CAMBRIDGESHIRE SAFEGUARDING CHILDREN BOARD

Annual Report 2014-15

CONTENTS OF REPORT

1. INTRODUCTION

1. 1 It is my pleasure to introduce the Cambridgeshire local Safeguarding Children Board's 2014-15 Annual report.

1. 2 This has probably been the most challenging year for the Board since I first became the Chair in September 2009. Not only were we undertaking three serious case reviews, which puts enormous demands on both the LSCB staff and relevant partners, but in June we were, for the first time, inspected by Ofsted separately from but together with the Council's children's services. We were fortunate, however, that our annual conference fell in the middle of the inspection. Whilst at the time that just seemed like an added pressure, in fact, it enabled us to demonstrate to Ofsted the commitment of practitioners across Cambridgeshire to safeguarding in general and in particular this year to E-Safety. Our young 'cyber-mentors' warrant a special thanks, not least because in addition to speaking at the conference we then asked them to meet with the inspectors.

1. 3 This annual report sets out how, over the last 12 months, in addition to meeting the challenges described above, 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. 4 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. Particular recognition must go to our business manager, Josie Collier, who made a huge difference to our work during the three years she was with us and who left in April, thus leaving the preparation of this annual report to our new business manager, Andy Jarvis.

Felicity Schofield
Independent Chair

2. EXECUTIVE SUMMARY

2. 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.

2. 2 Within three months of the year starting the LSCB was inspected by Ofsted and was given a judgement of Good. Areas for improvement were identified, and progress on these is included within this report.

2. 3 Three Serious Case Reviews (SCRs) were undertaken during the course of 2014-15. Not only did the LSCB seek to reflect existing good practice in how it managed these reviews and the subsequent embedding of the learning, it actively worked to develop innovative practice in this area. Its success in doing so was highlighted in the evaluation undertaken by independent academic research.

2. 4 During both the Ofsted inspection and the SCRs, business continued as usual. The LSCB required of agencies evidence as to the quality of their work and challenged them to show improvement where needed. In addition to the development of a more comprehensive dataset, the Board and its sub committees commissioned surveys and requested reports to build a comprehensive and robust picture of services in Cambridgeshire and to be able to assure itself, and the wider community, as to the quality of work undertaken.

2. 5 This continued to be a challenging year for all agencies. They needed to improve services and meet increasing demand, but to do so with a reducing level of resource. This has made it even more important that the LSCB functions to assist them in meeting this challenge in a coordinated and coherent way, and to challenge them to demonstrate their continued safeguarding of children.

2. 6 The main sections of this report cover:

- 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, and the key agreements and documents that underpin its functioning.
- The actions of the Board in agreeing, implementing and reviewing its business plans. In addition to feedback on progress against the areas identified by Ofsted as requiring improvement, it summarises the work of the sub committees up to March 2015 in delivering against their business plans.
- The work done to ensure policy and practice are fit for purpose and effective. This summarises the work undertaken by the Board and Business Committee to ensure that the requirements of government and the learning from research and practice are reflected in local policies and procedures.

- The evidence available to the Board about its impact and that of the agencies involved.
- The range, scope and depth of information available to the Board to give assurance as to the quality of service provision and the impact of the developments being undertaken by the LSCB and key partners. Overall, workload remains high but there is evidence that the quality of work has been maintained.
- How it has learnt from serious case reviews and used that learning to change practice. An outline of the three SCRs undertaken in this year, their key recommendations, and how the process was managed within the LSCBs Learning and Improvement Framework.
- How it identified, delivered and evaluated high quality training. This section gives account of the multiagency training commissioned and delivered by the LSCB. However, it also covers work in place to ensure the quality of single agency training, the vital role of the Local Practice Groups in reaching front line staff, and our very well received conference on how to keep children safe in a digital world.
- The work of the Child Death Overview Panel. An outline of the process in place to review every child death in Cambridgeshire, identify any pattern and agree appropriate responses to minimise the likelihood of future avoidable child deaths.
- A number of agencies operate in Peterborough as well as Cambridgeshire. The LSCBs therefore work together to ensure consistency of approach and minimise duplication of effort. Together with Norfolk, they have successfully bid for funds to deliver a project to enhance safeguarding practice with the Eastern European Community.

2. 7 Cambridgeshire LSCB is confident that this report provides an accurate account of its work and presents evidence that it has met its statutory duties, making a measurable contribution to the safeguarding of children in Cambridgeshire.

3. PURPOSE OF THE 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. GOVERNANCE AND ACCOUNTABILITY

4. 1 The statutory objectives and functions of LSCBs are laid out in Working Together 2015:

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

4. 2 The structure and work plan of the Cambridgeshire LSCB are designed to meet the requirements laid out in this Guidance. They are in place to support it in meeting its critical role, to enable all agencies to achieve the best possible practice in safeguarding all children in Cambridgeshire.

4. 3 In June 2014, Ofsted conducted an inspection of the effectiveness of the local safeguarding children board as part of a wider inspection of services. Its judgement was that the Local Safeguarding Children Board should be rated as 'good'.

4. 4 This was in the context of Cambridgeshire County Council being assessed as 'overall good' for its arrangements for children in need of help and protection, looked after children and care leavers.

4. 5 Two years previously the judgment had been one of inadequate. The LSCB has played a significant role in supporting the Council and other partners as they achieved a sea change in the quality of the services delivered to children.

4. 6 The full Ofsted Report can be found at:

http://reports.ofsted.gov.uk/local-authorities/cambridgeshire

4. 7 With regard to the LSCB, the inspection judged that:

"Governance arrangements between the Local Safeguarding Children Board (LSCB) and the Local Authority are effective. The independent Chair of the LSCB has regular meetings with the DCS, Chief Executive and the Lead Member to ensure that the local authority is fulfilling its safeguarding duties."

4. 8 The LSCB has the following governance documents:

- Terms of Reference for the LSCB were approved in November 2013 which laid down the strategic purpose of the partnership and defined the monitoring activity of the LSCB.
- Terms of Reference for the Business Committee which 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 that reflect Working Together 2013 and 2015, which defined the purpose of the SCRs but devolved decisions around methodology and approach to the individual LSCB.
- A Learning and Improvement Framework that describes the approach that the LSCB has developed over the past three years in terms of the generating and embedding the learning from activity including SCRs, multi-agency audits, and from feedback from children, families and practitioners.
- LSCB Compact for signature (describes the mutual responsibilities of CCC and the Board partners).
- LSCB Memorandum of Understanding with the Cambridgeshire MAPPA Strategic Management Board
- LSCB Constitution and Memorandum of Understanding between the Children's Trust Board and Cambridgeshire Local Safeguarding Children Board.
- Protocol between the Cambridgeshire health and well-being board, the Cambridgeshire local safeguarding children board (LSCB) and the Cambridgeshire safeguarding adults board (SAB)
- A Committee Structure (please see Appendix 1 for the structure diagram)
- Terms of Reference for the sub-groups

4. 11 These documents are reviewed as part of the annual reporting/business planning cycle and are available on the LSCB website.

4.2 Chairing of the LSCB

4.2. 1 The LSCB is chaired by an independent chair, Felicity Schofield, who has been chair since 2009. Working Together 2013 assigned the responsibility to appoint and hold to account the Chair of the LSCB regarding the effectiveness of the LSCB to the Chief Executive of the Local Authority. The Independent Chair has regular one to one meetings with Cambridgeshire County Council's (CCC) Chief Executive and the Director of Children's Services

4.2. 2 In Cambridgeshire, the independent chair of the LSCB also chairs the Business Committee, the Serious Case Review panel, and the Child Death Overview Panel. This arrangement is designed to bring continuity and consistency to the overall delivery of the Business Plan.

4.2. 3 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.

4.2. 4 The independent chair of the LSCB continued her consistent attendance at the Children's Trust Board meetings, the Local Authority Next Steps Board and the Domestic Abuse Governance Board. There was also complementary attendance by a member of the LSCB Business Unit at the Children's Trust Area Partnerships, the Improvement Board (where required), and the Domestic Abuse Implementation group.

4.2. 5 The impact of this approach has been the improved ability to spread significant messages

about safeguarding across the county, such as Safer Sleeping, as well as the learning from Serious Case Reviews.

4.3 Participation of partner agencies in the LSCB

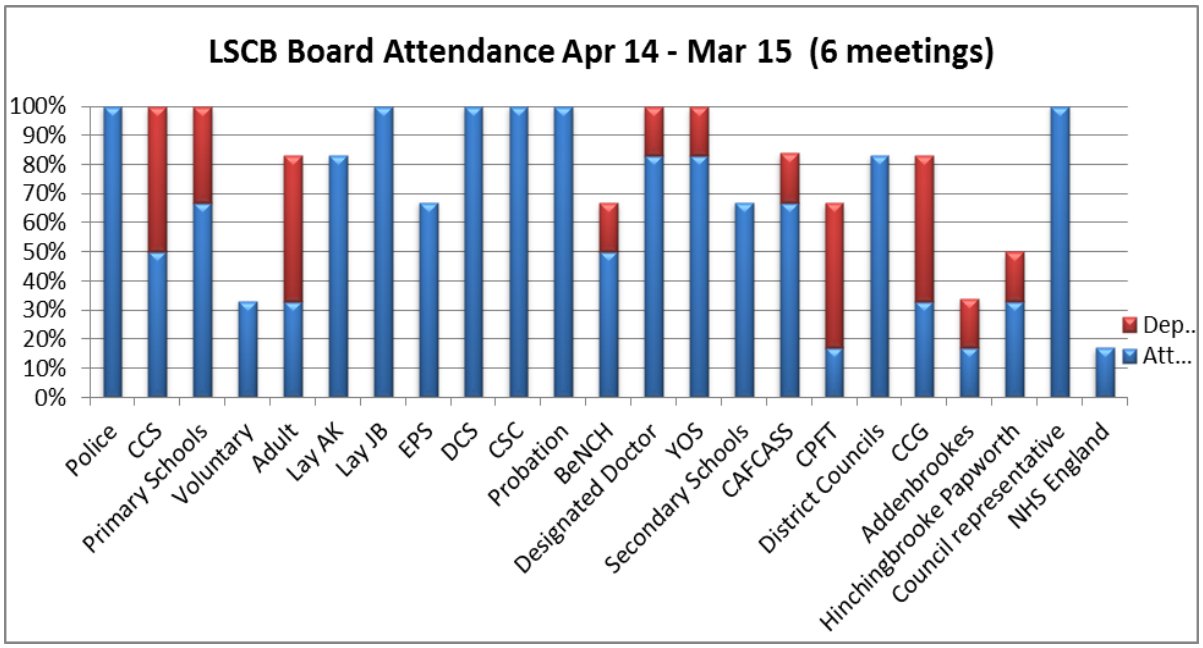
4.3. 1 **Attendance at LSCB Board meetings.**

The graph below depicts the level of attendance by agencies for the 6 meetings that took place over the year. Most of the agencies sent a deputy where the representative was unavailable. Overall the attendance and commitment of Board members was very good. The presence and contribution of the Lay Advisors has continued to be of significant benefit to the Board in adding additional independent scrutiny and comment. After a significant amount of work identifying new representatives, attendance from schools has been far better this year. If a Board member failed to attend two consecutive meetings, this was challenged by the Chair.

4.3. 2 The Board was advised in February 2015 that following a reorganisation and resource reduction, NHS England was no longer able to attend the Board. This issue applies across the region but not across the country as a whole. Clarification is being sought at a National level.

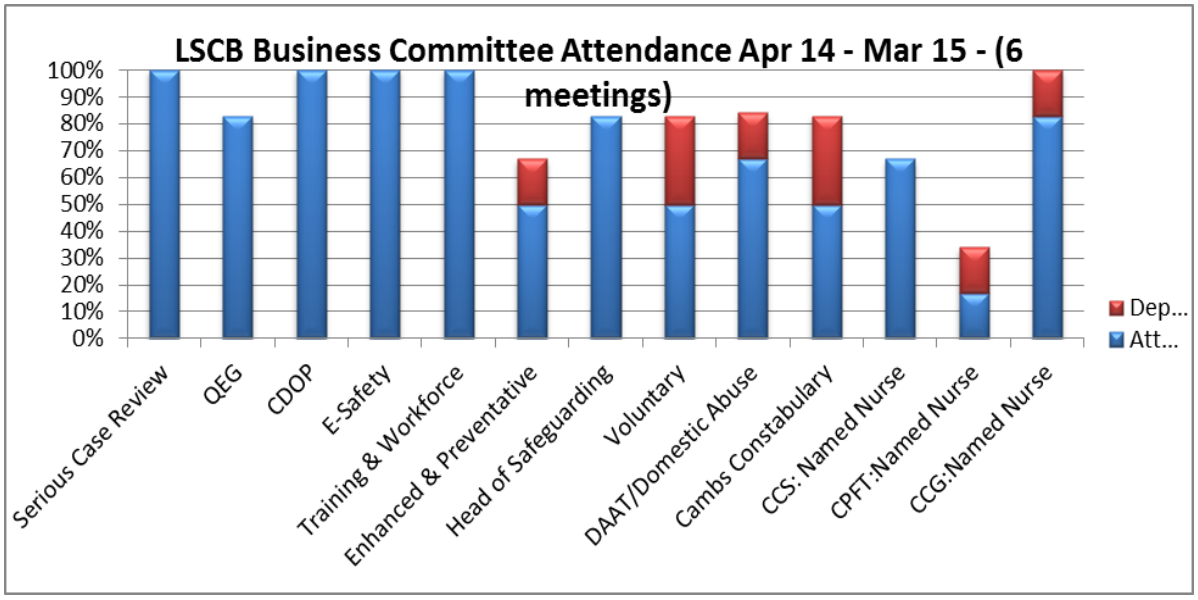
4.3. 3 Part way through this financial year, it was agreed that, with the exception of Cambridgeshire Community Services (CCS), our largest community health provider, the other health providers would be represented through their commissioning bodies who seek assurance on their effectiveness in safeguarding via the Health Executive Safeguarding group.

LSCB Board Attendance 2014-5 (6 meetings)

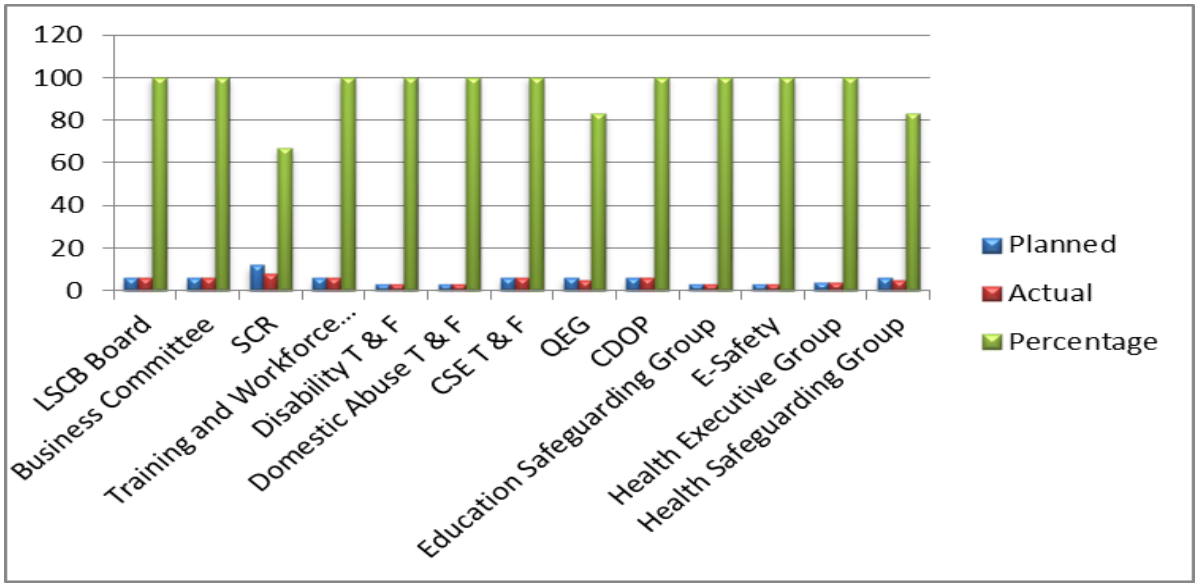


LSCB Business Committee Attendance (6 Meetings)

4.3. 4 The changes made to the Business Committee have now bedded in and the membership stabilised. Broadly, commitment to attendance mirrors that at the full Board.



LSCB sub-group activity.



4.3. 5 The figures above depict the number of LSCB-subgroups that took place during 2014-5. Where less than 100% of potential meetings took place this was often because the meetings were not deemed to be necessary. Most groups meet on a bi-monthly basis however the SCR sub-group is planned to meet on a monthly basis. Where there is not enough business to justify using partners' time, or the members are meeting in a different forum the meeting is cancelled. Such cancellation shows responsiveness to the need of

partners without a significant loss of effectiveness

4.4 The LSCB Budget.

4.4. 1 The LSCB has a budget made from multi-agency contributions from the following agencies in 2014-5

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

Details of the budget can be found at Appendix 5.

5.CHALLENGE AND SUPPORT

5.1 Ofsted Areas for improvement

5.1. 1 Whilst Ofsted was generally very positive about the LSCB, a few areas for improvement were identified:

"A comprehensive data report should be developed to enable partners to understand performance across all services and to identify and challenge areas where improvements in practice are required."

5.1. 2 A new dataset report was provided to the LSCB that reflected the recommendations from Ofsted. Work continues to progress as the LSCB applies the learning from good practice elsewhere and refines its capacity to make effective use of the available data in assessing and challenging service delivery across agencies. It is planned that there will be further improvements to the dataset that build on the achievements in 2014-15:

"*The LSCB training strategy should be informed by analysis of the child protection training undertaken by different professional groups across all partner agencies.*"

5.1. 3 A survey was initially completed in July 2014 and finalised as a bench marking exercise in December 2014; its findings have been built into the Training Action Plan. The exercise will be repeated on an annual basis to assess progress and is timetabled for July 2015. A robust process for validating single agency training is in place:

"The LSCB and health commissioners should ensure that there is a cohesive approach to the provision of child protection medicals in acute cases."

5.1. 4 NHS commissioners and the Cambridgeshire Constabulary have sought to establish a consistent level of provision. The initial commissioning process did not result in a permanent solution. An interim contract is in place and a further round of commissioning is in progress.

"The LSCB business plan lacks detailed actions that can be clearly measured and monitored by the Board."

5.1. 5 The Board prepared, and subsequently agreed, an Annual Plan with a focus on identifying "SMART" actions but has required further refinement of detailed actions with a set timescale for completion.

5.1. 6 In addition, the report highlighted that:

"The LSCB has developed a learning and improvement framework which, although helpful, does not yet use learning from complaints to influence service developments."

5.1. 7 A Report on Complaints has been built into the Board work stream to ensure the lessons are highlighted and acted upon.

5.2 Action Plan Progress

5.2. 1 The LSCBs priority areas in 2014-15 were in tackling Child Sexual Exploitation, meeting the needs of children suffering from the impact of Domestic Abuse and reviewing and improving services for disabled children. A specific campaign on Safer Sleeping was run through the LSCB following CDOP identifying a pattern of avoidable deaths

5.2. 2 In addition, there was a particular focus on further increasing the impact of the LSCB through:

- Developing a fit for purpose dataset and structured monitoring of partner agency effectiveness
- Building the voice of children into policy and process developments
- Launching a new website as the main point of contact for front line professionals, children and the public
- Applying and embedding the learning from SCRs through innovative approaches to communicating with the staff involved

5.2. 3 Items underlined indicate a significant use of evidence about work in Cambridgeshire or a benchmarking exercise to assess local compliance with good practice.

5.3 Child Sexual Exploitation (CSE) & Missing Children

5.3. 1 During the last 12 months the Joint Cambridgeshire and Peterborough CSE Implementation group has reviewed and revised the referral pathway for CSE. A joint Child Protection and CSE referral form was developed and successfully introduced. The Group revised and reissued the CSE risk assessment tool following a review of the effectiveness of the initial approach taken. This has embedded CSE into the main safeguarding referral process, thereby encouraging the referrer to think about CSE for any referral. These changes gave greater clarity to partner agencies' understanding thresholds for CSE.

5.3. 2 To complement the work of the strategic multi-agency Implementation Group, the partner agencies have formed an operational overview meeting to discuss themes, trends and live operations at a more tactical level. Linked to this operational group, the LSCB has agreed a revised approach to meeting the needs of individual children at risk of CSE. This is the Risk and Vulnerability Meeting (RVM), which will be held to devise a safety plan for a young person who has been identified as being at risk of CSE. This new approach was needed because children at risk of CSE do not easily fit into the existing child protection processes.

5.3. 3 Children who are missing or absent are at particular risk of CSE. Agencies have therefore been working to ensure that their processes are fit for purpose in both keeping safe the individual children and identifying any pattern of potential victims across the county.

5.3. 4 To follow up a major awareness programme in schools last year, a list of approved resources has been provided to schools in order to continue the momentum generated by the Chelsea's Choice drama production.

5.3. 5 Key agencies have benchmarked services against the findings from Rotherham and can demonstrate compliance with good practice.

5.4 Disability Tasking and Finishing Group

5.4. 1 The group has refined the scope of its work. Parental representation on the group has been achieved and work has been commissioned to consult children and ensure they have a voice in the planning and development of services.

5.4. 2 A major conference on neglect, being undertaken with Peterborough LSCB, has been initiated and will take place during 2015-16 to promote the consistent use of the Graded Care profile.

5.4. 3 An audit of practice in relevant cases was undertaken and the recommendations made are being implemented.

5.5 Domestic Abuse Tasking and Finishing Group

5.5. 1 Consistent use of the Domestic Abuse Risk Identification Matrix has been supported by the circulation of the tool and an intensive training programme. Training is now in place as part of mainstream delivery.

5.5. 2 Working with the county wide strategy group, a domestic abuse "Offer" of available services has been developed that mirrors the Model of Staged Intervention (MOSI) that is used to guide staff in identifying which services match the specific needs of children. This work has been undertaken alongside the active support of the LSCB in the development of the Multi Agency Safeguarding Hub (MASH). There was a limited response to a Youthoria survey regarding domestic abuse, so a further consultation project was commissioned with 6 young people's groups around the county. This covered both living with parental domestic violence and inter young person relationship violence. The results were reported in April 2015

5.6 E-safety Group

5.6. 1 The LSCB ran a highly successful conference in June 2014 'Digital Naivety – How do we keep Children safe?" Attendance was up two thirds on the previous year and well over three quarters of the attendees rated the Conference as good or excellent.

5.6. 2 Following a review of effective working there has been a reduced frequency of meetings to quarterly. The group reviewed its strategy and action plan in light of recommendations on policy made by EU Kids Online Network.

5.6. 3 The available resources on the website were reviewed and updated.

5.6. 4 The E-safety audit tool has been revised, and following this an initiative to have E-safety Champions in each of the Locality Teams has been undertaken, supported by training that has now started. The desired outcome is to enable staff to run e-safety sessions with parents as another means of trying to get the message across to parents.

5.6. 5 To ensure practice is based in the best available evidence, a session with the Internet Watch Foundation was held looking at their most recent research.

5.7 Education Safeguarding Group

5.7. 1 This group needed to manage a number of new Government initiatives with which schools needed support when responding. These included:

- Disqualification by Association, which was launched with appropriate advice and guidance as clarification was received from the Department for Education. This has been managed into place effectively with minimum disruption to children or staff.
- Heightening the profile of the Prevent Agenda and achieving a proportionate response.

5.7. 2 The group has worked alongside the CSE Implementation Group (see above) and overseen the implementation of relevant SCR recommendations. It has also introduced "Children's Safety Matters" which covers personal safety in early years settings.

5.7. 3 There has been a focus from the Learning Directorate on Safer Recruitment. The Board was provided with the results of an audit to give assurance as to local compliance.

5.8 Health Safeguarding Group.

5.8. 1 Much of the year has been dominated by one high profile criminal case that has led to an intense scrutiny of practice and procedures regarding safe recruitment and the chaperoning of children and young people. There has been a high level of participation by health in the multiagency developments to address this area of risk to children.

5.8. 2 Health professionals have fully participated in LSCB audits and the Learning Framework, including the recommendations made in the SCRs.

5.8. 3 There has been an active response to the Government's "A Call to End Violence against Women and Girls. Action Plan March 2014" and the identification of key staff, together with required training, has followed.

5.8. 4 Practice around Child Sexual Exploitation has been benchmarked against the working group guidance and gaps addressed**.**

5.9 Female Genital Mutilation

5.9. 1 Whilst not a formal subcommittee, there were two multi-agency meetings held within the auspices of the LSCB to coordinate the response to Female Genital Mutilation, including a high profile publicity campaign to increase staff awareness and competence in responding to this abuse where it arises.

6 POLICIES AND PROCEDURES

6. 1 The LSCB reviewed its procedures in light of Working Together 2013, taking the opportunity to simplify its structure and make the content more accessible for users. The agreed procedures were published in the summer of 2014 and are available on the LSCB website.

6. 2 In addition to ensuring that LSCB policies and procedures were in line with the latest government guidance and learning from research and Reviews, the Board placed considerable emphasis on:

- The use of surveys and research to support the use of the views and perspective of children and service users in the development of policy and strategy.
- Developing clarity and coherence in the work undertaken at all levels of need, particularly in Early Help. This was achieved through a CAF position statement (the end product of a major review and evaluation process) and a review of 'What if' discussions which resulted in revised guidance. The former provided evidence of the implementation of an e-form, guidance on the lead professional role, an interface between CAF and SEN, and a more streamlined planning template in the documentation.
- An expectation that agencies will provide information on major changes in service delivery, whether from resource pressures or for any other reason, and will consult with partners at an appropriately early stage.
- A continuing focus on the need for a joined up approach to "Missing" children that covers police, education, CSC and health process, and which consistently provides information relevant to the identification of CSE.

7 MONITORING AND EVALUATION

7.1 Quality and Effectiveness (QEG) Group

7.1. 1 QEG has monitored the work of agencies and evaluated the quality of services received by children through:

- Developing a process to report, validate and utilise single agency audits
- Undertaking multi-agency audits of service delivery and ensuring any lessons learnt lead to improvements through recommendations and action plans.
- Initiating a requirement for partner agencies to provide evidence of Section 11 compliance, with analysis and validation to follow in 2015-16.
- Coordinating a planned approach to auditing through the use of an audit plan

7.1. 2 This year's multiagency audits have included:

- Practice within substance misuse agencies, with a re-audit timetabled to measure the impact of changes made in line with the audit recommendations.
- Practice with disabled children, with the recommendations to be implemented through the Disability Task and Finish Group in 2015-16
- A review of referrals to CSC and compliance with the current procedures.

7.1. 3 Key outcomes from QEG this year have been:

- CSE referral process and referral forms have been generated from the audit recommendations
- The CSE strategy has been informed by the audit and priorities set by evidence from front line practice alongside national and local guidance and learning.
- The Board can be assured that a robust referral process and good levels of communication are in place and functioning
- An evidence based monitoring and evaluation of the Child Protection Conference process

7.2 LADO Annual Report

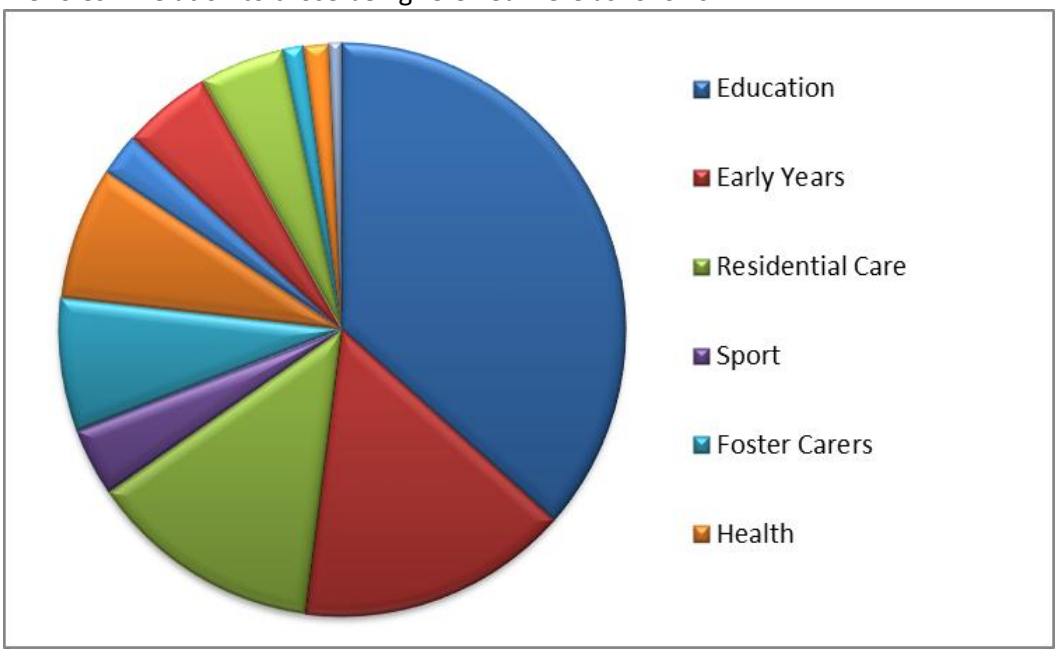
7.2. 1 Working Together to Safeguard Children was updated in 2015 and requires local authorities to have a designated officer or a team involved in the management and oversight of allegations against people that work with children. The guidance states that any such officer should be sufficiently qualified and experienced to be able to fulfil this role effectively. The existing Unit complies with this requirement.

7.2. 2 A total of 413 referrals were received into the LADO Unit. This is a 45% increase in the number of referrals over the preceding year, when there were 285. The LADO interprets this increase as evidence of increased awareness of their role, especially across health agencies.

7.2. 3 55% of referrals received during 2014/15 did not meet the LADO threshold for action (this is 32% less than last year's figure of 87%). 25% required the agency or organisation to undertake their own internal investigation using the agency's disciplinary procedures, referring back to the LADO if the concern increased. The LADO service offers advice to partner agencies about any concerns about a member of staff and their relationship with children. Overall, the service is satisfied as to why a significant number of referrals did not require action from the service.

7.2. 4 Whilst there has been a significant increase in the number of referrals into LADO over the course of 2014/15, there remains consistency as to the number of these referrals which meet the threshold for LADO intervention as stated within the "Working Together to Safeguard Children 2015" guidance and the Cambridgeshire LSCB procedures. This would suggest that the triage procedure used by LADO is robust and effective.

7.2. 5 The roles in relation to those being referred were as follows:



7.2. 6 The outcome of the 413 referrals is as follows:

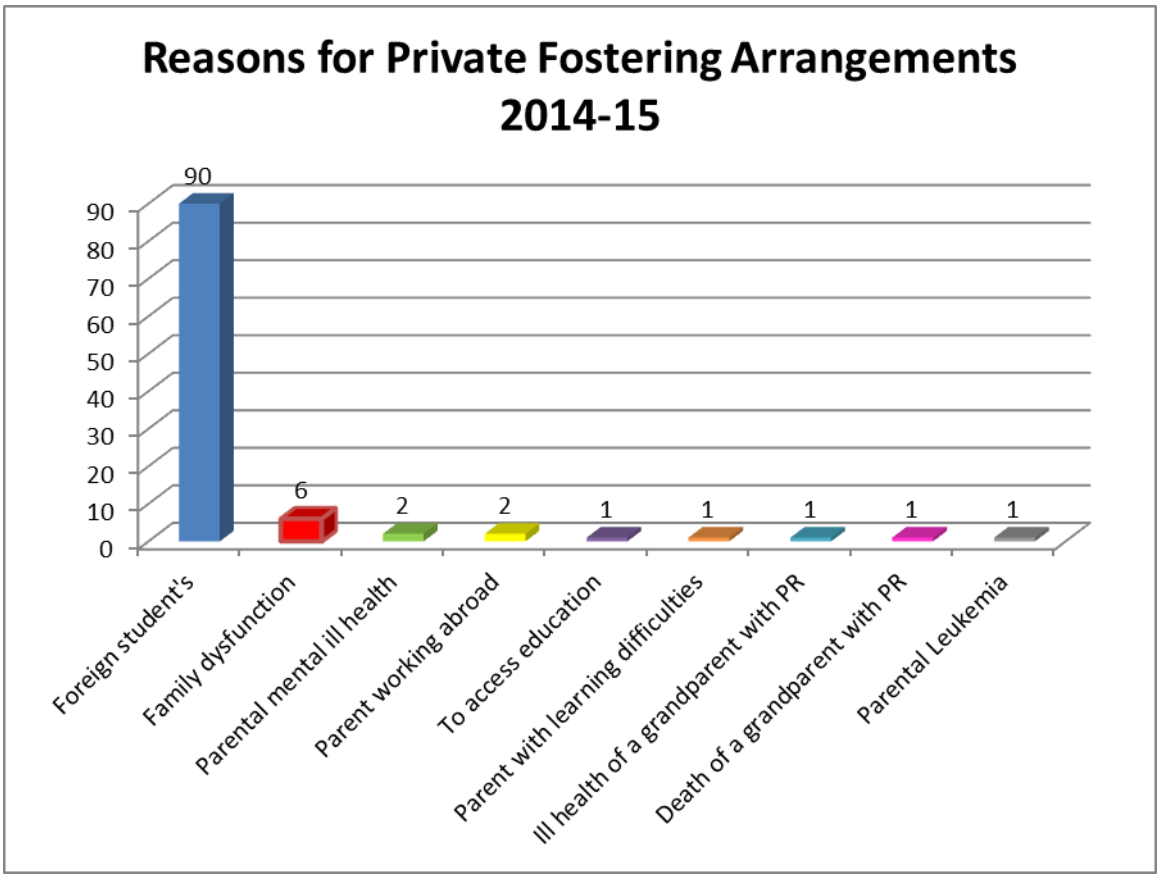
	Year total	%
No further action	226	55%
Internal investigation	103	25%
Complex Strategy Meeting held	68	16%
Outcome pending	16	4%

7.2. 7 Of the 103 that led to an internal investigation, the outcome was as follows:

	Year total	%
Substantiated	28	27
Unsubstantiated	52	50
Unfounded	9	9
Malicious	0	0
False	3	3
Not concluded/outcome unknown	11	11

7.3 Private Fostering

7.3. 1 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. The reason for this is the high number of language schools that specialise in teaching foreign national children, often on short term placements. The demographics and needs of this group are significantly different from those in other private fostering placements.



7.3. 2 There is confidence that the schools notify the Local Authority about relevant placements as required. The quality of the checks and safeguarding practice by the schools is variable but the minimum standards in place remain at an acceptable level. Checks are carried out by the private fostering service within Children's Services on the placement family and there is a meeting with them. The contact of the children with their originating family/parents can be variable, in part depending on the culture of the families involved.

7.3. 3 Nationally there is thought to be a significant underreporting of mainstream private fostering and this is likely to be true in Cambridgeshire. Placements happen for a wide range of reasons and the weight given to the child's needs and wishes is variable. There is a greater level of checking and scrutiny for these placements and more involvement with the family members than is required with language school placements.

7.3. 4 There is a proper structure in place to ensure oversight of the child's safety and welfare by the Local Authority.

7.4 Thematic Review of Safeguarding Arrangements in NHS Provider Trusts

7.4. 1 The LSCB was assured of practice within the Health sector following the provision of a report from the commissioners in September 2014. During 2013/14 the Safeguarding Team at Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) completed a programme of 'deep dive' reviews of safeguarding arrangements for all major NHS providers as part of the NHS contract. All of the health organisations reviewed had declared overall compliance with Sec 11 of the Children Act 2004 and had an action plan in place to address any areas of weakness. The Review did not find any examples where an organisation was falling significantly short of its statutory responsibilities, for example in relation to governance arrangements, supervision or training. It did however highlight some areas of concern and made recommendations for areas of improvement.

8. KEY DATA ABOUT THE CHILD PROTECTION SYSTEM

8..1 As in previous years, high quality data has been provided by CSC on a quarterly basis, with an annual summary (attached as Appendix 4). This has been enhanced by information from other agencies, including the police, and the provision of health data was developed during the final quarter of the year. The dataset available to the Board is now wider in scope and includes a more complete summary of the relevant information available to agencies.

8..2 At the end of March 2015, Cambridgeshire had 387 children subject to a child protection plan. This represented 30.34 per 10,000 children in Cambridgeshire. This compares with 33.0 per 10,000 children for our statistical neighbours and 42.1 per 10,000 nationally. Despite a recent rise in numbers, Cambridgeshire continues to have a lower number of children subject to a child protection plan than other similar areas.

8..3 The level of demand in requests for initial child protection conferences and the subsequent making of plans reflects the demand at the 'front door' within Children's Social Care. The children subject to child protections plans decreased slightly during the year but rose again to 387 in March 2015, a similar number as March 2014.

8..4 The increase in conferences has been maintained and it can be demonstrated that this has not impacted on either professional attendance or participation within conference, nor on the careful safety planning for children. Indeed, when compared to eastern regional authorities, Cambridgeshire performed better than others regarding the timely holding of conferences and not having children subject to plans for longer than two years. Both of these figures evidence a good multi-agency conference process which is closely monitored and provides effective planning for children.

8..5 The effectiveness of the child protection system has been scrutinised by both the Council's Improvement Board and the LSCB. Variations in the numbers of children with a plan have been carefully reviewed.

9. LEARNING AND IMPROVEMENT

9.1 In May 2013 the LSCB agreed a Learning and Improvement Framework. The Framework describes the approach that the LSCB has developed over the past three years in terms of generating and embedding the learning from activity including SCRs, multi-agency case audits, and from feedback from children, families and practitioners.

9.2 During 14/15, three SCRs were completed, two of which were published together in early 2015 and the third in June 2015. These reviews are summarised briefly below, with the full overview reports being available on the LSCB website.

9.3 The first review, child H, was about the murder of a 2 year old girl by her mother's teenage boyfriend. The boyfriend is currently serving a life sentence.

9.4 The conclusion of the SCR was that there was no evidence that the girl's death could have been either predicted or prevented by the professionals who knew the family. The reason for this was because there was nothing in the boyfriend's past that indicated that he might commit such a violent act. In addition he had only been in a relationship with the mother for a short period time. During that brief period some deterioration in the children's welfare had been identified and the case had been recently opened to children's social care services. However none of those concerns gave any indication that child H was at serious risk of harm.

9.5 As part of the review, some areas were identified where practice could have been improved, notably, the importance of practitioners across all agencies thinking about all the children in a family, the need for social workers to avoid verbal agreements with families except for very short periods of time and the need for referring agencies to seek the consent of families before making a referral to children's social care.

9.6 The second review, child J, was about the serious sexual assault of a 4 year old girl. Her stepfather is currently serving a 17 year prison sentence for the assault.

9.7 The conclusion of this review was that whilst the serious assault could not have been predicted, with hindsight, it is likely that the girl had experienced an earlier incident of serious harm in the weeks prior to the sexual assault.

9.8 The review found that agencies worked well together to protect the girl once the assault had been identified in hospital, although clearer advice to nursing staff when she was first admitted would have been beneficial. There was other learning for the medical profession with regard to the need to speak to children directly, to alert and consult with colleagues in children's social care if deliberate harm is a possibility and of the importance of following up referrals to specialists, especially if there are potential safeguarding concerns.

9.9 The third SCR, child K, was about a 2 year old boy with severe disabilities who died from an overwhelming infection but who was also found to be under-nourished. He had been made the subject of a child protection plan in the weeks leading up to his death. Whilst the infection was not preventable, the boy's underlying malnutrition and dehydration may have contributed to his death. His mother accepted a caution for cruelty.

9.10 The review found that the many practitioners involved in his care and in the support of his vulnerable young mother did not collectively appreciate the full extent of the mother's difficulty in caring for him and therefore the risks that he faced. The focus of their involvement was his disability and at times there was insufficient recognition that he also needed to be more actively safeguarded.

9.11 The learning from all three of these SCRs has been and continues to be shared across the children's workforce. This was done firstly through a joint initiative with the NSPCC and the Tavistock clinic entitled 'Embedding the Learning' which consisted of identifying key themes from the reviews and then inviting a large number of practitioners to workshops where they were encouraged to think about how their practice could change as a result. Whilst the impact of such events is difficult to measure, the enthusiasm and commitment of practitioners from many different agencies and organisations to attending and participating in these events demonstrated a real desire to improve services for children and their families.

9.12 In addition, the Serious Case Review sub-group has signed off and continues to monitor the progress of implementing both single agency action plans from each of the SCRs and a combined Learning and Improvement Action Plan which captures the multi-agency learning from all three of the reviews.

10. DEVELOPING THE SAFEGUARDING WORKFORCE

10.1 Attendance at LSCB training opportunities

10.2 1 LSCB training attendance remains strong and the need for LSCB training places and safeguarding topics increases year on year. 2014 – 2015 has seen a continued increase in attendance and the training opportunities offered to agencies through Cambridgeshire LSCB. Training opportunities available reflect the identified need from serious case reviews, section 11 findings, national direction and local priority safeguarding issues

10.2 LSCB Training Courses

10.2 1 55 training courses were provided to practitioners covering 42 safeguarding topics, at those events 755 practitioners attended (94% attendance) an increase of 2% attendance as compared to last year. Slightly fewer courses have been provided (2) with fewer people attending (74 people) as compared to last year though there has been a significant increase in the conference and LPG attendance.

10.2 2 There has been a positive spread of attendance across all of the professional roles, this year (as measured within Working Together 2013). Enhanced and Preventative sectors attendance has significantly increased (23%) and social care representation remains strong, when compared to their overall representation within the workforce. Education representation has increased (40 % - 31 people) as too have the police (16 extra people). Health attendance remains strong and there has been a variety of health professional roles in attendance compared to previous years. Early years services have remained static (18 people attending) though they are under-represented in terms of their overall workforce. For the first time we have had 2 people from the Adult Sector attending the LSCB training

10.3 Evaluation of LSCB training.

10.3 1 Both the LSCB and the Business Committee receive regular reports on various aspects of multi-agency safeguarding training. This ensures that in addition to the training events set out in the annual training calendar, the LSCB can respond to emerging need over the course of the year. This ensures, for example, that any learning from serious case reviews is timely.

10.3 2 The recent Ofsted inspection concluded that 'the LSCB provides a comprehensive and high quality training programme which is well attended by all agencies. There is a pool of multi-agency trainers and training is accredited to ensure that it is of a good standard. LSCB trainers have worked hard to ensure that the voice of children is heard through training and this is a strong theme in the Board's work'.

10.3 3 LSCB courses continue to be recorded, in the main, as 'Excellent' or 'Good' in terms of the achievement of the aims and learning outcomes, delivery and materials. The evaluation of the courses indicates that participants value the LSCB training and gain knowledge, awareness and an increased confidence in working with safeguarding children and young people. Consistent comments received across all of the training, on how the course has improved practice, are not

dissimilar to previous years' evaluations, indicating that the LSCB training is a 'grounded and well established training resource in terms of safeguarding'. Practitioner comments include:

- Considering the impacts from the child's point of view
- Improved confidence / clearer about my responsibilities
- Be brave and ask the difficult questions /Ideas for questions to help me access risk and parenting capacity for assessment
- Networking with other professionals/ Understanding multi-agency terminology
- Enhanced the ability to reduce and identify risk

10.3 4 Comments regarding the need for improvement were about practicalities such as venues and no lunch being provided which was similar to previous years. Certain individual trainer styles were not agreeable to a few of participants (i.e. they felt challenged / one specialist session too much power point no exercises / ability of facilitators) and there were a couple of concerning comments in relation to 'understanding' topics and safeguarding; where participants were spoken to individually and management support offered.

10.3 5 The general understanding of practitioners around cultural competence is a concern raised in previous training impact reports. As a result, the wording on the evaluation form has been amended and early indications show that this is a useful section enabling practitioners to reflect whilst reassuring the LSCB that participants do understand safeguarding within cultural competence.

10.4 Impact of the LSCB training on Practice

10.4 1 The LSCB receives an annual report regarding the impact of its training on practice. That said, it must be acknowledged that it is difficult to measure, with full accuracy, the impact on children and families in terms of safeguarding as a result of practitioners attending the LSCB training and local practice groups. This is because fluctuations in child protection referrals and improved assessments and practice, for example, could be due to a number of variables and not just attributed to LSCB training. However, what is clear is that practitioners and their managers comment that the LSCB training has improved their confidence, skills and knowledge and helped them to identify safeguarding concerns.

10.4 2 Managers' comments supporting the learning of practitioners include:

- The training has made XX more aware of the possible reasons for particular behaviour exhibited by children.
- There are now daily Staff briefings which have been recognised as paramount to discuss, reflect and record
- In supervision we have discussed perhaps the need to identify a key person within the locality to contact regarding this topic to ensure information is shared and awareness is raised across the team

10.5 Attendance at Local Practice Groups (LPGs)

10.5 1 There are four local practice groups which cover Cambridgeshire, that are successfully led by social care, health and Locality Team planning groups. During 2014 a fifth local practice group was set up within the MASH (Multi-agency Safeguarding Hub).

10.5 2 The success and popularity of the LPGs is demonstrated by an overall increase of 18 % (692

practitioners) compared to last year.

10.5 3 308 practitioners attended this year's regular local practice groups, which covered a wide range of safeguarding topics including the latest briefings on Cambridgeshire Serious Case Reviews and child trafficking.

10.5 4 From the general LPG topics, there was good representation from children's social care (16 %), health (21%) and the enhanced and preventative services (28%) which is roughly representational of the overall workforce. Education has slightly increased, with Early Years services and the adults sector remaining under–represented.

10.5 5 Presented separately as specialist LPG's were the domestic violence risk identification matrix (10 events 177 practitioners), safer sleeping campaign (104 attendees) and embedding the learning / action change groups (103 attendees). Within the specialist LPG's there were similarities in terms of job roles and attendance though within the safer sleeping LPG there were more health professionals. The safe sleeping campaign will continue into 15/16 aiming at a wider professional audience.

10.6 Evaluation of the Impact of Local Practice Groups

10.6.1. The LPG's continue to be well received and evaluated positively in terms of learning and improving practitioner knowledge and skills. Our recent Ofsted inspection noted the positive impact of these groups and this form of learning. The report stated that LPG's 'provide a critical forum for disseminating learning from audits and management reviews, providing training and hearing directly from front line practitioners. This is an effective mechanism for communication both to and from the Board'.

10.6.2. Some salient feedback points from the practitioners who attended the groups were

- Really good like these bite size sessions – thank you
- Good information about the cultural differences and perceptions
- Going through the SCR's – well presented!
- Networking! / Discussions with different professionals
- Key message of think sibling
- I would like to extend the subject to staff training but also student and parent sessions
- Could do with being longer to explore more

10.6.3. The Embedding the Learning (ETL) workshops initiated the process of putting into practice what we have learned from Serious Case Reviews and gave a platform for case and interagency discussions; the University of Bedford evaluated the project and noted:

- The discussion taking place in the group was consistently positive, with a high level of participation and a good level of analysis of the topics.
- Facilitators were also able to identify action points arising from the Learning Groups that they felt would not otherwise have happened.
- Questionnaire respondents highlighted 'having time to reflect' as the most important benefit of attending the groups, followed by meeting other people, identifying new ways of working and improving understanding

(Embedding Learning Approach for (Serious) Case Reviews: Evaluation of Cambridgeshire Pilot –

Summary Report: Patrick Ayre and Isabelle Brodie – University of Bedfordshire: February 2015)

10.7 LSCB Conference 'Digital Naivety – How do we keep Children safe? – 11 June 2014'

10.7 1 157 professionals attended the annual conference, which was an increase (62%) on last year's number of attendees. The Conference was aimed at practitioners and managers across the partnership and the majority of those who attended were either working with children, young people and their families (59 % practitioners) or managers (35%). There was a significant increase in lead professionals, strategic managers and LSCB board members. 84% of attendees were recorded as women, slightly more men than previous years, and 80 % were recorded as White British with an increase in ethnic minority attendees.

10.7 2 The majority of participants rated the organisation of the day as 'excellent to good' (97%) which was a significant increase (20%) from last year. There was particular praise for the Beat Bullying speakers, which included several young people from a local school.

10.7 3 The six workshops received roughly equal positive responses with the majority of people rating them as excellent to good. An illustration of one of the themes highlighted throughout the day by practitioners, was noted by one social care practitioner; 'The workshop was excellent – really informative and inspiring. Even as a Social Worker I was shocked at some of the information. I will consider how this might impact on future practice'. For some, the conference was a 'strong influence and learning experience'.

10.7 4 There were many exemplary comments to support the overall success of the 2014 LSCB conference; including:

- Knowledgeable speaker. Brilliant workshop I have learnt so much about online safety and wish to feed this back to people I know not just at work but friends and families with children and what they can do to keep their children safe online
- Confidence to discuss online relationships and internet safety with service users Referrals and signposting with concerns

10.8 Life Experience – Voice of the Child

10.8 1 The LSCB training continues to include young people and families within its training events to give a real lived experience of their lives and to offer advice to professionals about how best to work and support them.

10.8 2 The LSCB conference had a significant impact on professional's beliefs and practice with four 'beatbullying' young people volunteers facilitating to an audience of 200 professionals.

10.9 Validation of Single Agency Training

10.9.1. The LSCB has an 'expectation' that all single agency training courses on safeguarding children should be validated so that their content is consistent, up to date and gives the correct safeguarding messages and information to recipients. The Training, Development Workforce Strategic group has validated five courses this year. On reflection, this is a small number of submissions and it is hoped that more agencies put forward their training for validation over the coming year.

10.10 Bespoke LSCB Training

10.10.1. A number of bespoke training opportunities have been provided to those single agencies where it is recognised that the messages on safeguarding need to be taken to them. This year this has included primary school heads, the learning disability partnership, faith groups, sports leads and Cambridge University (teacher training).

10.10.2. The LSCB e-learning platform on 'basic safeguarding' was launched on 7 September 2013 to encourage hard to reach groups (those groups who have limited representation on the LSCB multi-agency training) to access the wider LSCB Training. By the end of March 2015 there were 211 practitioners signed up to the platform but with only 36 people having successfully completed the course. The contract terminates in September 2015 and, given the low numbers taking up the training, it will not be renewed.

10.10.3. General practitioner training has seen a 25% reduction this year in attendance with one event being cancelled in Peterborough due to poor uptake. As of April 2015 237 GPs (28% of all GPs across both regions) had undertaken the level 3 safeguarding training.

10.10.4. Child Sexual Exploitation is a priority area for the LSCB and a workshop package has been developed and facilitated to a number of agencies including; Hinchingbrooke staff, residential staff, student teachers, localities and foster carers

11. CHILD DEATH OVERVIEW PANEL (CDOP)

11. 1 The process

11.1. 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.

11.1. 2 This is a statutory process, the requirements of which are set out in chapter 5 of 'Working Together to Safeguard Children 2015.' The CDOP is chaired by the independent chair of the LSCB. The CDOP annual report can be found on LSCB website.

11.1. 3 The information in this summary relates only to Cambridgeshire children.

11. 2 Numbers of child deaths reported and reviewed

11.2. 1 Over the last year, thirty children have died in Cambridgeshire, which is the same number as last year and a similar number to previous years. Of those children who died, 30% died from a known life limiting condition, with a significant proportion being babies born with a congenital condition who died in the neonatal period.

11.2. 2 Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of 38 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.

11.2. 3 Of the child deaths which were reviewed, the pattern of deaths was similar to that noted above with the majority being babies under a year old. Similar to the last two years, the next largest group was teenagers aged 15 - 17 years old. Sadly, four young people committed suicide during the year, the highest figure since the CDOP was established in 2008.

11. 3 Modifiable factors & Safe Sleeping

11.3. 1 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.

11.3. 2 There were five cases in Cambridgeshire where a modifiable factor was identified. These were all different and cannot be described in a public-facing report as it might enable individual children to be identified.

11.3. 3 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,

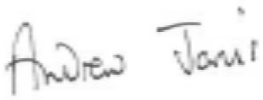
combined with highlighting other impacting factors on infant death such as parental alcohol behaviours. The safe sleeping campaign has been re-launched for 2015 and a further two workshops have been planned for early help workers, early years, locality teams and children's centres across the region.

12. CONCLUSION

12. 1 This report has outlined the impact of the LSCB during 2014-5 in adding value to the service delivery of all agencies involved in safeguarding children across Cambridgeshire. The LSCB has continued to develop specific areas of work in response to national guidance and expectations. Its multi-agency approach to auditing is embedded but under continual review to ensure maximum value is achieved from the exercise. The Learning and Improvement Framework ensures that lessons from research and reviews are used to inform practice across all agencies and to reach staff in every profession and every role. The multi-agency training programme continues to be very well regarded and strives to evidence its impact on practice.

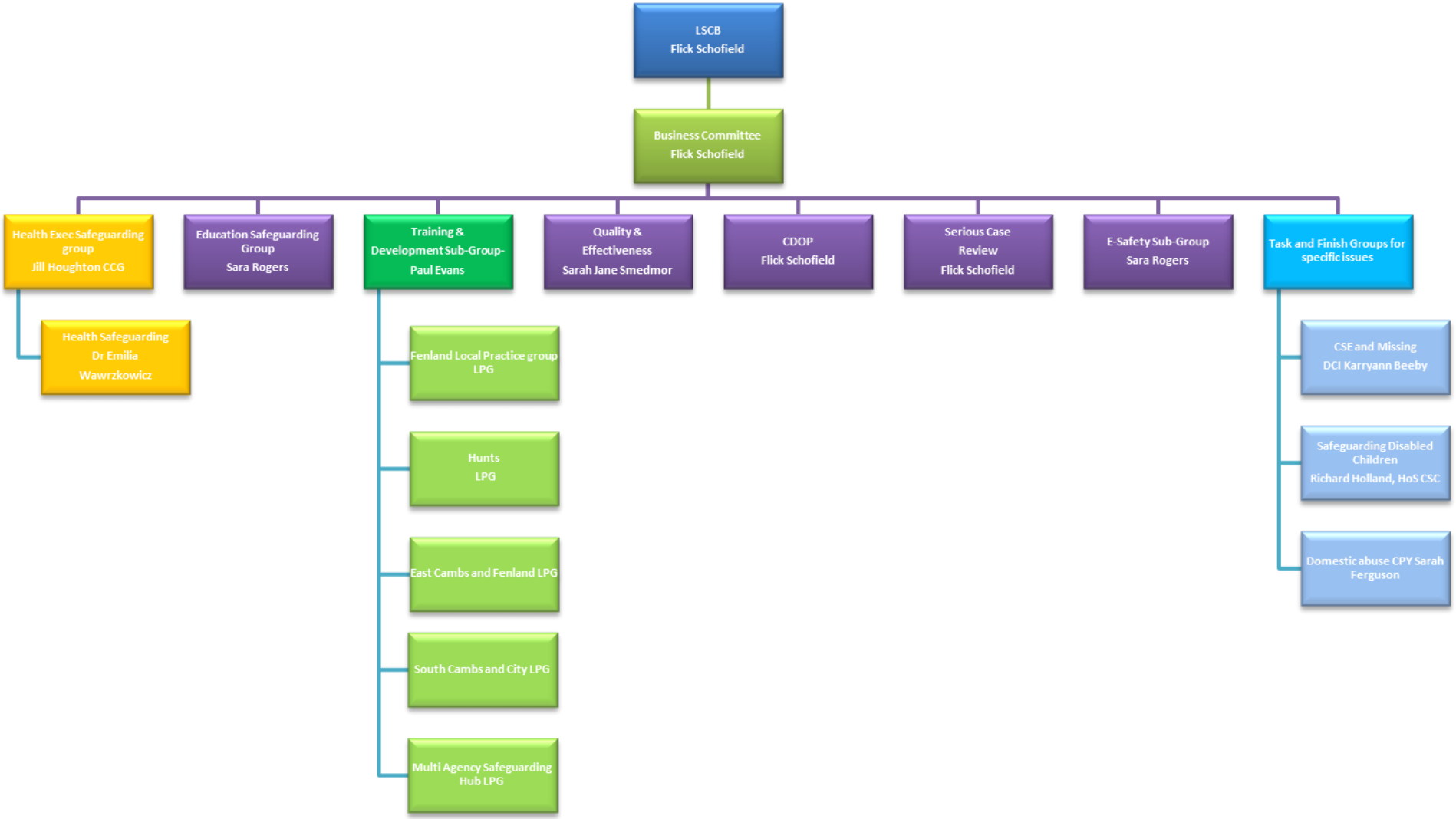
12. 2 The LSCB meets its statutory responsibilities and supports an effective partnership arrangement that challenges all to strive for the very best standards in keeping the children of Cambridgeshire safe.

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



Andy Jarvis, LSCB Business Manager –July 2015

Appendix 1 Structure Chart at 2015



Appendix 2 - Completed LSCB Business Plan 2014-6

LSCB Strategic Business Plan – 2014-6 end of Year One: March 2015

This plan refers to the LSCB activity for 2014-5 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. 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. Red: Not completed to timescale Amber In progress and to time Green Completed

LSCB Priority Theme One: Effective safeguarding response to Children Sexual Exploitation and Children who go Missing from Home and from Care (link to Child Sexual Exploitation and Missing strategy and action plan 2014)							
How will the LSCB do this?	**What will it do?**		**Responsible lead/ group**	**By when**	**What is desired outcome**	**What will impact be and how measured**	**RAG**
Challenge agencies to respond effectively to CSE	1	Embed recommendations from LSCB CSE audit	CSE Implementation group	September 2014	Co-ordinated multi-agency response	Evidence of embedding Through monitoring of CSE action plan and its impact measures and Learning and Improvement	
	2	Implement CSE strategy and action plan	CSE Implementation group	As per strategy and action plan	Co-ordinated multi-agency response	Through monitoring of CSE action plan and its impact measures	
Support agencies and staff to	3	Continue to deliver and review CSE and missing training as per CSE	CSE Implementation	March 2015 as per training	Confident competent	Through training evaluation and impact	

develop an effective response		strategy	group/ Training and Dev sub.	strategy	workforce	methodology – more clarity to be provided through s11 audit	
Commission and communicate with practitioners, families and children and young people re the risk of CSE	4	Conduct another survey of practitioner knowledge and practice	CSE Implementation group	September 2014 (website permitting)	Better informed LSCB CSE strategy inc W/ F dev	Workforce confidence = improved outcomes for children and young people	
	5	Gain views of young people and their families subject to LSCB audit on the services they received	QEG.	September 2014	Voice of the child and family in LSCB audit activity	Improved responses – through further learning and improvement work	
	6	Evaluate impact of Chelsea's Choice on CYP that saw it **Update – this action will be refreshed and updated in new plan**	Chelsea's Choice T and F group/ LSCB Business Unit	December 2014	Better informed LSCB CSE strategy	Effective protection of children and young people from risk of CSE, thought Learning and Improvement	

Current CSE action plan not embedded (NB There is a new CSE action plan – full report regarding move from old plan to new plan will be given to LSCB in March 2015)

Update statement key activity re Priority One re Child Sexual Exploitation

- The CSE Strategy has been provisionally updated– it has been radically simplified in line with national practice and the findings of key reviews e.g. Rotherham.

- Benchmarking has taken place in key agencies regarding the findings from Rotherham and there is general consensus of suitable practice in Cambs. CSE t and f has oversight of this
- Operational partnership established in Fenland re Operation Shade
- Briefings given to CCC members and to the Public Service Board regarding CSE and the current response to this in Cambridgeshire
- LSCB CSE training ongoing and available
- The LSCB CSE risk assessment has been revised and disseminated and will be audited via the MASH and all referrals will go in as safeguarding referrals via IAT
- Area Partnerships are considering re-commissioning of Chelsea's Choice after Peterborough study demonstrated impact amongst YP that had seen it there during 2013.
- QEG to consider follow-up to CSE audit with young people involved– this is a capacity issue currently in terms of time to conduct the work, therefore another approach will be considered
- LSCB website move will facilitate easier ways of communicating with public and CYP around issues such as CSE. New joint leaflets produced in 8 Languages for CYP, parents and professional audiences
- working group via Education Safeguarding sub-group has agreed a list of approved resources for CSE awareness raising in schools and this has been circulated in schools and on the LSCB websites.

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

to safeguarding concerns re disabled children	children.	sub		workforce		
	Review policy and procedure and responses re safeguarding disabled children so that they are effective	Safeguarding Disabled Task and Finish group	Carry forward to 2015-16	Effective multi-agency safeguarding response	= Improved outcomes for children and young people.	
	Review neglect guidance and LSCB training and GCP to include SEND cohort	Safeguarding Disabled Task and Finish group	Carry forward to 2015-16	Effective multi-agency safeguarding response	Effective protection of disabled children – measured through ongoing Learning and Improvement activity	
Commission and communicate with practitioners, families and children and young people	Consultation with parents re their perspective on priorities for safeguarding	Safeguarding Disabled Task and Finish group/ Pinpoint	June 2015	Better informed LSCB strategy	Positive impact for those involved in being heard and views acted on (evidence based) – to be evaluated through Learning and Improvement	
	Consult CYP around safety and safeguarding through survey and audit activity and ensure the voice of the child and family is heard in service planning	Safeguarding Disabled Task and Finish group	March 2015	Better informed LSCB strategy	Improved outcomes for children and young people.	

Update Statement re Priority Two – Safeguarding Disabled Children

- Due to capacity the Disability Task and Finish group has only twice so far however the action plan is underway and is embedded here The group includes a parent representative – and is considering how best to consult with parents after YP consultation is completed.
- The QEG multi-agency audit re disabled children has been completed – the report will be presented to the Business Committee in June 2015 after QEG has finalised
- However, the consultation project commissioned via Voiceability has commenced, with some very positive feedback received from the educational settings involved regarding the impact on young people of being involved
- Work around neglect will commence in the spring as part of LSCB work, however the NSPCC are currently working to evaluate the Graded Care Profile nationally. Cambridgeshire would like to update once this is completed and will request that the NSPCC consider the needs of disabled children within this review
- Preparation of a position statement re training activity around safeguarding disabled children in all agencies is underway, and will be also included in the s11 audit

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

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

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

Update re Priority 3 – Domestic abuse

The Domestic Task and Finish group have formulated an action plan embedded here which will be reviewed as part of the wider strategy and reviewed at the next Domestic Abuse Governance Board so once done this area this Business plan will be updated. Current work includes:

- There was a poor response to the Youthoria survey regarding domestic abuse, so a consultation project has been commissioned with 6 young groups around the county – this will be around living with parental domestic violence and around relationship violence – to be reported in April 2015
- There have been 10 Barnardos DVRIM workshops to date with approximately 177 trained in the use of the matrix in multi-agency audiences attending. This is now 'business as usual' and in the training calendar. Single agencies have so far reported 206 trained in education and EPS – other event planned during 2015-6
- Supporting the work of the Domestic Abuse partnership to create a county offer re domestic abuse aligned with the MOSI – which will then inform the LSCB multi-agency practice guidance

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

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

Update on Priority 4 – The Effectiveness of the LSCB – NB this stands as the work plan for the LSCB Business Unit

Post – OFSTED, most of the work of the LSCB has been around this priority:

- Two SCRs are close to being published and another is underway. The learning is being shared through workshops and LPGs. The SCR group has oversight of other cases which have given rise to concern
- The LSCB engaged fully in the Embedding the Learning approach pilot and was this was evaluated in a very positive report by the University of Beds in Jan 2015
- The LSCB training programme continues – the conference is provisionally booked for May next year and will be focusing on professionals that abuse.

- New website in place: www.cambridgeshire.gov.uk/lscb went live in March, content all managed by LSCB and the old website now forwards!!
- The Safer Sleeping campaign has concludes - a report came to the Business Committee in Feb 2015 – the required agencies engaged as did extras such as the night time economy – e.g. pubs and nightclubs and the work continues to be embedded via Single agencies. The information remains remains on the new LSCB website
- Whilst the CSE questionnaire on the YOuthoria website was successful, the Domestic Abuse one wasn't, therefore the LSCB has commissioned two direct consultations

Appendix 3 - LSCB Business Plan 2015-16

LSCB Strategic Business Plan (2015-6) Start Date 1 April 2015

This plan sets out the planned LSCB activity for 2015-6 and will be reviewed regularly at the LSCB and Business Committee. Progress will be rag rated after the first quarter. 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

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**	**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	
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 have provided training.	Confident competent workforce	Through training evaluation	

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	
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	
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	New joint referral form implemented April 2015. Op shade ongoing 2015.	Effective tool to assess CSE risks and support referrals to multi-agencies.	Evidence of use in Audit	

		Manager)	November 2015			
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.	
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	
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	Data to be reported regularly within LADO report to Board	

				children		
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.	
Increased workforce competence to deliver high quality services	Develop and support multi-agency training for wider workforce re SEND children.	LSCB Training and Development sub	September 2015	Confident competent safeguarding workforce	Attendance levels and evaluation of relevant training	
Establish a supportive policy and procedure working context for professionals, informed by the voice of service users	Review policy and procedure and responses re safeguarding disabled children so that they are effective	Safeguarding Disabled Task and Finish group	June 2015	Effective multi-agency safeguarding response	From the report on what young people and their families tell us.	
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.	
Policies, processes and practice	Consultation with parents re their perspective on priorities for	Safeguarding Disabled Task	June 2015	Better informed	Report on what young people and their families	

informed by the service user perspective (parents)	safeguarding. Parent representative on Disability Task and Finish group.	and Finish group/ Pinpoint		LSCB strategy	tell us.	
Policies, processes and practice informed by the service user perspective (children)	Consult CYP around safety and safeguarding through survey and audit activity and ensure the voice of the child and family is heard in service planning	Safeguarding Disabled Task and Finish group	May 2015	Better informed LSCB strategy	Report on what young people and their families tell us.	
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	
Increased effectiveness of services to safeguard children through coordination of	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	June 2015	Effective prevention, protection and recovery of children and	Feedback from CYP and their families on the impact of services.	

agency planning and implementation		partnership		young people		
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.	
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	
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	
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.	
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.	

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 safeguarding system.	Embed Learning and Improvement framework and audit programme	LSCB Business Committee/ LSCB Business Manager/ QEG	March 2016	Well informed LSCB developing a learning culture	Evidence available in Annual Report	
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	
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	
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	Use of dataset to review and set priorities and challenge inadequate services in Board Minutes	

				work		
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	
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	
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	
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.	
Increase agency capacity to deliver effective	Norfolk, Cambridgeshire and Peterborough LSCB's working together	Provide project worker to research and	Start April 2015 – 2016	To improve safeguarding arrangements	Effective safeguarding for children and young people of Eastern	

safeguarding services.	on Innovation bid.	summarise existing local learning and development. Multi-agency training. Practice standards development.		for the children and families of Eastern European migrant backgrounds within the Wisbech area.	European migrant backgrounds measured through positive outcomes. To be audited six months following the project completion.	

Appendix 4

SAFEGUARDING AND STANDARDS UNIT (SASU)
CHILD PROTECTION ANNUAL REPORT:
1 April 2014 – 31 March 2015

1. Introduction

1.1. This report provides an overview of Cambridgeshire's children subject to a child protection plan from 1st April 2014 until 31st March 2015.

1.2. Child protection procedures are a key statutory element of the safeguarding framework in all local authorities. Under the Children Act 1989, Local Authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local Authorities undertake assessments of the needs of individual children (single assessment) to determine what services to provide and action to take (Working Together 2015).

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

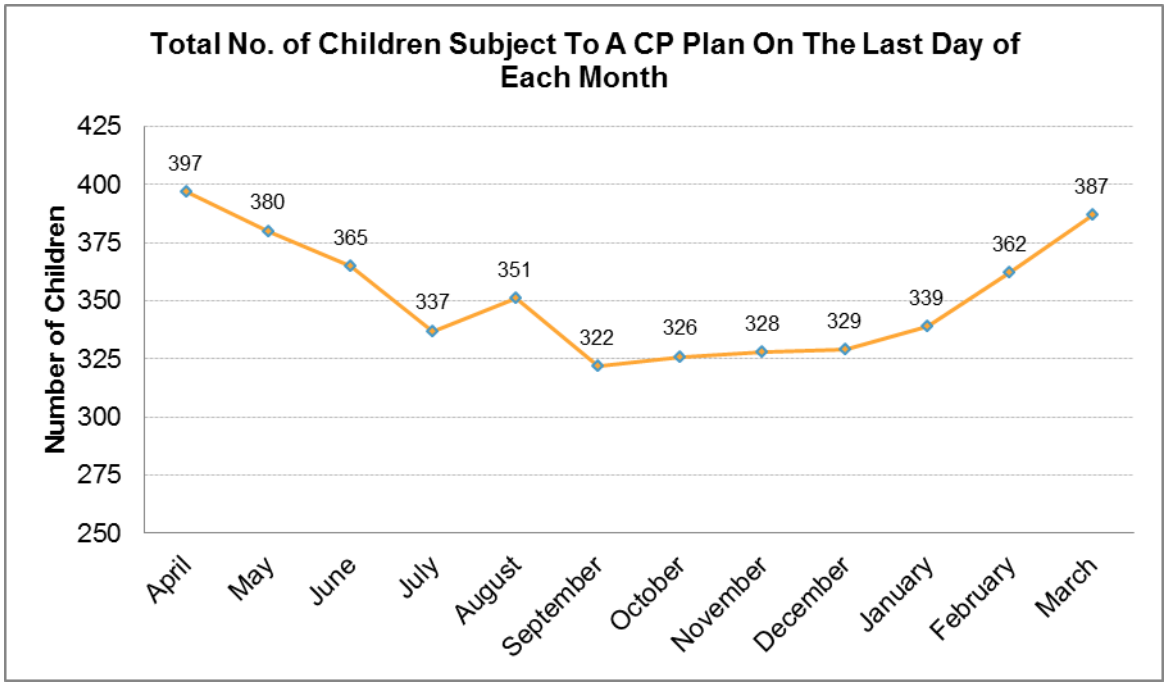
2. Executive Summary

2.1 At the end of March 2015, Cambridgeshire had 387 children subject to a child protection plan. This represented 30.34 per 10,000 children in Cambridgeshire. This compares with 33.0 per 10,000 children for our statistical neighbours and 42.1 per 10,000 nationally. Despite the recent rise again in numbers, Cambridgeshire continue to have a lower number of children subject to a child protection plan.

2.2 The demand in requests for initial child protection conferences and the subsequent making of plans for many of the children considered appears to be symptomatic with the demand at the 'front door' within Children's Social Care. The children subject to child protections plans decreased slightly during the year but rose again to 387 in March 2015, to a similar number as March 2014.

2.3 The increase in conferences has been maintained and has not impacted on professional attendance and participation within conference or the careful safety planning for children. Indeed, when compared to eastern regional authorities, Cambridgeshire performed better than others regarding the timely holding of conferences and not having children subject to plans for longer than two years. Both of these evidence a good multi-agency conference process which is closely monitored and effective planning for children.

3. Total number of children subject to a CP Plan

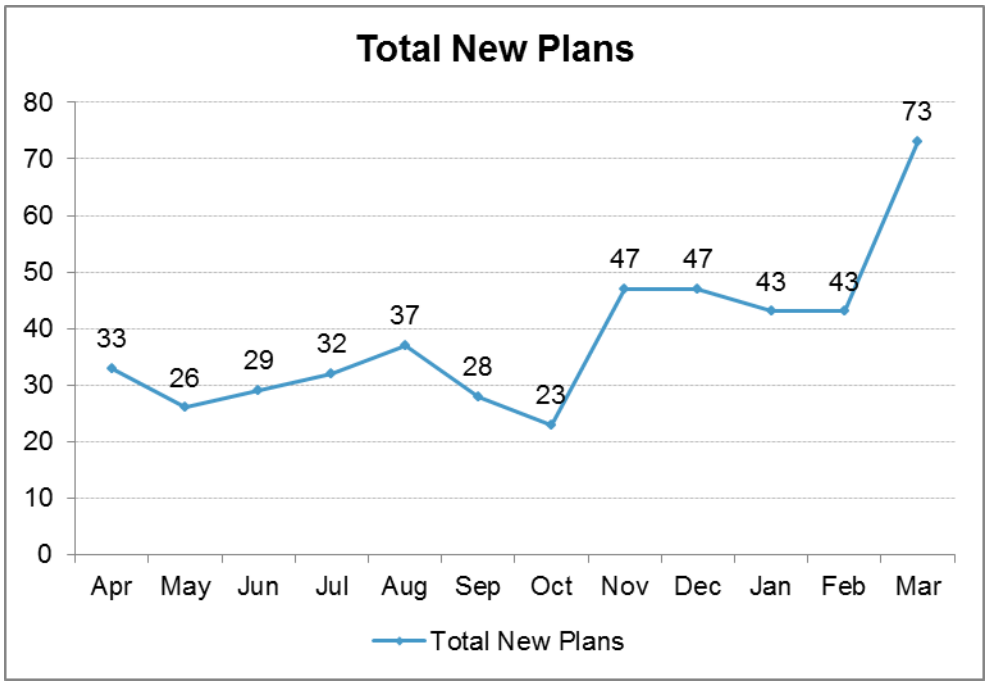


3.1 This year has seen the numbers of children with plans decrease slightly and then increase slightly to a final upsurge in March 2015. As we are aware, the amount of children who should be subject to a child protection plan in a Local Authority is not an 'exact science' and any rise and fall in numbers can be the subject of much interest, quite rightly as it is a clear indicator of what children and young people may be experiencing at a point in their lives and also pressures and demands on safeguarding services across the partnership.

3.2 Time has allowed us to identify the increase in numbers; from July 2013 onwards this has never decreased again to fewer than 330 children subject to plans. The Safeguarding and Standards Unit have taken the opportunity over the year to track the progress of children with plans who are aged sixteen and over (addressed in section 6), to ensure the plans are appropriate, to consider re-registrations and why children come back to conference for a subsequent time (addressed in section 7) and to consider the use of the strengthening families based conference model and how this process feels for families experiencing it.

3.3 The Eastern Region has also considered the number of children on plans in each Authority over the year. A regional and national trend for numbers to increase was identified from September 2013 onwards and in the main, most Authorities have not experienced the numbers significantly decrease, much the same as Cambridgeshire. The regional report was considered by the LSCB in January 2015.

4. Number of children made subject to Child Protection Plans per month - 1st April 2014 – 31st March 2015

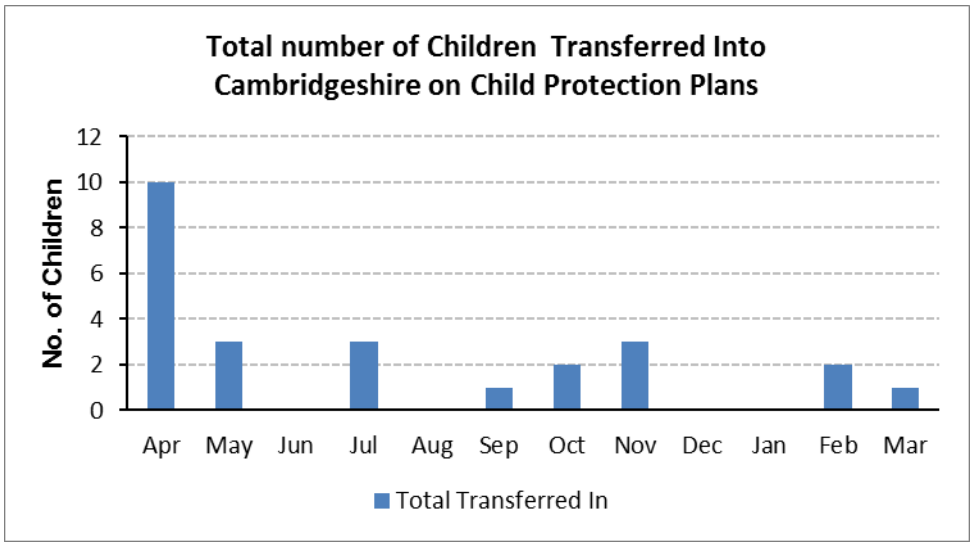


	Total New Plans	Notes
Apr	33	Eldest: 10 yrs. old
May	26	Eldest: 14 yrs. old
Jun	29	Eldest: 14 yrs. old
Jul	32	Eldest: 14 yrs. old
Aug	37	Eldest: 15 yrs. old
Sep	28	Eldest: 14 yrs. old
Oct	23	Eldest: 15 yrs. old
Nov	47	Eldest: 15 yrs. old
Dec	47	Eldest: 15 yrs. old
Jan	43	Eldest: 14 yrs. old
Feb	43	Eldest: 15 yrs. old
Mar	73	Eldest: 16 yrs. old

4.1 On average, between April 2014 and March 2015 36 children per month were made subject to child protection plans. This increased in March 2015 with 73 children in the month being made subject to a plan. From the data it is noted that there was an increase in referrals from the end of December 2014 and many of these children's needs had been considered in a single assessment. March 2015 also saw the highest number of children made subject to a plan within four weeks of social care intervention. This was mainly three large sibling groups and children who were felt to be at significant immediate risk from their care givers.

4.2 Scrutiny of the assessment for children to be considered at conference is a priority for Group Managers. Heads of Service continue to be aware of the children coming to conference but, as is appropriate, the decision making is between the group manager, their consultant social workers and the police and partner agencies where appropriate.

5. Transfer in Conferences



	Total TF in
April	10
May	3
June	0
July	3
August	0
September	1
October	2
November	3
December	0
January	0
February	2
March	1

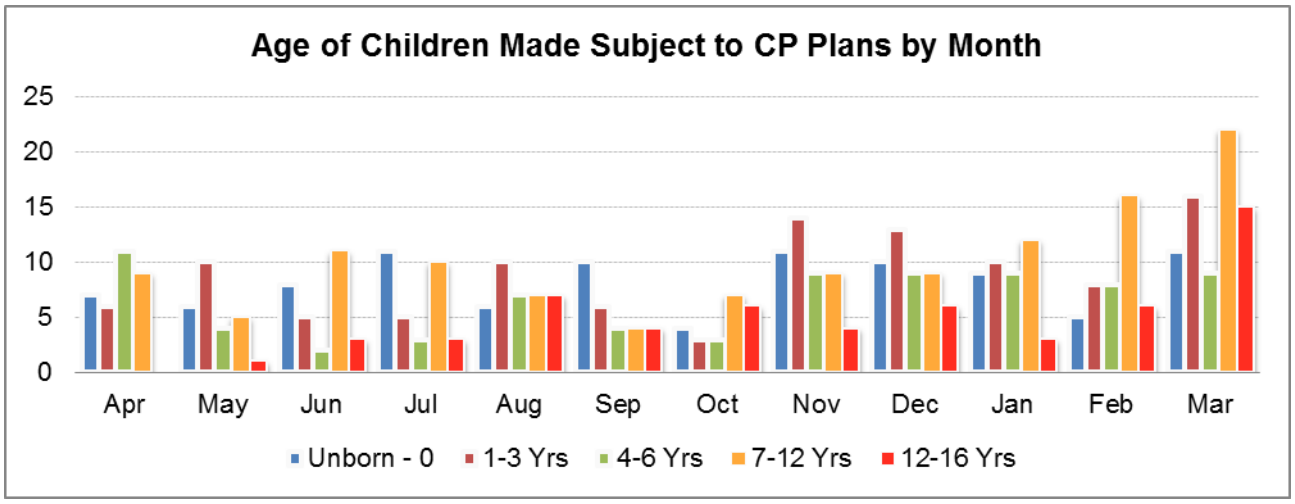
5.1 Children who have been made subject to a child protection plan in one authority and move to another to live on a permanent basis are then transferred into the new authority and a case conference is held to transfer the plan also.

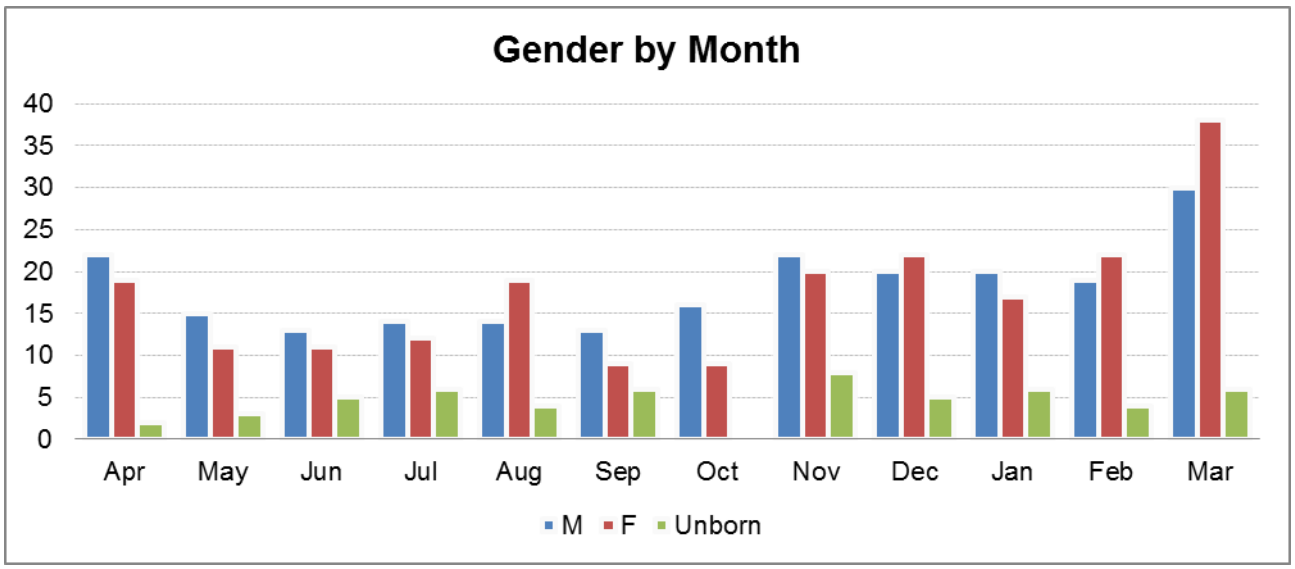
5.2 April was unusual in so many children transferring into Cambridgeshire. However, these children were from three families.

5.3 The Integrated Access Team and Safeguarding and Standards Unit work closely with the authority where the children are moving from to ensure that the family are moving to Cambridgeshire to stay and that the family are

not moving on the brink of legal proceedings. Both of these issues can heighten the risk of the transfer process causing unnecessary delay, sometimes for very young children.

6. Age and genders of children made subject to CP Plans: 1st April 2014 – 31st March 2015



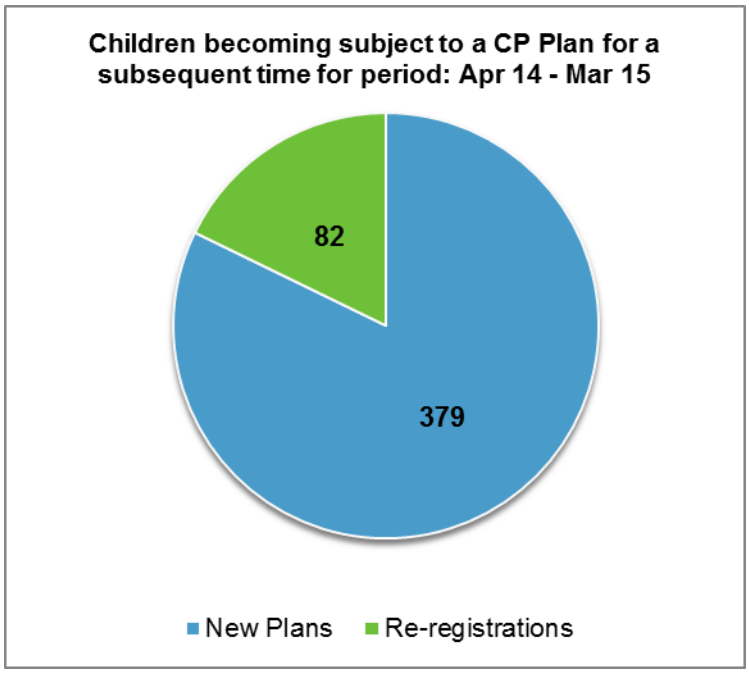


6.1 As would be expected, the majority of children subject to child protection plans are under the age of seven. The use of the LSCB pre-birth protocol supports the early identification of risk factors for unborn babies and in the main they are referred to Children's Social Care in a timely manner for the conference process to commence.

6.2 Planning using the child protection process is not always necessary for children aged twelve to sixteen years. This year has seen the increased use of the risk and vulnerability matrix when assessing the needs of older children and young people. The matrix promotes professionals to think about and identify the young person's social network and experiences which support their resilience.

6.3 With the national interest into Child Sexual Exploitation (CSE) and the publication of new information on a weekly basis to assist practitioners learning, awareness of the issues within the professional network has greatly increased. In Cambridgeshire we are advocating that children and young people should only be made subject to plans if the significant harm they are suffering is a direct result of the parenting they are experiencing. When Child Sexual Exploitation is the main concern it is very unusual that the main risk is from within the immediate family or indeed from the immediate care giver. Very often in these cases the main care givers are as concerned for the young person's welfare as the professional network. To address this, Service Managers from SASU and Group Managers from within the Children in Need Service have worked jointly to introduce a risk and vulnerability meeting. The meeting is multi agency and involves the young person and their parents where possible. The outcome is a robust safety plan for the young person.

7. Children becoming subject to Child Protection Plans for a subsequent time: 1st April 2014 – 31st March 2015



Subsequent CP Plan regs:

	Total Regs	New Plans	Re-regs	% of Total
Apr	**33**	26	7	21.21%
May	**26**	20	6	23.08%
Jun	**29**	22	7	24.14%
Jul	**32**	19	13	40.63%
Aug	**37**	26	11	29.73%
Sep	**28**	27	1	3.57%
Oct	**23**	22	1	4.35%
Nov	**47**	41	6	12.77%
Dec	**47**	47	0	0.00%
Jan	**43**	31	12	27.91%
Feb	**43**	36	7	16.28%
Mar	**73**	62	11	15.07%
TOTAL	**461**	**379**	**82**	**17.79%**

7.1 Children becoming subject to a child protection plan for a subsequent time always challenges practitioners to consider the effectiveness of previous decision making. 82 children (18%) had been subject to child protections plans previously. This is a slight increase from the previous year when 15% of children being considered at conference had been subject to a child protection plan previously.

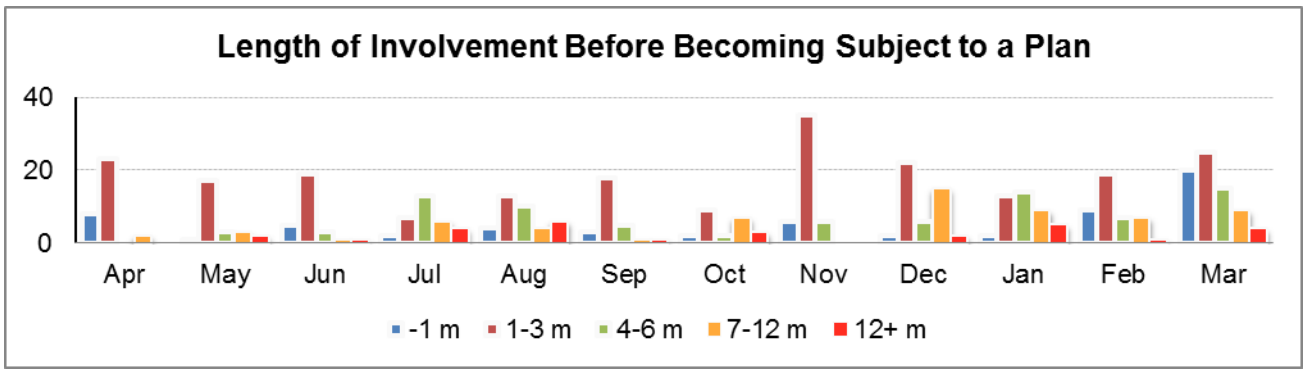
7.2 As part of the monthly reporting to performance board, Anna Cullen, Service Manager SASU, provides commentary to assist professionals to gauge why children have been considered at conference for a subsequent time. In a six month overview of these children she concluded;

7.3 'This snapshot would seem to suggest that the families who come to Conference more than once tend to almost always come back with similar or related issues to when they were previously considered at conference. Practitioners across the agencies seem to know these families well, and often have tried periods of Public Law Outline (PLO), SFSS, FiP and accommodation to try and address the issues the families are facing. The biggest challenge seems to be sustaining long-term positive change in families where problems are never quite serious enough for removal of the children or legal proceedings, but where cyclical patterns of behaviour – positive change followed by relapse – are evident. These families seem to represent the most difficult of our service users – families where we cannot effect lasting change, but where situations are not quite serious enough for removal'.

7.4 It is difficult to know from a one-off 'snapshot' if this is a regular or extraordinary pattern, as re-registrations have not been fully explored before, and it is not therefore possible to analyse the impact of Social Work Working for Families. To achieve any real learning, we are now aiming to complete a similar analysis year on year for comparison's sake and for more immediate learning are collating the information on a monthly basis at Children's Social Care performance board.

8. Social Care Involvement before a Child Protection Plan is agreed: 1st April 2014 – 31st March 2015

Please note that transfer-in cases are not included in the figures below.



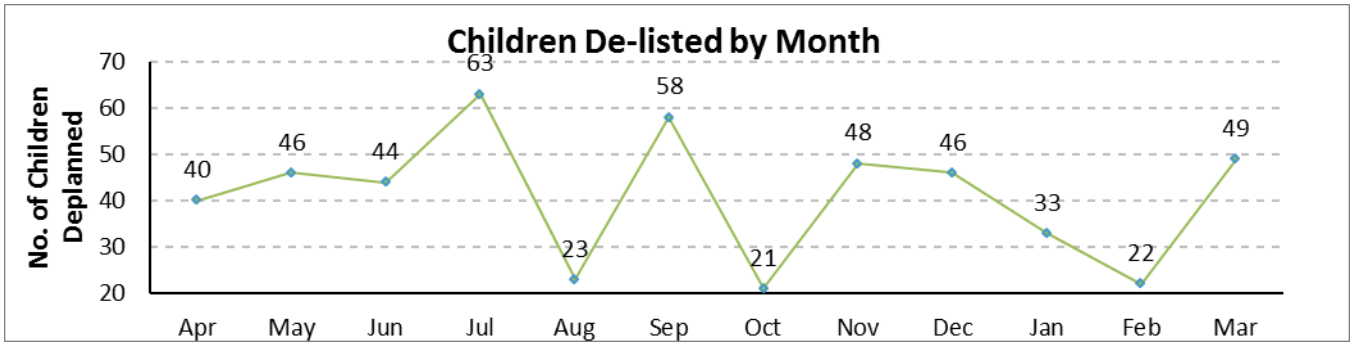
8.1 During this year the single assessment has been introduced to replace the initial and core assessment. Assessments should be completed where possible within 20 working days and at the most 35 unless there are exceptional circumstances where 45 days would be the maximum. Throughout the year the completions of assessments has been consistently high, with the end of year figure showing 96.8% of assessments completed within timescale. Oversight of the assessments by consultant social workers and group managers is priority and the few which are not completed within timescales are known by respective Heads of Service.

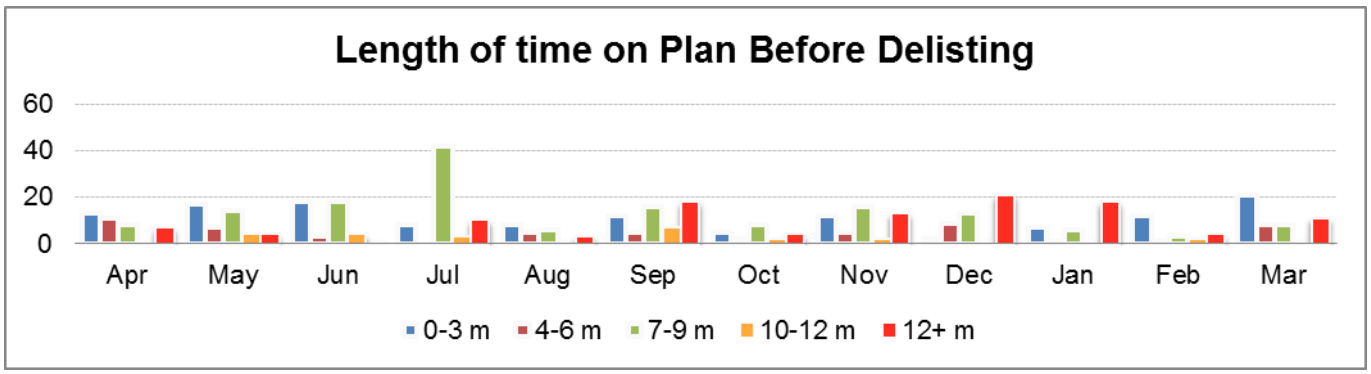
8.2 The figures above evidence single assessments being completed and decision being made to come to conference as an outcome, suggesting a thorough assessment of the risk underpinning this decision. The monthly case audit programme within Children's Social Care has reinforced the good use of single assessment to inform this decision.

8.3 Children who are considered at conference within the first month of being known to Children's Social Care are children who were deemed to be at immediate risk of significant harm, for example children with physical injuries or unborn babies where concerns have arisen late in the mothers pregnancy.

8.4 March 2015 saw an increase in the children becoming subject to child protection plans, nearly 30 more than the average for the previous three months. We know that the demand in referrals increased during this time and in the previous eight weeks into Children's Social Care and it is of note that 20 of the children made subject to plans in this time were only known to Children's Social Care for less than four weeks prior to conference. This is an unusual pattern and on closer examination what is overwhelmingly clear is the physical harm children or sexual harm to three separate groups of siblings, which shows in the high numbers.

9. Children de-listed from a Child Protection Plan: 1st April 2014 – 31st March 2015





9.1 To encourage and ensure multi agency attendance as much as possible, review child protection conferences are held during term times. The graph above evidences lower numbers of children being delisted from plans in August, October and February, during the school holidays and just prior to the holidays the number of children delisted increases as reviews are held.

9.2 Given the increase in demand, SASU have made partner agencies aware through the LSCB that the ability to continue to hold conferences mainly in term time is becoming less and less possible.

9.3 On average, children are subject to child protection plans between nine months and a year. Effective planning under the child protection process would take place within this timeframe, any longer may suggest drift and delay for the child or a significant change in the families circumstances. SASU report on children who are delisted on a monthly basis to ensure appropriate use of the process. Children who are delisted at the first review conference in the main are unborn babies or young children where legal proceedings are initiated and a child protection plan is no longer required as the Court Care plan would supersede this. Professional optimism can at times promote decision making to remove children from the plan at the first conference, however, from analysis of the information this is not common.

9.4 During this year, no children have been subject to child protection plans for longer than two years. This continues to be an indicator of effective planning for children.

10. Categories of abuse identified in CP plans of those made subject to a plan: 1st April 2014 – 31st March 2015

Most Recent Category of abuse	Number of children	%
Neglect	**306**	**63.22%**
Emotional	**124**	**25.62%**
Sexual	**18**	**3.72%**
Physical	**36**	**7.44%**

10.1 Neglect is once again the main category for which children are made subject to child protection plans. It is the most identifiable form of abuse as the signs and symptoms are normally very evident. The LSCB and single agencies continue to provide training for the workforce regarding childhood neglect and parenting capacity or parental willingness to understand the concerns about their parenting and to make long term meaningful changes in the best interests of their children.

10.2 The LSCB Disabled Children task and finish group are currently looking at re introducing the Graded Care Profile as a multi-agency assessment tool which focuses on neglect and the impact on the child and their family. The tool supports practitioners to identify signs of neglect quickly and to allow parents to partake in assessment as it is understandable and accessible for them.

10.3 It is of interest that last year saw a considerable increase in the number of children made subject to plans for sexual abuse. This has decreased this year by half, leading us to question if practitioners are not identifying sexual abuse in the same way or whether the heightened media interest last year brought sexual abuse into sharp focus for many. It is a really hidden abuse and for older children it is normally a disclosure from them which leads to a referral to the police and children's social care. The child protection conference chairs and the LSCB workforce development group are continually challenging professionals to look beyond the obvious and to be professionally curious. However, the identification of sexual abuse continues to be a challenge to all.

10.4 Domestic abuse continues to be high on the reasons why children are considered at a child protection conference. Focus has been given this year to identifying domestic abuse as emotional harm, as Working Together 2015 confirms, if there is not a direct physical threat to the child. The auditing of child protection plans and observations of conferences evidences that this leads to a lot of discussion amongst professionals at the time of decision making for the child as the overwhelming response is to think physical harm.

11. Ethnicity of children made subject to child protection plans: 1st April 2014 – 31st March 2015

Ethnicity	No. of Children
White, British	336
Any other White background	34
Asian or Asian British, Indian	4
Roma/Roma Gypsy (107 / W-103)	6
Asian or Asian Brit, Pakistani	3
Mixed, White/Black Caribbean	8
Not Obtained	11
Any other Black background	4
Black or Black British, African	3
Chinese	2
Asian/Asian Brit, Bangladeshi	2
Mixed, Any other Mixed background	24
Mixed White/Asian	12
White, Irish	3
Irish Heritage Traveller	4
Black/Black British, Caribbean	1
Not recorded	3
WBRI - British	1

11.1 Cambridgeshire has continued to become increasingly ethnically diverse. Throughout the year literature has been refreshed to ensure it is available in the child and families first language.

11.2 The collection of the child's ethnicity has been enhanced for the quarterly child protection report to the LSCB since September 2015. The information above is not the enhanced dataset; this will be available for the year as of September 2015.

11.3 In the data, any other white background identifies children mainly from an Eastern European background.

11.4 Cambridgeshire, Peterborough and Norfolk Local Safeguarding Children Boards made a successful bid to the Innovation Grant to undertake an innovative project that pools knowledge and concerns across the Boards to improve the effectiveness of safeguarding practice. The three Boards have shared concerns about the way agencies work with Eastern European migrant families, particularly around the identification of safeguarding risks and delivering effective interventions with children and young people. This proposal sets out our innovative and collaborative plans to improve the safeguarding arrangements across the three counties with this potentially vulnerable cohort.

11.5 This bid will host a worker to be based in Wisbech to undertake the task set out in the bid. This should have a positive impact on families and the workforce, building on understanding of cultural similarities and differences and child protection plan will be given priority within this work.

12. Cohort of children becoming subject to child protection plans: April 2014 to March 2015

12.1 The total number of children made subject to child protection plans within Cambridgeshire on 31st March 2015 was 387. This was a slight decrease of 8 children compared to March 2014, when the number was 395.

12.2 During the year there have been 461 instances of children being made subject to child protection plans which marks a decrease in comparison to 2013/2014 (534).

12.3 Out of the 461 children made subject to plans, 22 children had been previously looked after by the local authority at least once.

12.4 82 children (18%) had been subject to child protections plans previously. This is a slight increase from the previous year when 15% of children being considered at conference had been subject to a child protection plan previously.

12.5 At the time of becoming subject to a plan 96 children (20%) were already receiving social work services six months prior to being made subject to a plan.

12.6 365 children (80%) becoming subject to a child protection plan were not in receipt of a social care service (Access/CIN) in the preceding six months. These figures are in line with last year's figures.

13. Summary

13.1 This analysis suggests that the numbers of children with a child protection plan over the year decreased slightly from April 2014 to the end of the year but then, reflecting the increase in contacts and referrals to social care, the numbers of children made subject to plan again increased.

13.2 Social work units are reporting an increase in not only the number of children and families they are supporting but increased complexity of the issues and risks in their lives. This is turn reflects the timing of some children being considered at conference, some within four weeks of social care intervention.

13.3 We remain confident that all children who are considered at conference have their needs fully considered and a balanced, multi-agency approach is taken in deciding if the child requires a child protection plan or parental engagement is such that a child in need plan would be appropriate.

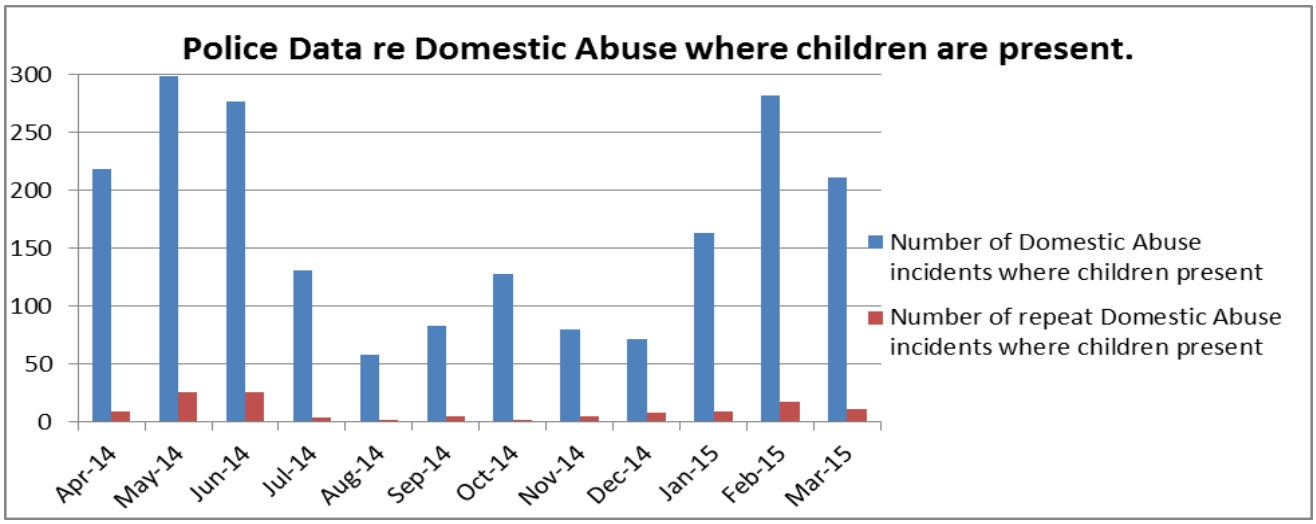
Sarah-Jane Smedmor
Head of Safeguarding and Standards

Date: 26.04.15

Additional Information from the Dataset 2014-15

Cambridgeshire Constabulary

The data in the following two pages was provided by Cambridgeshire Constabulary. It relates to activity undertaken in 2014-15 but covers all children and is not limited to those subject to a child protection plan from 1st April 2014 until 31st March 2015. The investigations are defined by the age of the victim when the offence was committed, but in a number of cases this will have been some years ago and the victim is now an adult.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Number of missing person reports for under 18s												
Cambridgeshire	27	30	41	30	25	20	29	35	18	16	28	52
Number of Violent or Sexual Offences against under 18s												
Cambridgeshire	89	139	160	136	122	129	111	93	86	104	138	183
per 10,000 CYP population	*7.0*	*10.9*	*12.5*	*10.7*	*9.6*	*10.1*	*8.7*	*7.3*	*6.7*	*8.1*	*10.8*	*14.3*
CP CATS Referrals (Constabulary)												
Child Concern	880	650	702	455	243	679	1195	468	428	623	701	715
FGM attempt or risk	0	0	0	1	2	0	1	1	0	0	0	0
Child Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	11	5	8	17	9	6	24	4	10	4	14	8
Prosecution Prevented	0	0	1	0	2	0	1	0	1	0	0	1
Prosecution Not In Public	2	4	6	10	0	6	6	6	3	5	3	3

Interest												
Prosecution Not Possible	22	23	29	23	27	19	27	28	16	25	14	34
Domestic Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	107	104	102	111	101	83	105	106	99	99	99	82
Prosecution Prevented	5	0	0	2	2	0	2	0	3	0	1	5
Prosecution Not In Public Interest	52	39	5	16	4	10	3	5	-2	2	4	2
Prosecution Not Possible	66	79	107	114	112	102	115	110	127	125	96	132
MARAC data												
Cambridgeshire Central												
Number of cases discussed	16	33	23	23	26	17	23	22	16	33	28	23
Number of repeat cases	4	14	6	8	6	9	10	5	7	7	9	4
Number of children in household	22	51	29	18	40	19	27	24	19	53	37	33
Number of referrals from police	12	20	16	19	19	15	17	17	12	29	22	18
Number of referrals from other agencies	4	13	7	4	7	2	6	5	4	4	6	5
Cambridgeshire Southern												
Number of cases discussed	10	11	15	29	19	26	36	26	21	42	15	
Number of repeat cases	4	5	8	11	4	10	9	5	3	9	8	
Number of children in household	13	9	26	41	22	43	52	25	21	48	18	
Number of referrals from police	7	10	11	23	15	20	27	20	16	32	10	
Number of referrals from other agencies	3	1	4	6	4	6	9	6	5	10	5	

* These crimes are identified by the use of markers; the data is therefore reliant on the accurate and consistent use of the appropriate marker

Cambridgeshire Clinical Commissioning Group Health dashboard – Metrics for April – June 2014-5

(These statistics were presented to the LSCB annotated with "Further work to take place between LSCB and CCG re identifying data." In addition, they cover the period up to June 2015 rather than March 2015.)

	Indicator	CCS	CPFT	CUHFT	HHCT
17a	**Development and implementation of good practice in safeguarding children, including demonstration of good practice (evidenced through audit)**	Not yet reviewed	Green Agreed at CQR to accept that no recent audits on safeguarding children have been carried out given the unprecedented work on SCRs by the Trust.	Green Safeguarding update provided for Q1	Green Safeguarding update provided for Q1 .
17b	**Evidence of learning from local and national serious cases**	Not yet reviewed	Green	Green	NA
17c	**Percentage of relevant staff trained in safeguarding children processes to the level appropriate to their role as defined by the CAPCCG Safeguarding Training Strategy (by level of training)**	Amber Level 1 – 86% Level 2 – 84% Level 3 – 92% Level 4 – 100%	Amber 85%-100%	Amber 83%-90% Some difficulty checking who has completed the training from the contract staff, such as those who only work once session a month.	Amber Level 1-92% Level 2-83% Level 3-50% The Trust has a small number of staff from A&E, Outpatient department and ward to operating theatre, who require level 3, as HHCT do not provide children's services
17d	**Safeguarding children annual report and Section 11 Audit for LSCB or equivalent and action plan**	Not yet reviewed	Annual report not yet available Section 11 update given	Not yet available	Received

Appendix 5

LSCB BUDGET 2014-2015

LSCB Board	2014-15 Budget £	Actual to End March 2015 £	Budget Remaining £
Staffing	114,188.00	116,277.09	-2,089.09
Consultancy & Hired Services	8,000.00	21,612.17	-13,612.17
Office Costs	14,800.00	16,558.59	-1,758.59
	136,988.00	**154,447.85**	**-17,459.85**
Chair Person			
Consultancy & Hired Services	42,500.00	42,855.58	-355.58
	42,500.00	**42,855.58**	**-355.58**
Training Budget			
Staffing	51,217.00	51,743.26	-526.26
Consultancy & Hired Services	1,500.00	4,588.90	-3,088.90
Venue Hire	8,500.00	5,234.05	3,265.95
Office Costs	0.00	1,757.38	-1,757.38
Income	0.00	-5,249.50	5,249.50
	61,217.00	**58,074.09**	**3,142.91**
Serious Case Review			
Consultancy & Hired Services	25,000.00	15,706.25	9,293.75
Other	5,000.00	3,144.27	1,855.73
	30,000.00	**18,850.52**	**11,149.48**
2014-15 Financial Position at 31/03/2015	**270,705.00**	**274,228.04**	**-3,523.04**
Unallocated Budget	**6,689.00**		
Income received from Partners carried forward from 2013-14*	**86,542.00**		
CDOP			
Joint Funding		18,391.32	18,391.32
Consultancy & Hired Services			0.00
Other Expenses			0.00
Unallocated Budget - C/F 2013-14		-4,741.00	-4,741.00
	0.00	**13,650.32**	**13,650.32**

***Includes ring-fenced funding for specific two year CSE Coordinator post 2015-17.**