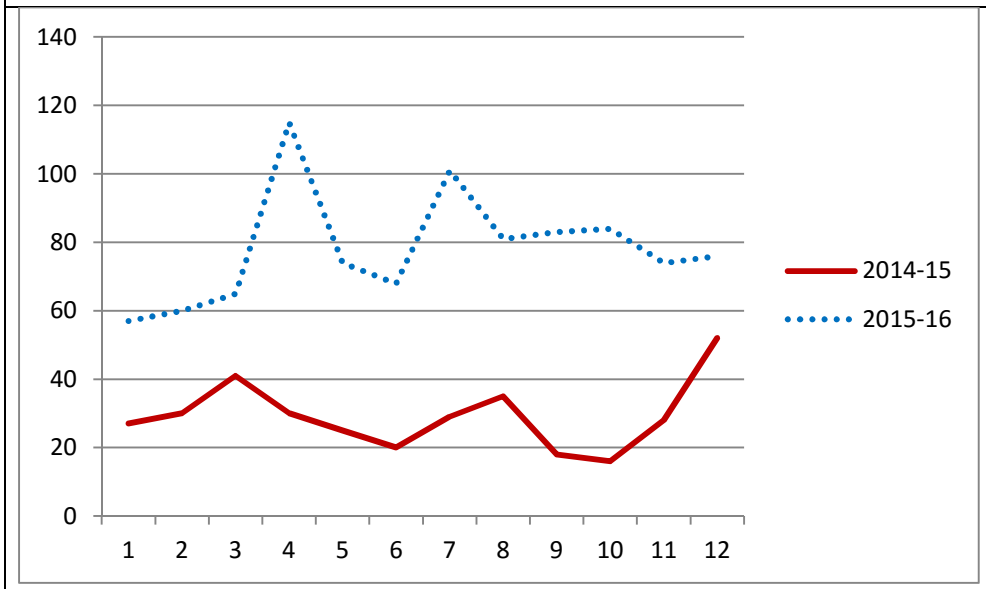
Comment: In 2015-16 there were 4168 referrals to Children Social Care, down from 4168 in 2014-15. A referral can have several secondary CIN codes and it is not possible to identify how many cases had one or more of these codes identified. However, it can be said that 16% of all referrals had domestic abuse present as a factor.

VULNERABLE GROUPS OF CHILDREN

1. Disabled children

	Disability Team	Total	Disability Team as a %
Referrals	193	4168	4.6
Re-referrals	19	753	2.5
Open	416	3048	13.6

As with the six monthly figures, there was a higher proportion of open cases within the disability team compared to the total caseload. This may in part be explained by the fact that the definition of which children goes to a disability Team includes the long term nature of the disability.

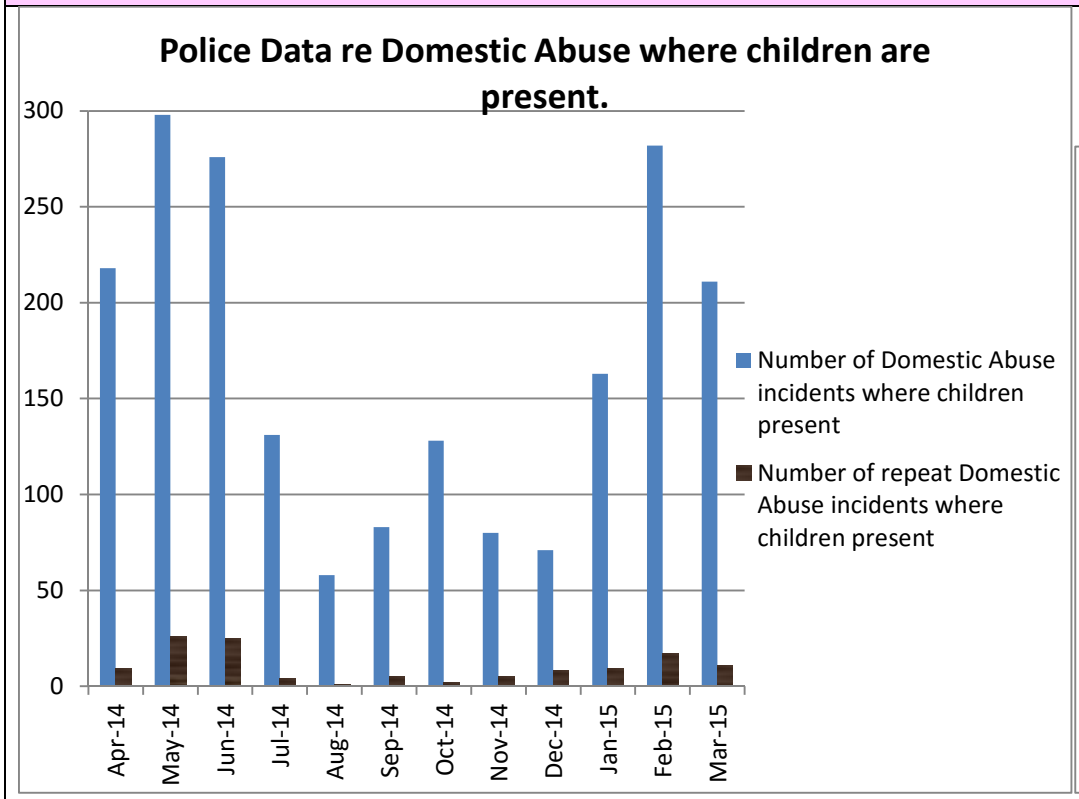


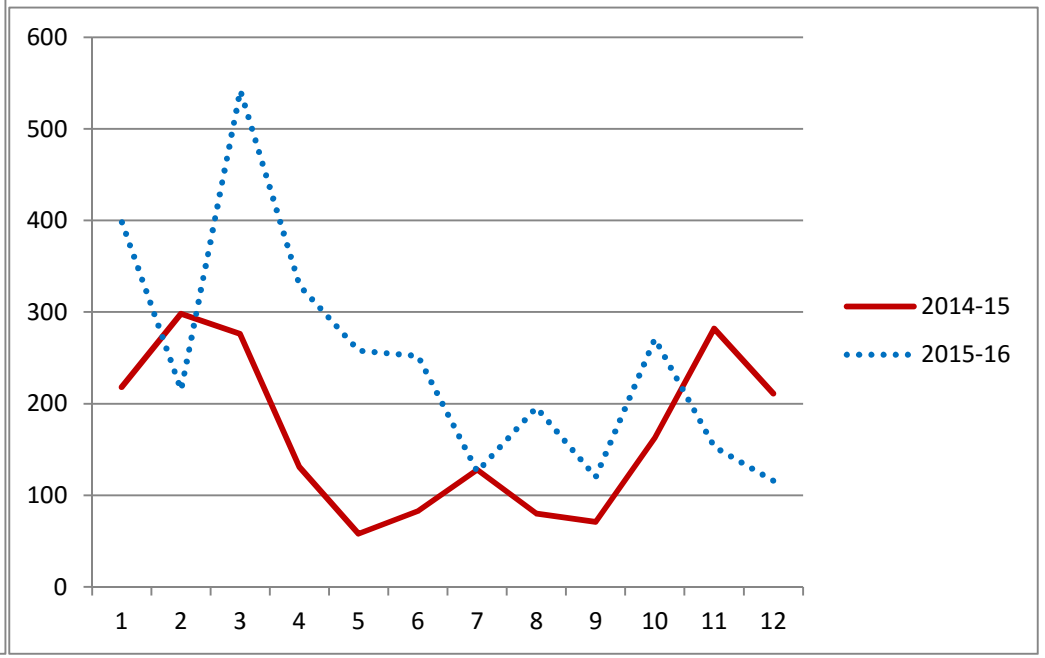
Police: Number of missing person reports for under 18s

2. **Number of missing person reports for under 18s**

The figures clearly show an increase year on year that seems to have started in March and February 2015. This has been a time of focus on Missing Children. There was a change in the police use of Missing and Absent categories and it is possible that these figures have been influenced by changes in definition and approach as much as the overall numbers of children involved

Domestic abuse
Police data regarding Domestic abuse incidents



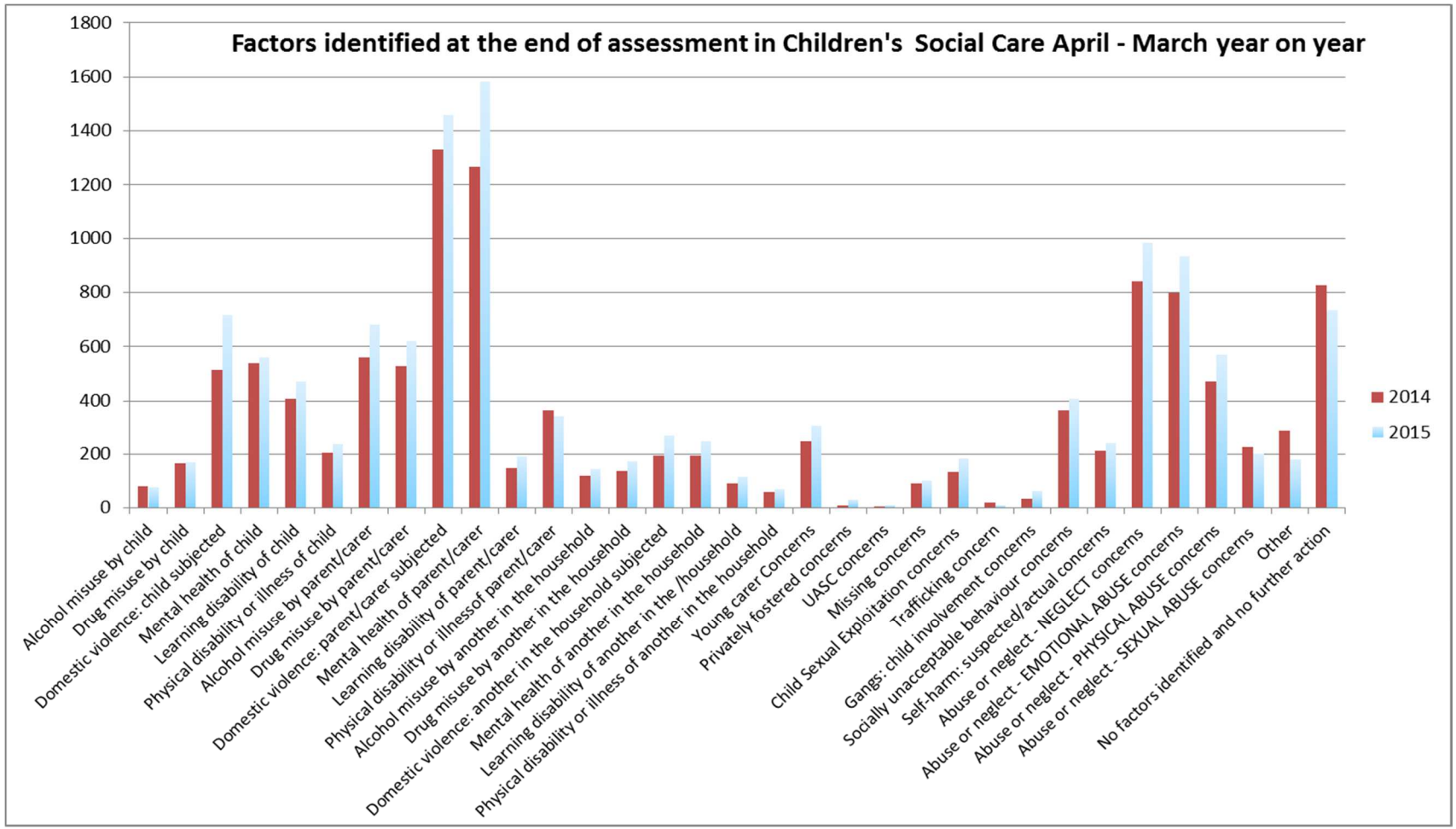


Number of Domestic Abuse incidents where children present

The numbers above are the numbers of children present at domestic incidents. The fluctuation in numbers of incidents is of interest, but these figures may have been strongly affected by police campaigns. Overall however there has been a significant increase in numbers over the past year.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number of missing person reports for under 18s												
Cambridgeshire	57	60	65	115	74	68	101	81	83	84	74	76
Number of Violent or Sexual Offences against under 18s												
Cambridgeshire	155	133	176	136	105	161	206	194	125	128	124	126
per 10,000 CYP population	*12.1*	*10.4*	*13.8*	*10.7*	*8.2*	*12.6*	*16.1*	*15.2*	*9.8*	*10.0*	*9.7*	*9.9*
CP CATS Referrals (Constabulary)												
Child Concern	514	1,099	1,059	1,117	720	853	664	799	513	713	620	547
FGM attempt or risk	0	0	0	0	0	1	1	1	0	2	0	0
Child Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	10	12	11	16	12	23	6	16	13	17	15	5
Prosecution Prevented	1	0	1	4	-1	1	5	1	1	2	3	0
Prosecution Not In Public Interest	0	0	3	4	0	1	0	0	3	1	0	1
Prosecution Not Possible	34	23	33	43	21	29	40	41	37	21	40	29
Domestic Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	81	84	102	109	85	107	83	137	103	119	128	105
Prosecution Prevented	2	6	3	3	1	2	4	1	7	0	6	5
Prosecution Not In Public Interest	3	2	9	3	1	2	6	1	0	1	2	1
Prosecution Not Possible	136	132	129	173	146	148	126	137	137	161	133	161
Domestic Abuse incidents (Constabulary)												
Number of Domestic Abuse incidents where children present	398	215	542	329	258	252	126	196	120	271	153	116
Number of repeat Domestic Abuse incidents where children present	23	25	52	19	19	15	7	12	1	16	8	11
MARAC data												
Cambridgeshire Central												
Number of cases discussed	27	28	27	51	38	43	30	24	31	18	5	
Number of repeat cases	11	8	6	13	9	14	10	11	11	7	4	
Number of children in household	43	50	35	64	47	62	28	27	41	29	11	
Number of referrals from police	22	17	22	41	37	41	27	21	27	16	4	
Number of referrals from other agencies	5	2	5	10	1	3	3	3	4	2	1	
Cambridgeshire Southern												
Number of cases discussed	24	42	30	59	34	34	29	30	42	27	4	
Number of repeat cases	7	17	12	20	12	11	7	11	13	11	2	
Number of children in household	30	42	32	92	39	46	47	32	48	38	7	
Number of referrals from police	23	37	29	55	29	31	26	30	38	24	3	
Number of referrals from other agencies	1	5	1	4	5	3	3	0	4	3	1	

WHAT ISSUES ARE PRESENT IN THE CASES
Factors identified at the end of single assessment (April - March) showing 2014 & 2015



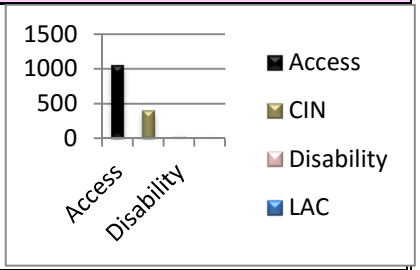
Commentary: The only reduction in numbers is the “No factors identified” column and “other”, both of which lead to a more complete picture of the factors identified. There has been attention given to accurate reporting of these factors within Children Social Care over the year.

IMPACT

How do we know that our responses to specific safeguarding concerns make a difference to children and young people?

NUMBER OF S47 ENQUIRIES

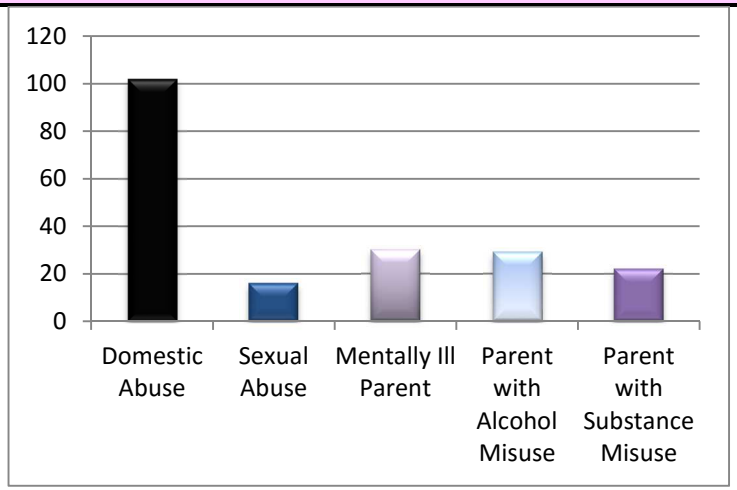
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL
Access	101	93	65	88	44	70	79	121	114	84	80	116	**1055**
CIN	18	40	27	25	32	40	42	26	62	24	28	40	**404**
Disability	0	0	0	0	0	4	5	3	2	0	0	12	**26**
LAC	0	0	1	0	0	0	0	3	6	0	1	0	**11**
Total	**119**	**133**	**93**	**113**	**76**	**114**	**126**	**153**	**184**	**108**	**109**	**168**	**1496**
2014	**197**	**155**	**155**	**143**	**103**	**127**	**119**	**124**	**149**	**114**	**90**	**106**	**1582**



As at the six month stage, this information was not available last year so comparison cannot be made. Variation in the number of cases going into Access looks to reflect school holiday patterns.

CP Categories and secondary CIN codes showing: Domestic Violence; Sexual Abuse; Mental Ill Parents; and Parents with Alcohol Misuse or Substance Misuse

Category	All Cases	All Cases 2015	Secondary CIN code showing				
			Domestic Abuse	Sexual Abuse	Mentally Ill Parent	Parent with Alcohol Misuse	Parent with Substance Misuse
Emotional	113	118	43	2	7	5	2
Neglect	289	233	49	8	19	23	20
Physical	21	20	10	0	4	1	0
Sexual	16	16	0	6	0	0	0
Total	**439**	**387**	**102**	**16**	**30**	**29**	**22**
2014	**387**		**92**	**8**	**16**	**21**	**14**



The most remarkable figure is the increase in Neglect cases. This confirms its importance as a priority area for the next Business Planning cycle. Sexual abuse had appeared to be reducing in presence but this has now reversed in the secondary CIN codes.

CHILD PROTECTION CONFERENCES

Levels of attendance. Snapshot from January 2016

	Number of invited attendances	Invited and did attend	Invited and did attend %	Invited but did not attend %
Child	11	3	27.3%	72.7%
Father (no PR)	3	1	33.3%	66.7%
Father (PR)	126	77	61.1%	42.1%
Mother	162	143	88.3%	11.7%
Oth Fam (no PR)	44	33	75.0%	52.3%

Family Member attendance

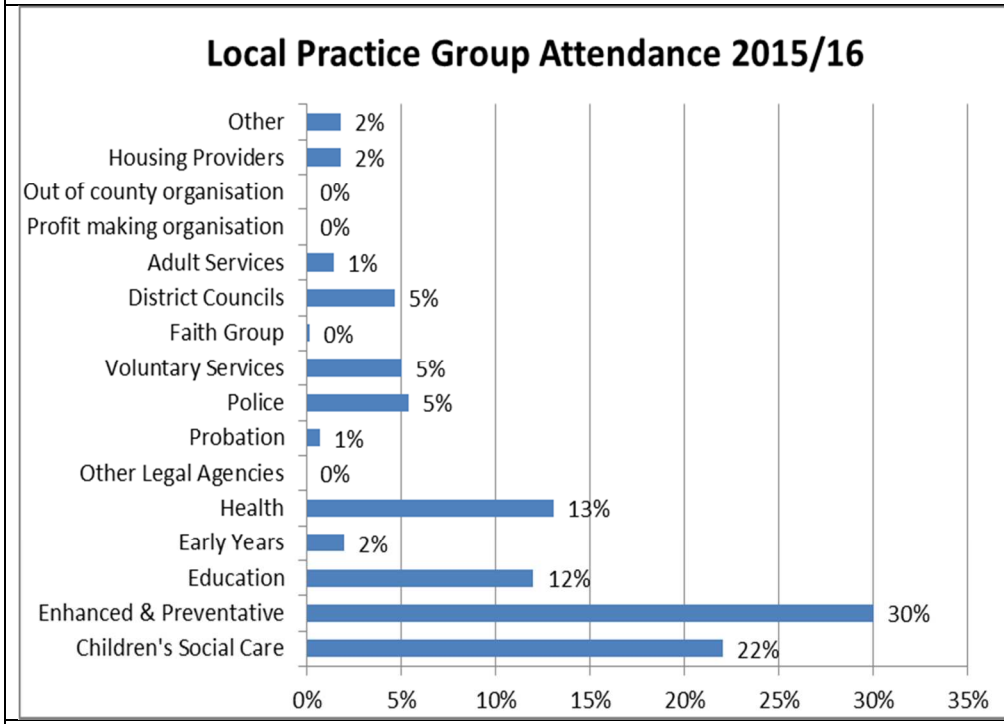
Number of invited attendances	Invited and did attend	Number of reports received	Attendance %	Report %
948	492	486	52	51

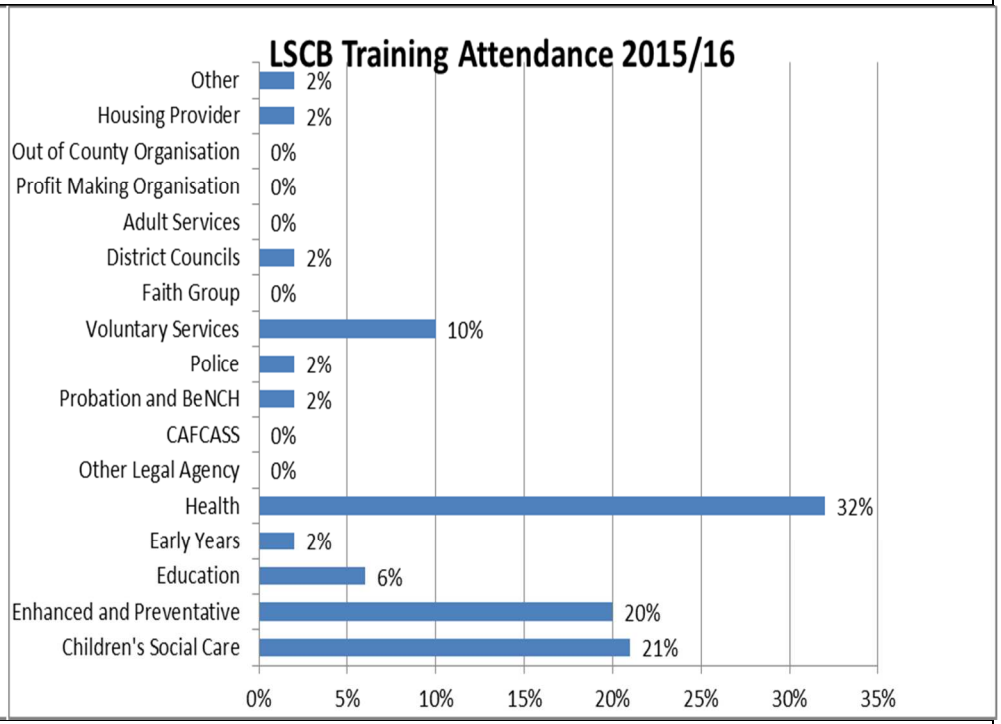
Professionals' attendance and report submission.
(These figures do not include invites for Advocates whose attendance is in line with that of the child they are working with.)

Comment: It is has proven difficult to extract attendance and report writing data from the record. In order to ensure accuracy a "snapshot" was taken for one month with the Conference Chairs actively seeking and confirming the accuracy of the information. Given the levels of attendance this has been the subject of a focused effort to improve compliance through the Business Committee and QEG.

LSCB activity data

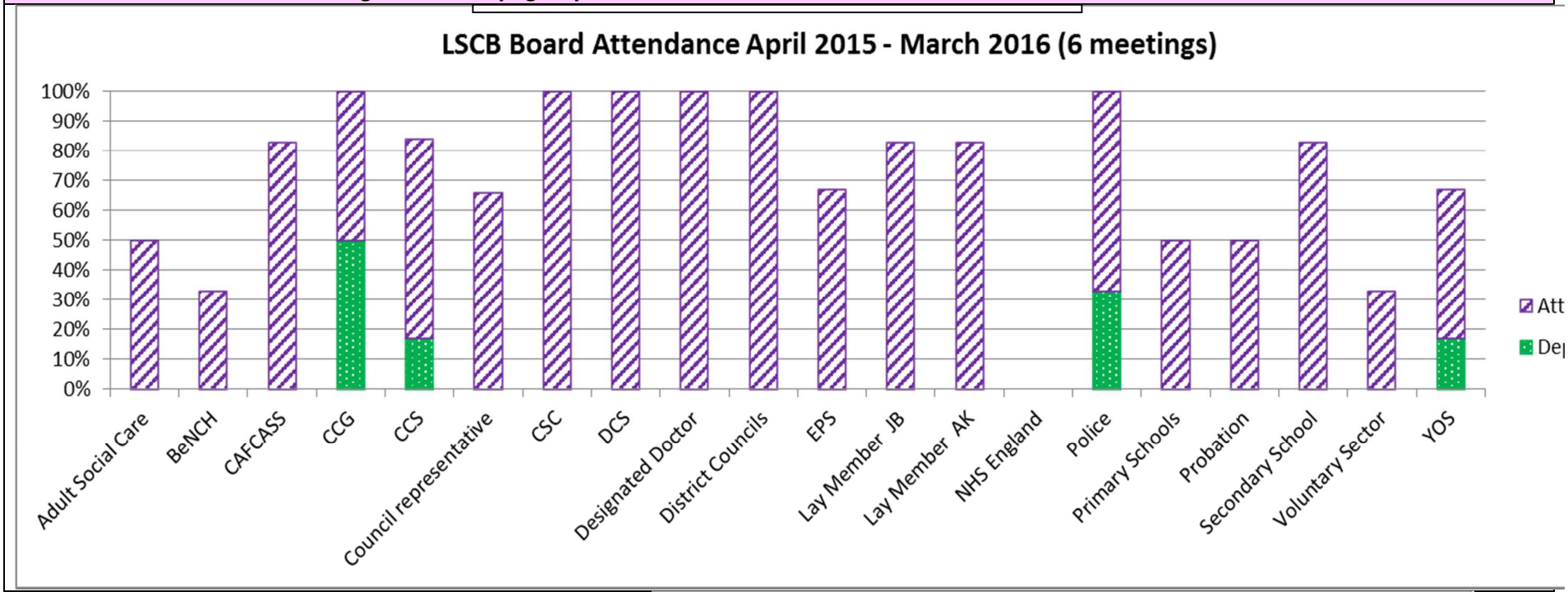
Number and %Attendance at LSCB training / LPG data by agency – this is reported on to the Training and Development subcommittee in full and then to the Business Committee. Non-attendance is also monitored as there are sometimes 'serial' non-attendees on courses that could be attended by someone else





This data is commented on more fully in Training Reports. However, there has been a positive trend in increased attendance over the past year.

LSCB Effectiveness: % LSCB meetings attended by agency



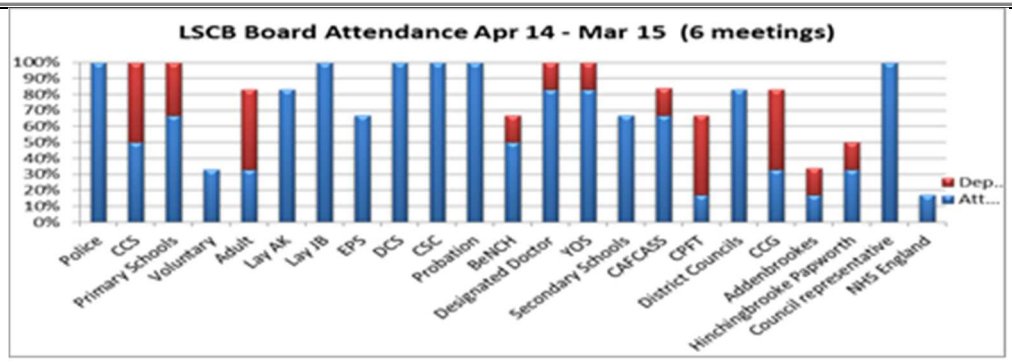
Commentary:

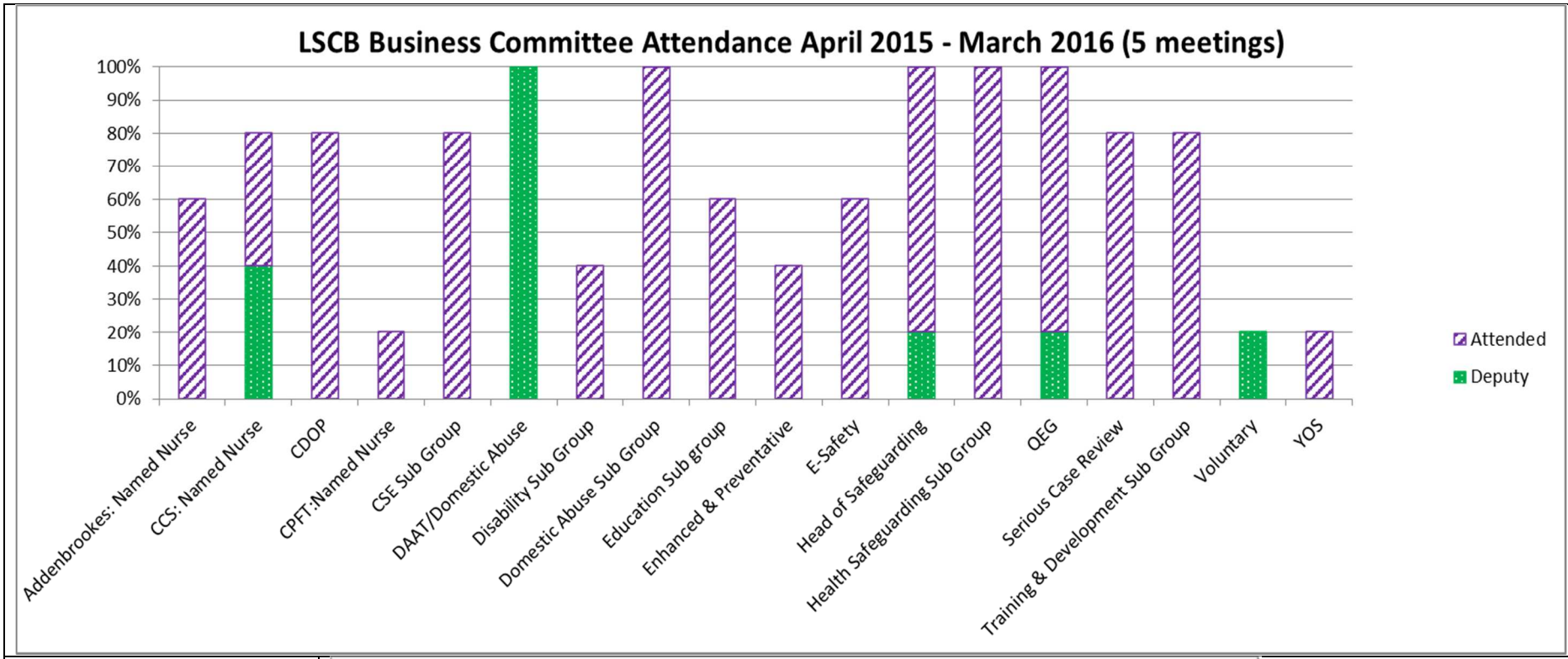
An EPS attendance is always covered as the Executive Director, CFS, has overall accountability.

NHS England have said that they will not be attending LSCB Board Meetings, and their absence is noticed when issues where they have a significant role are discussed.

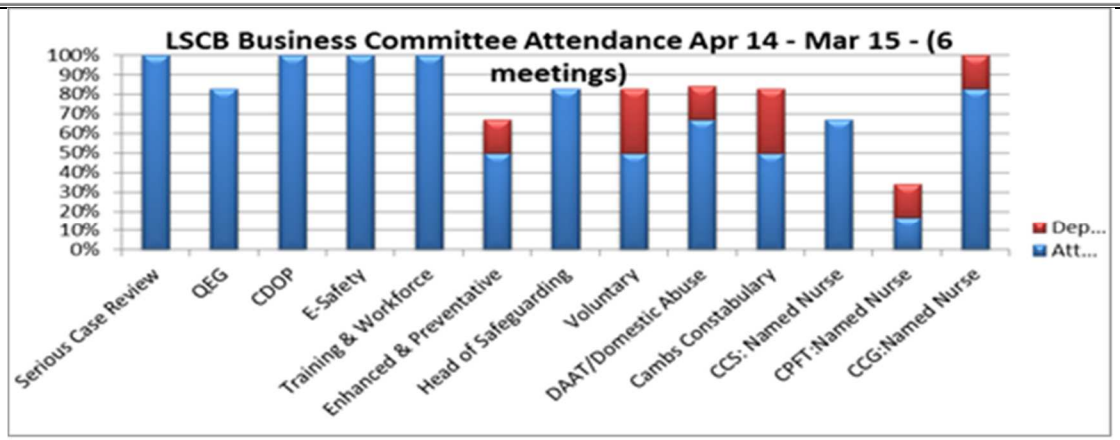
A new representative from the Voluntary Sector has joined the Board.

Were an attendance has not been consistently good this has been challenged by the Chair.





Comment. Following a review of membership, the comparison graphic has attendees in a different order to the previous year.



CDOP
The number of preventable deaths is not statistically significant – every year there are a number of deaths of infants due to unsafe sleeping arrangements. Last year the LSCB launched a safer sleeping campaign to ensure that the message that is given by all professionals is consistent and as far reaching as possible

Number of Deaths reviewed by CDOP where there were modifiable factors	
2011-12	5
2012-13	5
2013-14	6
2014-15	5
2015-16	6

Appendix 5: SOURCES OF INFORMATION ON SAFEGUARDING IN CAMBRIDGESHIRE

Title	Type of Information	Range and scope of the Information
Annual Dataset from LSCB	Data and Statistical Information	A range of relevant safeguarding processes
Agency attendance and Reports at CP conference	Multi-Agency Audit	CP Processes
CCS (NHS Health Community Services) Summary of Audits	Single Agency Audit	Agency or sector specific
Child Abuse Problem profile	Data and Statistical Information	CP Processes
Child Death Overview Panel	Report	CDOP
Children and Young People Survey: Disability 2015	Commissioned Survey of users	Voice of the Child
Children and Young People Survey: Disability 2016	Commissioned Survey of users	Voice of the Child
Children and Young People Survey: Domestic Abuse	Commissioned Survey of users	Voice of the Child
Children held in Cells	Report	Issue Specific
Safeguarding Children in Complex Circumstances Audit	Multi-Agency Audit	Issue Specific
Core Group Audit	Multi-Agency Audit	Issue Specific
CSC CP Annual Report and CP Quarterly Reports	Data and Statistical Information	CP Processes
CQC inspection report & action plan	Report	Agency or sector specific
Disability Audit	Multi-Agency Audit	Issue Specific
Education Annual Child Protection Monitoring Report	Single Agency Audit	Agency or sector specific
Elective Home Education	Report	Issue Specific
Enhanced and Protective Service Summary of Audits	Single Agency Audit	Agency or sector specific
Feedback on parent's perspectives on CP conferences	Report	Issue Specific
Health Executive Safeguarding Board Annual Report and quarterly updates	Data and Statistical Information	Agency or sector specific
Health Related Behaviour Survey	Data and Statistical Information	Voice of the Child
HMIC Inspection of Cambs Constabulary	Report	Agency or sector specific

Innovation Bid Project Dataset and report	Data and Statistical Information	CP Processes
LADO Annual Report	Report	Issue Specific
Missing Children: Care, Home and Education	Report	Issue Specific
Missing in education and home education	Report	Issue Specific
Cambridgeshire Police Summary of Audits	Single Agency Audit	Agency or sector specific
Private Fostering Report	Report	Issue Specific
Referral audit	Single Agency Audit	CP Processes
Report on Safeguarding of LAC placed outside Cambridgeshire	Report	Issue Specific
Safeguarding and Primary Care GP Sec 11 Audit	Single Agency Audit	Agency or sector specific
Section 11 audit 2015	Multi-Agency Audit	Agency or sector specific
The Participation Service Report	Report	Voice of the Child
Young Carers	Report	Issue Specific

Appendix 6 FINANCIAL STATEMENT 2015-16

Income:

Income	Contributions from partner agencies	Training	From Reserves	Total
2015-16	248,269	7,125	15,000	270,394

Up to 2016-17, Contributions from agencies have remained broadly static since the previous agreement to reduce funding by a standard percentage across all contributors. However, the budgets set and actual expenditure have reduced over time. The budget set in 2012-13 was £286,848. The budget set for 2015-16 (excluding the separately funded CSE post) was £244,418, a reduction of £42,430.

Expenditure:
Currently there is money held separately to fund the CSE Coordinator post for two years. The appropriate proportion of the money is brought into the LSCB budget each year to cover the cost involved. In 2015-16 Dave Sargent was in post for six months and £15,000 was transferred into the main budget. The cost of this post appears in the figures given below.

2015-16 Budget in £s	**Actual to End March 2016**	**Budget Remaining**
LSCB Unit Costs		
118,878.00	112,532.19	6,345.81
Chair Expenses		
42,500.00	38,248.48	4,251.52
Training		
75,891.00	68,334.08*	7,556.92
Serious Case Review Costs		
22,149.00	3,340.84	18,808.16
Total for the whole budget		
259,418.00	222,455.59	36,962.41

*income from training is accounted for in this sum

- The Chair expenses and SCR cost underspends exist because there was no SCR commissioned in 2015-16. The demand on these budgets is cyclical and underspends are carried forward to fund future demand, which could very significantly exceed £22,000 in any given year.
- The training underspend reflects the income level, which is variable and not predictable.
- No Business Manager was in post for three months in this financial year. This will have saved significantly more from the budget than the £6,345.81 total underspend. There were some additional costs to cover other staff absence, but less than the savings accrued from the vacancy.

Budget 2016-17

The budget for the current financial year has been set in line with that for 2015-16. However, contributions by one partner agency have reduced significantly and it will need to be reviewed. We have been informed by another statutory funder that they intend to make a reduction in their contribution in future years as they anticipate savings will be realised from closer working with the Peterborough SCB and Cambridgeshire Safeguarding Adults Board.

Appendix 7 GLOSSARY OF ACRONYMS AND TERMS USED

Acronym/Initials Used	Name	Description
CAMH	Child and Adolescent Mental Health	Secondary services covering child mental health
CCC	Cambridgeshire County Council	
CCG	Clinical Commissioning Group	Responsible for organising the provision of health services in the area
CDOP	Child Death Overview Panel	To identify the avoidable causes of child death and reduce or prevent future deaths
CJB	Criminal Justice Board	Strategic Board of agencies involved in the Criminal Justice System
CP	Child Protection	The formal multi-agency process for safeguarding children at immediate risk of serious harm
CPFT	Cambridgeshire and Peterborough Foundation Trust	Local provider of CAMH
CQC	Care Quality Commission	Health Inspectorate and regulatory body
CSC	Children's Social Care	CCC Division working with CP cases
CSE	Child Sexual Exploitation	Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status
DOLs	Deprivation of Liberty	The legal context that authorises controlling restrictions being placed on children and adults
GCP	Graded Care Profile	An assessment tool for Neglect
GP	General practitioner	
HWB	Health and Wellbeing Board	Statutory partnership responsible for integrating Health and Social Care provision
LPG	Local Practice Group	Open meetings for all staff involved in working with children to improve practice and communicate learning.
LSCB	Local Safeguarding Children Board	Statutory partnership responsible for monitoring and supporting effective safeguarding of children
MASE	Multi-Agency Sexual Exploitation	A meeting to coordinate the protection of individual children at risk from CSE
NICE	National Institute for Health and Care Excellence	National Health body responsible for setting Standards and Guidance on practice issues.
QEG	Quality and Effectiveness Group	LSCB monitoring and audit committee

SAB	Safeguarding Adults Board	Statutory partnership responsible for the safeguarding of adults with care and support needs
SCR	Serious Case Review	A Statutory case review held when a child dies or is seriously harmed where neglect and/or abuse is a factor.
TDWSG	Training, Development and Workforce Strategy Group	LSCB Training Committee