

Annual Report

2012 - 2013

Independent Chair of the Board: Dr. David N. Jones

A draft annual report was considered by the Safeguarding Children Board (LSCB) on 27th June 2013 and this final version was published on 13th September 2013.

The format of this report takes account of the analysis of LSCB Annual Reports carried out by the Association of LSCB Chairs that was completed in May 2013. The content of this LSCB Annual Report follows the recommended model laid out in the Association's analysis report.

The term "LSCB" stands for 'Local Safeguarding Children Board', although in a local context it is also taken to mean the 'Leicester Safeguarding Children Board'. In Leicester, the terms are used interchangeably.

The Independent Chair wishes to thank contributors to the report:

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1. Foreword

I am pleased to present my third annual report as Independent Chair of the Leicester Safeguarding Children Board.

The report covers a year of major challenge for all agencies represented on the Board.

We have witnessed growing social problems, increasing referrals in many areas, rising child poverty and a lively public debate about revelations of sexual abuse of young people leading to court cases involving well known media stars and groups of men.

The government issued new and significantly changed statutory guidance in 2013.

Agencies in Leicester have responded robustly to these challenges and the work which is being done is set out in this report.

We welcome public scrutiny of our work to protect the wellbeing of children and young people in our city. However we recognise that there are continuing challenges. We have a professional and legal responsibility to take action to protect children, but we cannot do this alone.

We welcome comments and suggestions from the community about how we tackle those challenges. Safeguarding is everybody's business and we call upon people in Leicester to play their part in helping our children and young people to have the best life we can give them.

Our report takes a new shape this year, also reflecting the revised guidance on *Working Together*. I am required to give a personal report on the quality of safeguarding in the city and this overview forms chapter 2, which is in effect the Executive Summary of the following chapters.

I would like to thank all the members of the Board and our working groups for their commitment and achievements over the past year.

There has been a significant turnover of Board members reflecting the management reductions and changes in most agencies.

I must particularly thank the former Director of Children's Services, **Rachel Dickinson**, for her personal support to me but above all for her burning commitment to championing the interest of children and young people. She helped to improve the quality of services for children in the city and her professionalism and enthusiasm will be sorely missed. I am grateful too, for the contributions of the following, who also left the Board during the year: Donna Thomson (Police), Jackie Ardley (Leicestershire Partnership Trust), Ann Habens, Kamal Adatia, and Susan Harrison (all from Leicester City Council), Cath Pritchard (NHS Leicester) Rosemary Beard (Connexions), Jane Appleby (Strategic Health Authority). Louise De Groot (East Midlands Ambulance Service), Trevor Worsfold (Probation), Louise Wells and John Snaith (LSCB office).

I was reappointed by the Board for a second three year term in 2013. I am grateful for the confidence placed in me and reaffirm my commitment to serving the families and people of Leicester to the best of my ability, always preserving my independent scrutiny and judgement.

David N Jones (PhD, MA, BA, CQSW, RSW) Independent Chair



2. Safeguarding Children in Leicester

This is my third annual report on the work of the Leicester Safeguarding Children Board and my first report under the government's new statutory guidance:

'The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. This is a statutory requirement under section 14A of the Children Act 2004.' (Working Together 2013).

The report is presented in a new format recommended by the Association of Independent LSCB Chairs.

This chapter is my personal report to the people of Leicester on the work of the Board during 2012-13. It is followed by chapters which present the supporting detail, recording the work of the Board, its working groups and many individuals from partner agencies. Our intention is to provide 'a rigorous and transparent assessment of the performance and effectiveness of local services, identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action' (Working Together 2013).

JUDGEMENT ON THE EFFECTIVENESS OF LOCAL SERVICES

On the evidence available to me from many different sources, I

consider that services are working together effectively to minimise the risk to children and young people in Leicester and to provide help when needed.

I am satisfied that the LSCB is 'independent' and not subordinated to, nor subsumed within, other local structures. I have appropriate access to the City Mayor, Police and Crime Commissioner and chief officers of all agencies to raise any safeguarding concerns when needed.

Parents are responsible for the care of their children in the first instance and nobody can prevent all instances of ill-treatment and poor care. Helping to keep children and young people safe in Leicester is a responsibility of us all. Public agencies have special responsibilities for safeguarding and must work well together to minimise risks to children and young people but they can never be in a position to completely remove risk nor to prevent all instances of child abuse. All agencies are committed to providing help to families facing difficulties, doing their best to understand the needs of parents and providing support for goodparentina.

I am confident that agencies work together in Leicester to improve services and to learn from problems which are identified. External research has been commissioned to evaluate services and suggest improvements, services respond quickly to external inspections, serious case reviews are commissioned when necessary and their findings are quickly fed back to staff and used to make improvements, agencies have their own internal case audits and the results are shared. There is an honest discussion of problems and a determination to improve.

Areas for priority attention in 2013-

14 include improved arrangements for early help when problems are first identified and more effective intervention to reduce the number of children who stay on plans for longer periods and the number who are put on plans for a second time. Developing more effective ways to assess need and assist families is a priority for all agencies. File audits and serious case reviews also identify that more needs to be done to improve work with families where there are long-term problems of child neglect, something which has been identified as a national challenge. New arrangements are being introduced to strengthen the joint approach of agencies to monitoring the effectiveness of services.

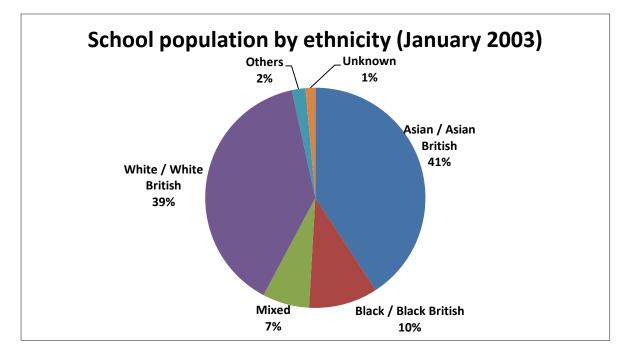
Agencies need to make sure that they continue to resource front-line services so that they can respond to the continuing increase in child protection referrals and, just as importantly, provide the longer term support which families need.

Agencies are working well together on the national strategy to improve early help which is given to children, young people and families when problems first emerge. This includes help to the increasing number of vulnerable newborns.

LOCAL CONTEXT

Leicester is the largest city in the East Midlands, with a population of 306,600 of whom around 20% are children and young people under 15 (61,300 approx). Leicester's adult population is relatively young compared with England; 20% (62,300) of Leicester's population are aged 20-29 years old (14% in England).

The Leicester population is predicted to grow to around 346,000 by 2020, an increase of nearly 40,000 from 2010. The birth rate has been rising significantly in recent years creating increasing demands on midwifery, health visiting and school services. The population is very diverse, as indicated by the following chart.



The Board is aware of its responsibilities to children and young people from all the diverse communities in the city and the need to ensure that people from all communities have confidence in services to support parents and protect children and young people.

Leicester has a high level of deprivation compared to the country as a whole. Whilst poverty and child rearing problems do not necessarily go together for all families, we know that poverty and related issues do make it more likely that there will be a range of social problems, including increased risk of mental health problems, suicide and self-harm, domestic violence and problems with children. Given the national economic environment and reductions in the financial support available to families, the Leicester Board has been predicting an increase in the number of families experiencing

significant problems. The number of families needing support continues to increase and problems are becoming more complex.

The past year has seen major changes in the structure and organisation of agencies which are members of the Board. I am reassured that all these changes have been effectively managed with less disruption than has been seen in some other cities. Major changes have taken place within the police, health, city council, probation, housing and schools, with significant impacts on voluntary and private sector providers. A programme of visits to Chief Executives of local agencies has been initiated by the Chair of the Leicestershire and Rutland Board and myself to ensure that safeguarding continues to receive a high priority. Effective child protection depends on trust and good cooperation between all

agencies. This can be undermined when the key people change and there are organisational uncertainties. It is to the credit of local agencies that, so far, the reforms have been implemented without significant disruption.

However for front-line services, the reality is increasing 'demand' for services with reducing resources and capacity to respond. This increases risk for children and young people.

NATIONAL AND REGIONAL CONTEXT

Each local authority is required to establish a Local Safeguarding Children Board (LSCB) for their area (Section 13 of the Children Act 2004) and the organisations and individuals that should be represented on the Board are specified in the Act. The government issues detailed statutory guidance about how the Boards must operate and has been consulting on major revisions to that guidance. The revised Working Together guidance was published in March 2013. This restated the significant role of the LSCB but very significantly reduced the amount of central guidance, leaving more to be determined by local areas and individual practitioners. The Leicester Board had anticipated these changes and is working through the implications.

Leicester recognises the need to work closely with neighbouring Boards in the East Midlands to ensure consistency and effective cross-border working. We make a positive contribution to the regional network of Independent Chairs and the regional improvement programme coordinated by the Association of Directors of Children's Services.

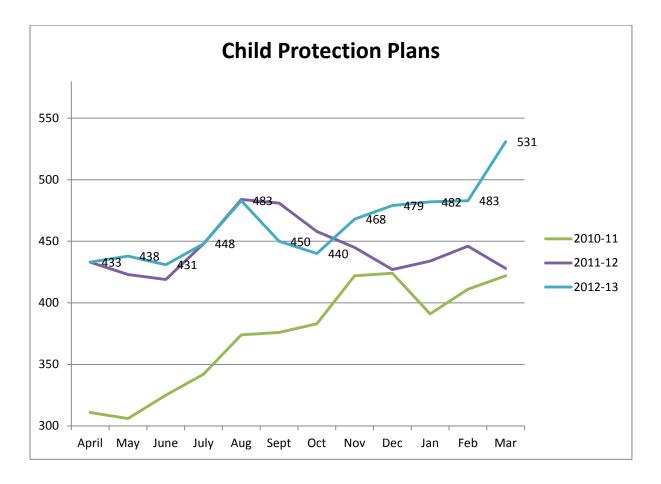
The Board has been acutely aware of the impact of the government's welfare reforms and the impact this is having on the income and housing of those who have least resources. We are monitoring the extent to which families are moved to Leicester from London and other cities as a result of changes in housing benefit. We have noted the national experience that some of those families who are required to move include children with child protection plans or who are otherwise vulnerable. It is not easy to identify these families when they move but agencies aim to provide support where appropriate. I welcome the report of the City Council's Child Poverty Commission and its recommendations, which have safeguarding implications.

Child protection, especially in the context of sexual abuse, has been the focus of continuing media attention and public concern throughout the year. The Board has been kept informed of national and local developments and local agencies have made significant contributions to national work on improving policies to identify and protect children who go missing and those at risk of sexual abuse. A new protocol for multi-agency responses when young people go missing was launched in February 2013 and there has been an active programme of work with local

communities about child sexual exploitation.

SAFEGUARDING IN LEICESTER

There was an increase of almost 25% in the number of child protection plans during 2012-13, reflecting similar increases elsewhere. The primary purpose of the plan is to prevent the child suffering harm or a recurrence of harm in the future and to promote the child's welfare. The number of children subject to plans increased from 426 in March 2012 to 531 in March 2013. The Board commissioned independent research to review the pattern of referrals which has led to changes in working arrangements within Children's Services.



The complexity of cases is also increasing, according to case audits, with significant numbers involving a volatile mix of parental mental health and substance abuse problems and domestic violence. Whilst this might in part be due to improved identification of cases, my impression is that this reflects the significant social pressures faced by parents. The growing public concern about sexual exploitation of young people also presents challenges to public agencies, opening up discussion about the respective legal and moral rights and responsibilities of parents and older teenagers.

Social workers, police, schools, health visitors and hospitals have responded to this very significant increase in 'demand' whilst also coping with 'efficiency savings' and resource reductions. We owe a considerable debt to all those in Leicester who continue to provide effective support to children, young people and parents.

There are established assessment protocols and frameworks in place in line with relevant legislation and policies. The development of a revised local protocol for assessment, as required by *Working Together 2013*, and revising the threshold document will be done in partnership with the Leicestershire and Rutland Board in 2013/14.

A multi-agency early help offer was agreed by the LSCB and Children's Trust in March 2013. Early help is about how different agencies work together to help children, young people and their families at any point in their lives prevent or reduce difficulties or problems occurring, or stop them from getting any worse. The board also set up an Early Help Strategic Group with representation from schools, statutory and voluntary sector partners: this work will be led by the Leicester Children's Trust Board.

The national focus on adult and young people who go missing and the launch in February 2013 of the local protocol for multi-agency

responses when young people go missing have highlighted the need to strengthen practice in this area. Young people who go missing are at considerable risk of various forms of exploitation and violence. Agencies are especially aware of the difficulties faced by some young people in residential care who go missing and the high cost of the response to the police and other public agencies. Agencies agree that the most effective way to prevent young people from going missing is to ensure they have access to trusted and caring adult relationships.

The number of allegations of abuse against adults working with children and young people in a paid or voluntary role has fallen slightly but the proportion requiring detailed investigation has increased. There were 268 referrals between April 2012 and March 2013, a decrease from 2011. There was a major change in procedure during the year following the launch of the Disclosure and Barring Service (DBS) in December 2012, merging the Criminal Records Bureau and the Independent Safeguarding Authority (ISA). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

Agencies contribute to a range of strategic and operational safeguarding activities such as Multi-Agency Public Protection Arrangements (MAPPA) (the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public), Domestic Abuse services, Prevent (preventing people from being drawn into terrorism and ensuring that they are given appropriate advice and support), Safeguarding in Education, Safeguarding Adults (including links with the Leicester Safeguarding Adults Board) and safer workforce activity including the Local Authority Designated Officer arrangements (for managing allegations against people who work with children, for example, those in a position of trust, including volunteers).

Leicester works closely with Leicestershire and Rutland to ensure the provision of a range of training opportunities for staff. The Board agreed new arrangements during the year which gave lead responsibility for the provision of training to the Leicester Children's Trust. The LSCB is developing more effective ways to evaluate the quality and impact of the training provided. There has continued to be training sessions delivered to Madrasah staff, jointly, with the Federation of Muslim Organisations.

EVALUATING THE QUALITY OF SAFEGUARDING IN LEICESTER

The Board uses several methods to monitor the quality of work,

including case statistics, serious case reviews and case file audits, 'Section 11 audits' of internal agency arrangements, externally commissioned research, inspection findings, peer reviews and complaints. The Board also receives a quarterly report at each meeting. This includes information from most member agencies about financial, workforce and service demands that have a bearing on safeguarding.

The Board identified the need to strengthen the monitoring of services in the city in order to provide public assurance about the quality of services and tasked a working group to develop an evaluation framework. Leicester has contributed to national work to improve ways in which Boards can fulfil this important task. We have noted that, nationally, most agencies have quantitative and aualitative measures of safeguarding effectiveness but there are few indicators of the effectiveness of multi-agency working. This is a priority for all LSCBs and one for our board

The statutory Section 11 audits have produced satisfactory reports on services provided by agencies and any services that they contract out to others. Services were found to have appropriate regard to the need to safeguard and promote the welfare of children. Agencies have provided evidence to demonstrate their compliance with the requirements of Section 11. The integration and scrutiny of Section 11 audits will be strengthened in 2013/14.

The LSCB commissions statutory serious case review (SCR) when required. Two reviews were initiated during the year. Reports have been published and the Chair has given interviews to media organisations about them. The purpose of these and other case reviews is to identify improvements which are needed and to consolidate good practice. The LSCB and its partner organisations translate the findings from reviews into programmes of action so that there is learning from good practice and problems identified. Leicester contributes to the East Midlands LSCB network which ensures dissemination of the findings of SCRs between Boards. External feedback has commended the SCRs for being robust & transparent and we have received positive feedback from the independent authors on the quality of the review process in the city.

The Board worked with the Social Care Institute for Excellence to pilot new approaches to undertaking SCRs in 2012-13. We also commissioned a Serious Incident Learning Process (SILP) as a new way of reviewing cases where a full SCR was not required. These provided valuable learning for local agencies and prepared us well for the new arrangements launched in Working Together 2013, allowing more local freedom in how reviews are conducted.

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by the Child Death Overview Panel (CDOP). The CDOP is chaired by the LSCB Chair's representative, Dr. Tim Moore. Dr. Moore is not involved directly in providing services to children and families in Leicester. Given the small number of cases considered, it is difficult to draw general conclusions. A regional CDOP summit was held in April 2012 to look at the way in which data is currently collated across regions. The aim of the summit was to share learning but also look at the feasibility of collating a regional picture in order to try to establish emerging trends and themes. The LSCB would like to see a national report drawing conclusions from the CDOP processes.

The most recent full inspection of safeguarding and child protection services was carried out in December 2011. Safequarding services were judged adequate overall, with good capacity to improve. The inspection of Youth Offending Services which reported in July 2012 found 'examples of effective engagement with children and young people and of thoughtful, sensitive practice. However, performance relating to Risk of Harm work needs substantial improvement'. At the start of the current year a Peer Review (by representatives of other organisations in the region) found that safeguarding was sound and made recommendations for improvements; this will be reported in full in the next annual report. The Review contributed to a fundamental review of the structure of the Children's Trust Board, with changes likely to be made in the current year.

GOVERNANCE AND REPRESENTATION

I am satisfied that there is a commitment to the work of the Board and attendance at relevant meetings is usually good. The Board meets quarterly to undertake formal business and to ensure a shared understanding of topical issues affecting children and young people. Most of the work is undertaken by working groups; commitment to the work of the aroups is sometimes affected by other work demands on members. Attendance of agency representatives at the Board is reported for the first time in the appendix.

The main responsibility of the independent chair is to enable all agencies to hold each other to account for their work in relation to safeguarding and to ensure proper processes for the conduct of business. I was appointed as Independent Chair of the LSCB in April 2010 and my contract was renewed in 2013. I am also the Independent Chair of Leicester's Safeguarding Adults Board. I am grateful to the Board for supporting my national work helping to launch the new national Association of Independent LSCB Chairs. I was elected Vice Chair of the Association in 2012 and have participated in national meetings with Ministers and aovernment officials about reform of the safeguarding systems. This has ensured that Leicester is briefed about national developments.

There is an open and honest culture in the business of the Board.

Agency representatives have a commitment to children and there is robust debate and challenge when necessary. The Board has an annual review of its own governance and business plan.

The Board fulfils the statutory requirement to appoint 2 lay members who are not employed by any agency in the city. One lay member has previous experience of serving on a board dealing with issues of public safety. The second lay member is a young person who was appointed during the year of this report with a specific remit to strengthen the Board's engagement with children and young people and to work with the team of Young Advisers who support the Board and also the Leicester Children's Trust.

Engagement with children and young people is essential to effective safeguarding and coordinated by the Participation Group. The group includes young people as members. The group links with other participation groups in the city, such as school and children in care councils through which young people have been consulted about how safe they feel. This will feed into a summit in October 2013 involving around 200 young people focussing on education, leisure, home and community. A charter for safequarding and a report to the Board are likely outcomes. Key safeguarding messages are also shared through sessions in schools and colleges.

The Board office arrangements are hosted by Leicester City Council. The Board office structure is made up of the LSCB Manager, an LSCB Policy Officer and 1.5 full time administrative staff. The Executive keeps the resources of the Board office under review.

I am grateful to all the members of the Board and local staff in Leicester for their commitment to children and young people and for their support to me in this role.

David N Jones Independent Chair

3. Local background and context

The population of Leicester

The East Midlands is the second smallest region behind the North East with a population of just under 4.5 million. It is a less deprived area compared to the West Midlands and the North, but more deprived than areas of the South.

Leicester is the largest city in the East Midlands, with a population of 306,600 (Source: Office for National Statistics mid-2010 population estimates) and covers an area of 73.3 km². Much of the area is urban, with a high population density of 4,182 people/km² making it the most densely populated area in the East Midlands and the 29th most densely populated area in the country (Source: Office for National Statistics Population Analysis tool).

The current population estimate for Leicester City is 306,631 of which 151,277 are males (49%) and 155,354 (51%) are females. Leicester's population is relatively young compared with England; 20% (62,300) of Leicester's population are aged 20-29 years old (14% in England) and 12% (35,600) of the population are aged over 65 (16% in England). The large numbers of young people in Leicester are partly students attending Leicester's two universities and partly immigrants to Leicester. This latter aroup reflects growth in the city's population since around the year 2000.

Leicester City Council estimates that the Somali community comprises about 10,000 people, migrants of working age (from Poland, Portugal, Slovakia, Latvia and Lithuania) between 6,000 and 8,000 people including 1,000 - 2,000 people from the Roma community in Slovakia. Other new communities include asylum seekers and refugees. Leicester is a National Asylum Seeker Service designated dispersal city. The maximum number of asylum seekers in Leicester at any one time is 800. In 2011-12 this number was around 450 people.

The Leicester population is predicted to grow to around 346,000 by 2020 (Source: Office for National Statistics 2008-based population projections), an increase of nearly 40,000 from 2010.

Deprivation in Leicester

Leicester has a high level of deprivation compared to the country as a whole and is ranked 25th worse out of 326 local authority areas in England on the national Index of Deprivation (2010).

41% of Leicester's population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas. Only 1% of Leicester's population live in the 20% least deprived areas.

4. Statutory and legislative context for LSCBs

Section 13 of the Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specified the organisations and individuals (other than the local authority) that should be represented on LSCBs.

Statutory objectives and functions of LSCBs

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

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

The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

- 1(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- training of persons who work with children or in services affecting the safety and welfare of children;
- (iii) recruitment and supervision of persons who work with children;
- (iv) investigation of allegations concerning persons who work with children;
- (v) safety and welfare of children who are privately fostered;
- (vi) cooperation with neighbouring children's services authorities and their Board partners;
- (b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this

can best be done and encouraging them to do so;

- (c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- (d) participating in the planning of services for children in the area of the authority; and
- (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) relates to the LSCB Serious Case Reviews function and regulation 6 relates to the LSCB Child Death functions.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

- 2. In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:
- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations

set out in chapter 2 of this guidance;

- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The LSCB does not commission or deliver direct frontline services.

While the LSCB does not have the power to direct partner or other organisations, it does have a role in making clear where improvement is needed.

Each Board partner retains their own existing line of accountability for safeguarding.

5. The work of the Leicester Safeguarding Children Board

Policies and procedures

The Executive Group of the LSCB takes a lead role in overseeing the LSCB Child Protection Procedures and ensuring that they are up to date and used across all agencies. It was agreed at the point of disaggregating from the former tripartite board (2009) that the procedures would remain joint with the Leicestershire County and Rutland Board, since this made better sense for agencies and families.

A Procedures and Development sub group meets on a quarterly basis to co-ordinate the revision and addition of procedures to ensure that they reflect changes necessary as a result of previous learning, emerging priorities and new developments.

The procedures will need to be updated again in relation to the revised Working Together 2013 and the Executive Group will ensure this happens in a timely way. The procedures are hosted for the Board by a third party: Tri-X. The shared procedures are accessible through the Board's website at: www.lcitylscb.org/

Single and Multi-Agency training provision

The strategic overview of safeguarding learning across Leicester, Leicestershire & Rutland is overseen by the Leicester, Leicestershire & Rutland Safeguarding Multi Agency Training, Learning and Development Commissioning and Delivery Group, and is supported by and the work of the Leicester, Leicestershire & Rutland LSCB Training Project Development Officer and the Leicester, Leicestershire & Rutland LSCB Multi agency Project Coordinator.

The subgroup has representation from key partners across Leicester, Leicestershire and Rutland: the representatives of the group are individuals who have the strategic authority to contribute to safeguarding learning, training and development. The group includes representation from Social Care and Safeguarding, the Clinical Commissioning Group, the Primary Care Trust, University Hospitals Leicester, the Youth Offending Service, Corporate Learning and Development / Workforce Development, Adult services, Voluntary Action Leicestershire, Leicestershire Police, Probation and Education.

As well as supporting the implementation of the Training Strategy, the sub group supports

the statutory duty and responsibility that the LSCB has;

- To develop policy and procedures in relation to 'the training of persons who work with children or in services affecting the safety and welfare of children.'
- To monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.
- To ensure that a culture of information sharing is developed and supported as necessary via multi-agency and single agency training.
- To support a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children.

These duties are determined by Working Together 2013, Regulation 5, Local Safeguarding Children's Boards Regulation 2006 & Children Act 2004.

The work of this group will link in with the work of the LSCB Safeguarding Effectiveness Group. The training strategy has an emphasis on evaluation and scrutiny of learning, as follows:

- A formal process for a Quality Assurance Framework, and process and audit and evaluation information for the multi-agency programme is being developed.
- 'Best Practice' principles for safeguarding learning have informed the strategy.
- Quarterly monitoring reports are produced providing detailed evidence, analysis and evaluation

of the multi-agency Safeguarding Training Programme. These will provide information and evidence for inspection purposes, and by which effectiveness can be measured. This quarterly reporting allows for learning to be measured. It will contain data in relation to uptake, attendance etc. The new infrastructure and tracking systems for the multiagency programme will allow for contributions by partners and priorities to be tracked and measured.

Changes made as a result of previous learning/priorities and new developments

There is an implementation plan for the redevelopment of the Training strategy and launch of the new infrastructure and Framework for safeguarding learning.

Over the last 12 months, there have been a number of developments and work streams overseen by the subgroup which has supported single agency and multi-agency learning;

- A change of remit, and terms of reference: Training Task and Finish Group has now become the Leicester, Leicestershire & Rutland Safeguarding Multi Agency Training, Learning and Development Commissioning and Delivery Group
- Re-establishing the Trainers Network to offer support to all staff that deliver or have involvement with development of Safeguarding learning.
- Regular mail outs of resources and information to staff,

managers and safeguarding trainers.

- Development of Best Practice Principles for Safeguarding learning (to be endorsed.)
- Progression of development of a 'Best Practice' Matrix – to support agencies in selecting trainers and commissioners to deliver training (to be endorsed.)
- Review of first year of multiagency programme, planning and development for 2013 – 14.
- Development of an infrastructure for the running of the multiagency programme. Formalising the process for the 'mixed economy' that is used to resource the multi-agency programme, which allows for all contributions to be valued, and areas of expertise to be developed and utilised.
- Undertaking a priority needs analysis for the multi-agency programme and developing a process for tracking and audit purposes which will support the Quality Assurance process. This also links in with tracking how recommendations from Serious Case reviews and business plan priorities are met.
- Quarterly evaluation reports and analysis of multi-agency training programme.
- Strengthening inter agency partnerships in relation to safeguarding learning, by regular formal meetings of the group, and contact with Project Coordinator and Project Officer with partners across the workforce.
- Work is currently underway on developing a formal Quality Assurance framework with LSCB

Safeguarding Effectiveness groups.

- Work to develop a draft Competency Framework for Safeguarding Learning across all groups in the children's workforce. (To be endorsed.)
- On-going support and commitment to provision of Level 2 training to the Private, Voluntary and Independent (PVI) sector.

Future Developments

To develop a formal system for Quality Assuring Safeguarding learning. Work is currently underway with Safeguarding Effectiveness groups and the LSCB Project Officer. (completed by Autumn 2013)

Communication Strategy: Work around a link to a new process with the communication strategy / sub group to support key messages / learning that needs to be communicated to a particular sector or the wider workforce. Liaison is planned with Board managers and associated sub groups to establish a formal process. (completed by Jan 2014)

Training website and use of other technologies: Development of a Leicester, Leicestershire & Rutland (LLR) training website / use of other social media that complements other existing websites, in which information can be shared and resources available for practitioners and trainers relating to safeguarding learning. This work stream will be considered in the future and linked in to the work around the LSCB website (by March 2014).

Fit with, and contribution to, the LSCB's current priorities

The primary focus of the group is to support practitioners in the workforce to have the skills, knowledge and confidence to undertake their roles and responsibilities in relation to safeguarding.

This work contributes directly to safeguarding children and promoting their welfare, by supporting organisations to have clear guidance about the expectations and learning that is required, in order to support the workforce to effectively safeguard and take appropriate action in line with their roles and responsibilities.

The scrutiny role allows the LSCB to consider the impact and effectiveness.

The proposed refreshed standards and essential content for training and also the competency model will allow for a formal basis for the workforce to be assessed against.

For the multi-agency training programme 641 level 3 staff received training in 2012-13. There is a mixture of quantitative and qualitative evaluation data, which shows overall that there is an increase in skills, knowledge and confidence at the 3 month stage of evaluation.

As systems and evaluation methods are further developed into more detailed focus groups, we will be able to further measure the direct impact on practice, which in turn should support effective safeguarding practice. The on-going liaison and work to develop and implement the training strategy has developed and strengthened existing relationships, and allowed for new working relationships with key partners to be developed. Small task and finish groups have allowed for the work to have a broader multi-agency perspective, and this input has supported engagement and commitment to the multi-agency programme and training strategy.

The development of the Quality Assurance Framework and Competency Framework, will give all partners clear guidance in terms of the expectations and scrutiny role that the LSCB will undertake.

However an approach of consultation and cross agency development work with many of the partners, has underpinned the work and has indicated support for the new Framework, which in turns promotes and supports the culture of continuous learning.

Quality and effectiveness of arrangements and practice

How the LSCB determines its own effectiveness as well as the effectiveness of the collective effort

LSCBs coordinate the work to safeauard children locally and monitor and challenge the effectiveness of local safeguarding arrangements (Working Together, 2013). The Safeguarding Effectiveness Group (SEG) is responsible for monitoring and challenging the effectiveness of safeguarding arrangements of the partners of Leicester Safeguarding Children Board. The purpose is to enable the LSCB to reach a judament based on the work submitted to SEG, in order that it can provide assurance to the Board that local safeguarding arrangements are robust.

In the last 12 months the collective efforts of Board Partners has resulted in the following work being completed:

- Section 11 Audit satisfactory assurance was received in regard to members safeguarding arrangements. No concerns were noted.
- Serious Case Review action plans were reviewed and assurances obtained in relation to implementation of case recommendations.
- Clarification and refining of safeguarding indicators – which are aligned to the children and young people's plan.

- Development of data and commentary reporting sheet.
- Safeguarding Babies multiagency review in-depth of three cases (two in detail)

Description and evaluation of priorities that relate to maintaining and improving LSCB effectiveness

The work of SEG is based on four key areas:

- Performance Framework
- Co-ordination of Audits
- LSCB Effectiveness
- Embedding Learning from Review processes

The SEG has adopted those priorities identified in the partnership's Stay Safe group. These priorities are themselves informed by those in the local Children & Young People's Plan.

Further work needs to be done to rationalise the requests for data from partner agencies, and it is anticipated that the coming year will see the emergence of a clearer reporting framework around performance measures.

Impact on safeguarding and children

It is difficult to quantify the impact that the work of the SEG has directly on the lives of children and young people. The collation of data the scrutiny that SEG undertakes in relation to partners safeguarding arrangements and the implementation of recommendations from Serious Case Reviews (SCRs) will impact of improving outcomes locally for children and young people. SEG has this year developed a strong foundation in relation to quality assurance and through critical challenge in the future, the scrutiny of safeguarding arrangements on behalf of the Board will ensure best outcomes for children within Leicester City.

Impact on partner agencies

Partners are required to submit information to SEG in regard to the key performance indicators but also in relation to their own quality assurance work that they have undertaken. SEG is widening its scope beyond children's social care to ensure engagement with the wider LSCB partnership.

Impact on community awareness

As an individual sub-group it is difficult to quantify the impact of the work of SEG has directly on community awareness. If SEG has scrutinised its partners effectively then local communities will have an awareness of effective and robust local safeguarding arrangements.

Section 11 Audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Section 11 places a duty on:

- Local Authorities and District Councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services;
- NHS organisations, including the NHS Commissioning Board and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts;
- the Police, including Police and Crime commissioners and the Chief Officer of each police force in England;
- the British Transport Police;
- the Probation Service;
- Governors/Directors of Prisons and Young Offender Institutions;
- Directors of Secure Training Centres; and
- Youth Offending Teams/Services.

These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

 a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;

- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- appropriate supervision and support for staff, including undertaking safeguarding training:

- employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
- all professionals should have regular reviews of their own practice to ensure they improve over time.
- clear policies in line with those from the LSCB for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:
 - behaved in a way that has harmed a child, or may have harmed a child;
 - possibly committed a criminal offence against or related to a child; or
 - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Audit work with partner agencies conducted by the LSCB's Policy Officer has ensured that the relevant local partner agencies have the required arrangements in place and they have provided evidence to demonstrate their compliance with the requirements of Section 11.

This work is overseen by the Safeguarding Effectiveness Group under its' 'Co-ordination of Audits' priority.

The LSCB's case review function

Professionals and organisations protecting children in Leicester need to reflect on the quality of their services and learn from their own practice and that of others. It is important that good practice is shared so that there is a growing understanding of what works well.

Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

These processes must be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

The LSCB is in the early stages of creating a local learning and improvement framework to be shared across local organisations who work with children and families. This framework will enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

The local framework will support the work of the LSCB and its' partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.

The local framework will cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.

Some of these reviews (i.e. SCRs and child death reviews) are required under legislation. The LSCB understands the criteria for determining whether a statutory review is required and always conducts those reviews when necessary.

The LSCB may also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services.

Such reviews may be conducted either by a single organisation or by a number of organisations working together.

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. The LSCB and its' partner organisations translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The different types of review include:

- child death review: a review of all child deaths up to the age of 18;
- Serious Case Review: for every case where abuse or neglect is known or suspected and either:
 - o a child dies; or
 - a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;
- review of a child protection incident which falls below the threshold for an SCR; and
- review or audit of practice in one or more agencies.

Child Death Reviews

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP).

The Panel has a fixed core membership drawn from organisations represented on the LSCB and it has flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.

The CDOP is chaired by the LSCB Chair's representative, Dr. Tim Davies. Dr. Davies is not involved directly in providing services to children and families in Leicester.

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004.

The LSCB is responsible for:

- a) collecting and analysing information about each death with a view to identifying—
 - (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - (ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
 - (iii) any wider public health or safety concerns arising from a particular death or from a

pattern of deaths in that area; and

 b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The timeframe covered within the report relates to cases that have been reviewed by the LLR CDOP from April 1st – March 31st 2012 (this coincides with the timeline of data that is supplied to the Department for Education for their statistical release).

Whilst this will provide an overview of the number of cases reviewed it does not demonstrate the number of notifications received (within the time period).

The Leicester, Leicestershire & Rutland CDOP has undergone a review of its current functions and processes and a report outlining the findings was presented to both LSCBs in mid-2012. The report showed that the Leicester, Leicestershire & Rutland (LLR) CDOP had effective working processes and good inter agency engagement. Under the leadership of the new panel Chair this work will continue to be built on and developed.

The remit of CDOP panels nationally is to provide an overview of cases and identifying learning that may seek to reduce future deaths and as such views the 'wider picture'. It is not the intention of CDOP panels to identify a list of failings and it does not

review the cases under the same criteria as that considered durina a Serious Case Review process. Therefore in a vast number of cases it is acknowledged that there will be no recommendations to be made by CDOP. All cases are reviewed thoroughly before a decision of no further action is reached. It is important to note that even in those cases where specific recommendations or learning is noted and acted upon, from a statistical viewpoint it is almost impossible (due to the low numbers of cases) to demonstrate a direct correlation between action undertaken and a decrease in the number of deaths in a particular category year on year.

Strong links have been established with both Serious Case Review sub groups and the Stay Safe Development Group. This has ensured that the priorities outlined within the respective Children and Young Peoples Plans for Leicester City and Leicestershire underpin the work of the panel. Work also continues to progress with partners looking at the emotional health and wellbeing of children and young people, as well as addressing specific areas such as infant mortality rates and incidences of road traffic collisions.

Work is currently underway led by the Police, working in conjunction with the Child Death Review (CDR) Manager, to update a booklet for Police personnel on the processes required in the review of unexpected deaths. Once complete this could be adapted for other organisations. Significant work has also been undertaken with regard to awareness raising for 'end of life' care decisions. This includes:

- Attendance (by the police, health commissioners and CDR Manager) at a parent forum to seek views on how current processes can be improved.
- Meetings with both of HM Coroners within LLR, Police, East Midlands Ambulance Service and the CDR Manager to review current practices and ensure all relevant professionals are aware of any changes to practice.

Panel members are requested to ensure learning points are captured within appropriate forums within their respective organisations in order to ensure any actions that are undertaken by panel's members are logged.

A multi-agency day is planned to facilitate by the CDR Manager and colleagues from Police and Health. It will be used to update professionals on the current processes and any recent changes as well as providing an opportunity to discuss scenarios based on recent cases, share learning and develop future practice. The plan will be to run similar sessions on a 6 monthly programme aimed at other disciplines involved within the process.

CDOP has worked hard to establish links with the Health and Safety Executive (HSE) to ensure collaborative working in cases where there will be an overlap. This has since been taken up nationally and resulted in a meeting with representatives from HSE and the Department for Education to establish guidance on how CDOP, HSE and Safeguarding Boards will work together.

The reduction of infant mortality and keeping children safe is recognised as a priority within both LSCBs. CDOP has worked closely with both Boards to support work that has been undertaken in these areas.

In recognition of the number of deaths in the "under one year old" category, the CDR Manager attended the task and finish group hosted by the Leicestershire and Rutland LSCB developing the Safeguarding Babies workshop.

Current data shows that children under one year of age form a significant number of those cases notified. Of the 48 cases reviewed between April 1st 2011 and March 31st 2012, 29 were less than 1 year of age. Of those 29:

- 6 were unexpected deaths
- 18 were neonatal deaths (i.e. less than 28 days old)
- 5 were expected and related to chromosomal or genetic anomalies.

A regional CDOP summit was held in April 2012 to look at the way in which data is currently collated across regions. The aim of the summit was to share learning but also look at the feasibility of collating a regional picture in order to try to establish emerging trends and themes. All present felt it would be extremely beneficial but that ultimately what is required is a national database. This would allow for a true picture to be collated and would strengthen the use of resources.

Colleagues also supported the use of a database that would allow for 'live' entry in order to flag up any possible trends as they were occurring.

Building on the success of the regional summit – LLR CDOP has agreed to support the next event planned for 2013.

The CDOP annual report provides a fuller account of the work of the CDOP and refers specifically to:

- Accountability and Assurance
- Panel membership
- Procedures
- Sudden Unexpected Death in Childhood (SUDIC) arrangements
- Learning and dissemination arising from the work of CDOP
- Additional areas of work undertaken
- Awareness raising
- Areas for action/development

A copy of the CDOP Annual report is available from the LSCB website.

Serious Case reviews

Regulations 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 sets out the functions and requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

In the year 2012 – 2013 two such reviews have been initiated by the LSCB.

Engagement with and the participation of, children

Ensuring that children and Young People are consulted and listened to regarding safeguarding issues was identified as core business for the LSCB and a priority in the LSCB 2011/12 Business Plan. It remains a priority for 13/14.

The aim of the participation work is to:

- Ask children and young people across the City whether they are safe and feel safe
- Work with children and young people to ensure that they know how to keep safe
- Consult with children and young people about service delivery
- Ensure young people's representation on the LSCB Board

Consultation with and the participation of children and young people with regards to services that they receive is good practice. This is highlighted with regards to safeguarding services in Working Together 2010 and also the newly revised version Working Together 2013.

By consulting with a broad range of children from across the city about the topics of "are safe, feel safe and stay safe", we can benchmark the success of current safeguarding services, identify gaps and ask children and young people how best to deliver those services. They can offer a critic of those services as users. The work is co-ordinated through a Participation Group chaired by the Head of Children's Safeguarding and Quality Assurance Leicester City Council and supported by the LSCB Policy Officer. Representation on the group was initially limited to key participation leads from across the city, primarily the City Council, the SDSA and education including colleges. The group has subsequently grown and now includes wider representation including young people.

Initially the group met bi-monthly with work led by the Policy Officer taking place between meetings. The group now has a specific pieced of work to focus on and is meeting once a month.

The participation work has developed into three areas:

The first area

- The development of a "federation" of children and young people from the councils across the city, including the Big Mouth Forum, the Children in care Council (CICC), School Councils and the Young Peoples Council. These groups were consulted and formed the idea of having a children and young people's summit.
- Schools from across the city have been asked to work with their School Councils to:
 - a) collect information from pupils as to whether they feel safe, are safe and know how to stay safe and then

b) allow members of their Councils to attend a summit in October where we will consult with up to 200 children on those three areas, are safe, feel safe and stay safe.

The summit will be split into two age zones and each zone will have four areas reflecting, education, leisure, home and community.

- This information will be collated and form a significant benchmark for services.
- The summit is being organised by children and young people for C&YP
- One outcome proposed is that children and young people in partnership develop a "charter" for safeguarding.

The second area:

 Work is underway through the RSE curriculum to ensure key safeguarding messages are incorporated.

The third area:

• Recruitment of a young layperson to the Board

6. Governance and accountability arrangements

Leicester Safeguarding Children Board structure

Board membership is listed at Appendix A.

The diagram at Appendix B shows the relationships between the various structures of the LSCB.

The Board meets on a quarterly basis and the format of its' meetings alternate between standard business meetings (June and December) and less formal "development" meetings (March and September), which enable the Board to consider particular priorities or topics in greater depth.

Attendance at the Board by partner agencies is contained in Appendix C.

In order to provide effective scrutiny, the LSCB must be independent. It is not subordinate to, nor subsumed within, other local structures.

The local partnership and accountability arrangements are specified in the Board's Constitution document available on the LSCB's website at: www.lcitylscb.org/

Infrastructure arrangements

The Board office arrangements are hosted by Leicester City Council. The Board office structure is made up of the LSCB Manager, an LSCB Policy Officer and 1.5 full time administrative staff.

A project development Officer is hosted by the city's LSCB and the cost of the post is shared across Leicester, Leicestershire and Rutland.

The LSCB office is located in city council premises at 6 St. Martins, Leicester, LE1 5BD.

Independent Chair arrangements

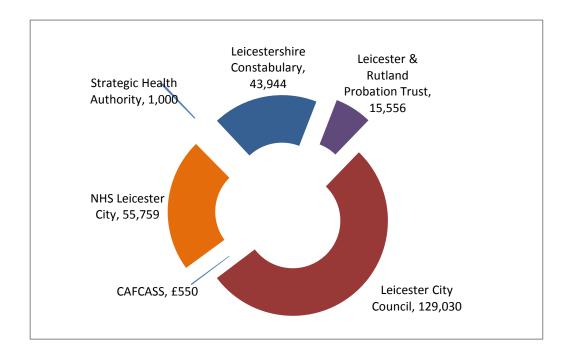
Dr. David Jones, the Independent Chair of the LSCB was re-appointed in April of 2013 for a second 3 year term. Dr. Jones is also the Independent Chair of the Leicester's Safeguarding Adults Board.

A central responsibility of the independent chair is to hold all agencies to account for their work in relation to safeguarding.

LSCB Budget and expenditure

The contributions from the partner agencies during 2012/2013 were agreed and received as follows:

	£	%
Leicester City Council	129,030	52.5
NHS Leicester City	55,759	22.7
Leicestershire Constabulary	43,944	17.9
Leicester & Rutland Probation Trust	15,556	6.3
CAFCASS	550	0.2
Strategic Health Authority	1,000	0.4
TOTAL	245,839	



The total amount carried forward from the financial year 2011/2012 was \pounds 186,358.

Cost areas agreed as part of the LSCB Business Plan for 2012/13	Planned 2012/2013 Spend	Actual Spend for Q1	Actual Spend for Q2	Actual Spend for Q3	Actual Spend for Q4	Total 2012/ 2013 Spend
Staff costs (3.5 WTE)	134,700	22,300	22,600	22,300	53,800	121,000
Transport costs	7,000	100	0	200	200	500
Supplies and Services	1,000	3,100	200	0	4,900	8,200
Independent Chair	20,000	6,900	6,900	7,500	5,500	26,800
Review process costs	30,000	10,800	8,900	7,600	3,000	30,300
Conference event and room costs	6,000	1,400	700	5,400	400	7,900
LSCB Procedures	7,700	0	1,900	0	0	1,900
Communication and Raising Awareness costs including STOI	6,000	0	0	0	0	0
Child Death Overview Panel	16,800	0	0	0	5,400	5,400
Other	0			600	300	900
TOTALS	229,200	44,600	41,200	43,000	73,500	202,900

Planned and actual expenditure from the base budget in 2012/2013

Planned and actual expenditure from the underspend carried over from 2011/2012

Cost areas agreed to be set against the underspend from 2011/12	Planned 2012/2013 Spend	Actual Spend for Q1	Actual Spend for Q2	Actual Spend for Q3	Actual Spend for Q4	Total 2012/ 2013 Spend
LLR Project	21,800	0	0	11,000	11,000	22,000
Development						
Officer (training)						
Voluntary Action	15,700	0	15,700	0	0	15,700
Leicestershire (Level						
3 training support)						
Research (Thorpe)	43,000	0	0	0	0	0
Stay Safe Priorities	50,000	0	0	8,000	0	8,000
TOTALS	130,500	0	15,700	19,000	11,000	45,700

End of year figures

Total Spend 2012-13		202,900	
Total one-off spends 2012-13		45,700	
		248,600	
less contributions from partner agencies	-	115,200	
less LCC contribution	-	129,000	
less contributions from L&R LSCB for E Ranger	-	10,500	
less b/fwd underspend from 2011-12	-	186,400	_
	-	441,100	_
			_
underspend c/fwd into 2013-14	-	192,500	_
			-

7. The effectiveness of safeguarding arrangements in Leicester

This chapter presents our evaluation of the effectiveness of the safeguarding children arrangements in Leicester. The Board recognises that evidence of effectiveness must be gathered from a range of sources, including statistical measures and smaller scale, in-depth, qualitative evaluations. The Safeguarding Effectiveness Group has been charged with developing a core set of information combining qualitative and quantitative information.

All agencies collect data on their individual performance in relation to child protection and safeguarding, frequently combining statistical and qualitative findings. The challenge for all LSCBs is to develop ways to report on the effectiveness of the partnership and joint working, given that evidence of poor joint working is frequently found in reviews of cases with tragic outcomes.

The Board is especially keen to ensure that there is a broadly consistent approach across Leicester, Leicestershire and Rutland to evaluation of effectiveness and is working to develop greater consistency across the East Midlands region and nationally.

The Board is kept informed of national and regional

developments in reviewing effectiveness through active engagement in national and regional officer groups and the Association of Independent Chairs of LSCBs and draws on best practice identified through those networks in developing our local arrangements.

Governance arrangements

The Board has kept the adequacy of its governance arrangements under review since its formation as a city Board in 2010. Time was devoted specifically to this at the Board development day in 2011, resulting in some changes to the sub-committee structure.

The Board approved a values statement, jointly with the Adult Safeguarding Board, during this year.

The protocol with the Children's Trust was approved during the year and will be kept under review.

The Peer Review in 2013 raised some issues for consideration, notably the nature of the LSCB's role in the Stay Safe Development Group and around the lead responsibility for commissioning early help services. This will lead to some structural adjustment to the Trust and the LSCB in the coming months. The Board agreed to report publically on attendance at Board meetings. This is included in this report.

The city and county Boards have a formal structure for collaboration, including regular joint Executive meetings, shared arrangements for training, shared procedures and joint arrangements for learning from serious case reviews and other case reviews. The Board is committed to sustaining this collaborative approach.

Two lay members have been appointed to the Board, in accordance with statutory requirements. One lay member is a member of the Safeguarding Effectiveness Group providing an independent perspective within the Group and to the Board. A younger lay member was appointed during 2013 and is already making a significant contribution to arrangements for communication with children and young people.

Improvement priorities

The Board approves a rolling annual Business Plan whose implementation is monitored by the Executive Group. The Executive also monitors financial expenditure. The Executive reports on these matters to each Board meeting.

The Business Plan identifies areas for priority action and improvement. These priorities are identified from the findings of serious case reviews and local audits, national policy developments and government requirements and other local and national developments. Comment on specific priorities is included below.

The national and local context

Earlier chapters have presented detailed information on the factors which influence the welfare of children and young people in Leicester:

- The global <u>economic situation</u> and government policy are contributing to increasing pressures on families;
- Unemployment in Leicester is approaching twice the level of unemployment for the region (see table below), with an especially high impact on younger people;

Unemployment rates: International Labour Organisation definition; April 2012 to March 2013

	April 2012 - March 2013		April 2011 - March 2012	
Area	ILO Unemploy- ment Rate (working age)	Total Persons ILO Unemployed	ILO Unemploy- ment Rate (working age)	Total Persons ILO Unemployed
United Kingdom	8.0%	2,471,800	8.2%	2,514,200
East Midlands	8.0%	177,300	8.1%	181,300
Leicester Shire	8.2%	39,100	8.5%	41,000
Leicester City	14.4%	21,500	13.1%	19,400
Leicestershire County	5.4%	17,500	6.5%	21,600

Source: Labour Force Survey/Annual Population Survey, Office for National Statistics (Nomis)

Leicester has seen the <u>highest</u> <u>growth in population</u> in 10 years after London, Manchester and Milton Keynes. Between 2001 and 2011, the number of residents went up by 47,100 (almost 17%), from 282,800 to 329,900, according to the 2011 Census figures. This, with a rising birth rate results in greater pressures on health and education services;

Table: Live births by local authority of usual residence of mother, numbers, General Fertility Rates and Total Fertility Rates, 2012

Area of usual residence	Live births	General Fertility Rate ²	Total Fertility Rate ³	TFR in 2000
England	694,241	64.9	1.94	
East Midlands	55,645	63.1	1.95	
Leicester UA	5,273	66.8	1.92	1.72

¹ Rates for 2012 have been calculated using mid-2012 population estimates based on the 2011 Census.

²The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15–44. The GFRs have been calculated using mid-2012 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

- Changes in <u>housing policy</u> and <u>welfare benefits</u> were being implemented during the period of this report and will have an increasingly significant impact on families in the coming year;
- Changes in the organisation of the justice system, including significant reductions in <u>access</u> to legal aid to children and parents in family cases, are beginning to affect the

management of cases involving legal action.

There have also been significant changes in the organisation and governance of a number of member agencies of the LSCB:

- The New <u>Police and Crime</u> <u>Commissioner</u> took office, having made a commitment to focus on safeguarding in his manifesto.
- The health service was subject to major transformation; safeguarding was identified nationally as a significant risk to be managed in the handover.
- The City Council has managed very significant <u>funding</u> <u>reductions</u>.
- The Probation Service faces <u>major change</u>.
- The voluntary sector has experienced significant funding reductions from public and private sources.
- Schools have been given greater independence to manage their affairs.
- Advice services for young people are being reshaped

The year of this report also witnessed a number of national, high profile safeguarding cases which attracted substantial public and media interest and which have an effect on the general safeguarding climate.

Operation Yewtree (allegations against Jimmy Savile) followed a TV programme in October 2012 and has resulted in evidence of abuse of a large number of young people and vulnerable adults over several

decades. Other cases which subsequently came to light drew attention to the protection afforded to those with celebrity status and the lack of concern shown for those victims who tried to register complaints. The LSCB made enquiries to satisfy itself that there was no evidence of such offences taking place within the city. Individual agencies also reviewed their policies, procedures and past practice and assured themselves that they had safe arrangements for recruitment and supervision of staff and volunteers and for whistle-blowing and that they were compliant with existing national policy.

Winterbourne View was a residential facility for adults with learning difficulties. The government published its responses in December 2012 and requires an update from local agencies in July 2013. The report is significant for the LSCB because of issues concerning the transition of young people into adult services.

The <u>Francis Report</u> into events in Staffordshire Hospitals again focused mainly on adult services, but there are general safeguarding issues which are of relevance to the LSCB.

The Adult Safeguarding Board has considered reports on the response of local agencies to the recommendations in both reports and will oversee a coordinated response, ensuring liaison with the LSCB where appropriate. In general terms, competition between service providers in all sectors has been increased as a national strategy intended to reduce costs and improve quality. The benefits of these changes are yet to be seen but the disruption as they are being implemented has been evident as managers change roles (and employers) and new ways of providing services are brought in.

This environment of fundamental change risks creating a very unstable and risky safeguarding context. As noted in last year's annual report, effective safeguarding arrangements depend on cooperation between agencies and individuals, trust (which comes from positive experiences of joint working) and consistency. All these are being tested and kept under review.

Agency participation in informing and planning services

The Board identified the risks associated with rapid organisational change around three years ago and established a regular pattern of reporting on pressures to each Board meeting. These reports have reflected the context described above and identified how agencies are responding to them. This pattern of honest sharing of pressures and challenges has strengthened the partnerships and laid an effective foundation for joint work in difficult times. The reports have also documented how agencies are

approaching quality assurance in a challenging environment.

The Board is also open to external challenge and actively seeks feedback on how services in Leicester could be improved. The Board commissioned independent research (by Professor David Thorpe) into patterns of referral of concerns about child protection and ways to get help to families more easily. This resulted in significant changes in the Children's Services arrangements for receiving notifications of concerns from other agencies which are being implemented during the current year.

The Board welcomed a Peer Review by a team of colleagues from a number of East Midlands authorities who focussed especially on arrangements for early help. The Board has also cooperated in a study by DeMontfort University looking at safeguarding cases which had to be re-opened for a second time.

The framework for planning and commissioning children's services is coordinated by the City Children's Trust. A protocol setting out the respective roles and responsibilities of the Trust and the Board was agreed during the year. A review of the structure of the Children's Trust will be implemented during 2013-14 with implications for the LSCB.

Research shows that the social pressures identified above create problems for some families, which result in harm to some children. Whilst there is not a direct link between financial and emotional stress and child ill-treatment, and the proportion of children seriously affected is small, nevertheless the overall incidence of ill-treatment increases with other pressures and poverty makes it more difficult for all children to thrive and <u>succeed</u>. This reality was explored in the <u>Leicester City's Child Poverty</u> <u>Commission</u>, which was reported to the Board.

In anticipation of these trends, the Safeguarding Board recognised some time ago the need to prepare for an increase in child protection referrals and family problems in general, within the context of severe budget reductions in all agencies.

Some examples of the changes implemented, partly as a result of this analysis of pressures, include the launch of the Family Nurse Partnership scheme (especially for vulnerable younger mothers), an increase in the number of health visitors, the Think Family programme (funded by the government's Troubled Families initiative) and the implementation of a new set of standards for social work practice, developed by a working group of practitioners and front-line managers, aiming to implement a less bureaucratic form of social work as recommended in the Munro review.

Monitoring and evaluation of front-line practice and the quality of management oversight

The Board has initiated outside reviews of services to inform its own evaluation of risk and need. The three studies include the action research by Dr Thorpe and his team, research by Leicester University and the Peer Review under the East Midlands scheme. The Board has also had presentations on the outcomes from series case reviews and other audit processes.

The Board has collated the outcome of individual agency Section 11 audits of the adequacy of safeguarding services. This was a thorough process and no issues of concern were identified by agencies. The Board has started a programme of multi-agency performance audits to report on the adequacy of partnership arrangements and practice.

The Board regularly receives reports (via the Safeguarding Effectiveness Group) from member agencies about their internal audits of safeguarding practice. These arrangements are being strengthened during 2013.

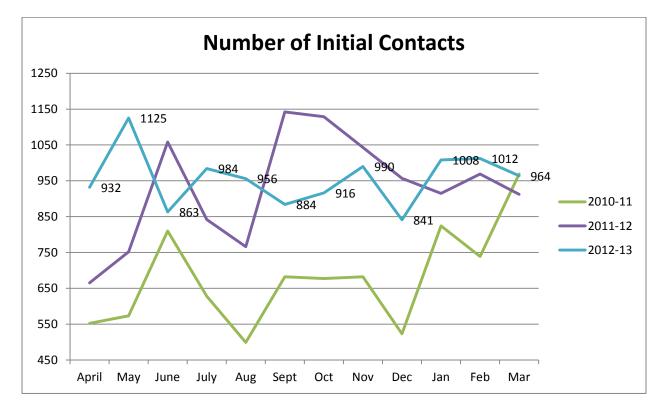
Key issues for practice arising from the evaluations

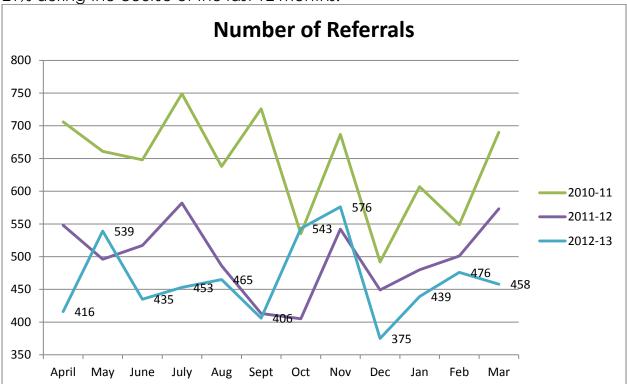
The following factors have been identified as priorities requiring attention in 2013/14:

Increasing 'demand' at a time of severe resource constraint

As anticipated, an increase in 'demand' for family support has been seen over recent years and was sustained during the year of this report.

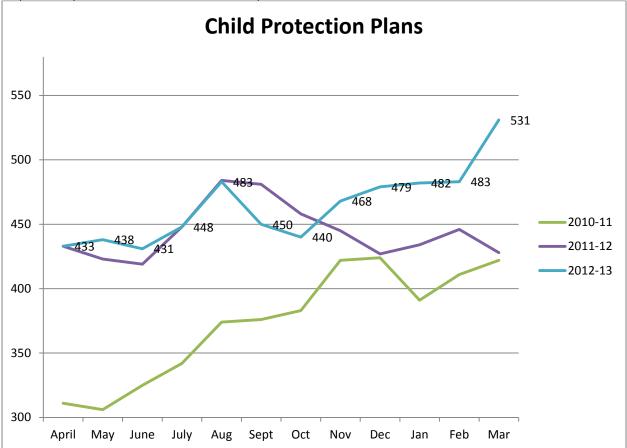
At their highest, the number of initial contacts to children's services increased by 39% during the course of the last 12 months:





At their highest, child protection referrals to children's services increased by 21% during the course of the last 12 months:

Child Protection Plans have increased by 23% in the year, having an impact especially on children's services, police, health and schools.



The rising birth rate has meant that the intended improvement in health visitor ratios has not occurred, the increase in the number of HVs merely keeping pace with the increasing population.

The Board was informed about the outcome of a review of maternity and midwifery services undertaken by University Hospital Leicester. The impact of these pressures is being kept under review.

Alongside rising 'demand', budget reductions in the council, police, health services, voluntary sector and elsewhere have put pressures on the workforce, although frontline child protection work has generally been protected. There is already evidence that the reforms implemented as a result of the Thorpe review are reducing the referral rate by finding more effective ways to respond to less serious concerns.

These matters have been reported to the Board in the quarterly pressures reports.

Early help

The arrangements for ensuring that there is early identification of family problems and appropriate intervention to reduce the risk of emergence of serious problems is a national priority. The Board, working with the Children's Trust, established a review of early help which led to the emergence of a new approach across the city. This is reported elsewhere in this report.

Factors which emerged from the review included evidence of inconsistency in the response of different agencies to the need for early help and a tendency for problems to re-emerge suggesting that early help has not been fully effective.

Child protection referrals higher than average

The Board is aware that the rate of referral of new cases to children's services is significantly higher than the national average. Research was commissioned during the year of this report to help agencies and the Board to understand this phenomenon. Whilst the social pressures in the city suggest that a higher referral rate would be anticipated, the pattern is still abnormal. The research found that children's services in Leicester tend to accept a high rate of referrals for initial assessment, many of which are found not to need a full assessment and on-going assistance. The initial assessment arrangements are being adjusted to ensure a more detailed scrutiny at the point of referral and more effective signposting to other services.

There is some evidence that partner agencies 'talk up' the level of risk in individual cases, in order to be sure that a referral for assessment is accepted. This practice results in unnecessary distress for families and a resource burden for agencies. Work is being undertaken with referrers and referral takers to deal with this and to ensure that sound advice to staff in other services is available so that appropriate alternatives can be considered.

Response to neglect

File audits and a serious case review suggest that there is evidence that practice in cases of child neglect could be more decisive and that in some cases intervention is needed at an earlier stage either to support families or to find alternative care arrangements for children affected, so that they are more likely to fulfil their potential. This is a national problem for all agencies but it needs a more effective local response. This issue was identified as a priority for staff training and is also likely to be affected by the new approach to providing early help to families.

Effective training

The SEG reviews the effectiveness of the safeguarding training which is commissioned by the Children's Trust (and described earlier in this report).

SEG and training commissioners recognise the need to strengthen the evaluation of the impact of training. Agencies now survey people who have attended training some months later and their managers to evaluate whether the training has had any impact on practice. This a recent development and the results will be tracked by the Board.

Involving children and young people

The Board has a strategy for engagement with children and young people, which is reported elsewhere in this report. The Children's Trust also has an engagement strategy, involving a team of Young Advisers who work on specific issues concerning services for children and young people in the city, selected by mutual agreement.

The Board is seeking direct feedback from a day conference on safeguarding specifically for children and young people which will be held next November.

Conclusion

Service evaluations suggest that basic child protection arrangements in Leicester are sound and there are effective services to protect children and young people. This does not mean that all incidents of abuse or illtreatment can be stopped or prevented. Identification of risk is not a fail-safe scientific process and remains a matter of judgement. Given the unpredictability of human behaviour, it is never possible to say that all children are safe and serious case reviews and internal monitoring have identified areas where management and practice need to be strengthened. However the system does usually respond well when concern about a child or young person is reported or significant problems are

identified and appropriate action is taken.

All agencies need to work more effectively together to ensure that parents and young people get the help they need early enough to prevent problems getting worse. Work is well in hand to achieve this.

Further work is needed to reduce the number of families who experience a revolving door service. It is important that cases are not 'closed' too quickly. It is equally essential to ensure that, when formal child protection cases are closed following improvements in child care, the parents and young people know where to get early help when new problems arise.

A new approach to evaluation of services will be implemented in 2013/4 ensuring a more systematic sharing of the outcomes of individual agency quality assurance as well as indicators of the effectiveness of partnership working. Strengthening the quality assurance oversight of the Board is the top priority for the current year.

8. Allegations against professionals

The management of allegations of abuse against adults has been a significant part of safeguarding within Leicester City in 2012-13.

Chapter 7.2 of LSCB procedures sets out local guidelines and is designed to ensure that if an allegation of harm is made or there is any suspicion of harm, appropriate enquiries are made to protect children and maintain public confidence in services.

The service works closely with investigations officers (2 posts) based within the Duty and Assessment Service, with police colleagues and with colleagues in Human Resources.

The Allegations Independent Chairs have delivered training to 120 staff in 2012-13 including Children's' and Adults' Social Care staff, Police, Education and Health.

A smaller number of staff from transport services, Leisure Centre Services, Property Services and voluntary organisations have also attended. Bespoke sessions have been delivered at team development sessions to Health Safeguarding leads and Diocese of Leicester.

There has continued to be training sessions delivered to Madrasah staff, jointly, with the Federation of Muslim Organisations.

The Safeguarding in Education training delivered to safeguarding

leads from schools also includes information regarding allegations about staff who work with children/vulnerable young people.

There were 268 referrals to the service between April 2012 and March 2013. This is a decrease from the number of referrals in 2011. However, there has been an increase in meetings convened which indicates that these are appropriate referrals for the service. There have been 230 meetings convened in this period, in 2011 there were 177 meetings convened.

There is an improvement in the performance of the timeliness of outcomes of referrals with 78 % being concluded within one month.

There are a small number of referrals that have taken up to 12 months to conclude, these are due to complex police investigations and have included referrals with multiple victims or victim with additional needs.

There are always interim safeguarding measures in place in such cases and review meetings are convened to monitor progress.

The Local authority Designated Officer (L.A.D.O.) and/or the Allegations Manager meet regularly with a Police Senior Officer and a Duty Assessment Team Manager to track progress and timeliness of referrals. Themes that are emerging from the referral activity are:

- There is an increased number of referrals that reflect the level of activity involving transport of vulnerable children, also the increased awareness following the training of transport services and Social Care staff.
- There is an increase in referrals in the category 'risk of sexual abuse'. This may reflect the increase of concerns involving the use of digital technology. There have been a small number of referrals involving downloading of indecent images/use of digital technology to the service. (There were 7 referrals, i.e. 3% involving the use of digital technology.)

The increase may also reflect raised awareness following the publication last year of the Somerset Serious Case Review which involved the sexual abuse of children by a teacher in a school and the abuse of digital technology. This case is referred to in allegations/safeguarding in education training.

 There is a significant number of referrals arising from the risk that an adult who works with children, may present to their own children. There were 22 referrals ie 8 % .This reflects raised awareness in respect of the L.A.D.O. role, amongst agencies receiving referrals about risks to children ,eg Police and Social Care. The figure for allegations substantiated may appear low, this is higher than in previous years. The outcome of unsubstantiated and unfounded applies to the judgement regarding risk of harm to a child/young person.

However, in these cases there will be recommendations made regarding the circumstances that led to the referral and investigation. This often includes staff not following procedures, so disciplinary action may be recommended. In many cases there are concerns regarding training needs identified and actions for employers in respect of training , supervision and monitoring of staff.

Throughout the L.A.D.O. activity, the process considers the vulnerability of the child/young person and ensures that the voice of the child is heard. The service has developed individual outcome letters for child/young people, if they have made an allegation of harm. This includes the opportunity for the young person to feedback to the service, regarding 'feeling' safe.

The strategy process emphasises the duty of care that the employer has for an employee and considers vulnerability issues for the adult of concern and any support required.

There are regular case audits as part of the Quality Assurance of the service undertaken by Senior Managers in Children's Social Care and Safeguarding and the L.A.D.O. and quality assurance reports to the Service Management Team.

Changes implemented in 2012/13

In December 2012 the Disclosure and Barring Service (DBS) was launched. The Criminal Records Bureau and the Independent Safeguarding Authority (ISA) have merged into the DBS. The DBS help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

It is also responsible for placing or removing people from the Children's' barred list and Adults' barred list in England, Wales and Northern Ireland. The L.A.D.O. process, if harm is substantiated, includes recommendations to employers to consider a referral to the D.B.S.

In March 2013 the new statutory guidance 'Working Together. (2013) was published. The L.A.D.O. role is reinforced in the new Working Together including the timeliness of referrals to the L.A.D.O. ('...any allegation should be reported immediately to a Senior Manager within the organisation. The L.A.D.O. should also be informed within one working day of all allegations that come directly to an employer's attention or that are made directly to the police'...)

9. Early Help and Prevention

Early help is about how different agencies work together to help children, young people and their families (at any point in their lives) to prevent or reduce difficulties and problems from occurring, or stop them from getting any worse.

The concept of early help reflects the widespread understanding that it is better to identify and deal with problems early rather than to respond when difficulties have become acute and require action by more intensive services.

Early help is not just for very young children, as difficulties may emerge at any point throughout childhood and adolescence. Early help is about how universal and targeted services are coordinated to identify, reduce and prevent specific problems from getting worse or becoming entrenched. Early help gives families the opportunity to address their problems; ensuring children stay safe and achieve their full potential.

In December 2012 the Leicester Safeguarding Children Board commissioned a piece of work to produce an early help offer for Leicester. This was because the board was of the view that whilst there was a range of early help activities and interventions delivered by a range of statutory and voluntary agencies, there was no single document where the early help offer was articulated.

The early help offer was agreed by the LSCB in March 2013, where the board also commissioned an Early Help Strategic Group with representation from schools, statutory and voluntary sector partners.

The Early Help Strategic Group has three aims:

- To oversee and coordinate implementation of Leicester's Early Help Offer
- To ensure clear systems are in place for communicating Leicester's Early Help offer strategically and operationally across the city
- To develop processes for quality assuring the effectiveness of Leicester's Early Help offer ensuring this assists the Leicester Safeguarding Children Board in assessing the effectiveness of early help

Working Together 2013 is clear about the importance of effective early help services and the role of safeguarding boards in assessing the effectiveness of early help, and establishing effective quality assurance processes with scrutiny and challenge from the Safeguarding Effectiveness Group is a key priority in 2013.

10. Assessment Protocol and Frameworks

There are established assessment protocols and frameworks in place in line with relevant legislation and policies. Assessment processes for children's social care are in line with the Framework for the Assessment of Children in Need and their Families (2000) and Working Together to Safeguard Children (2010).

Prompt assessment and effective child protection planning is a priority in the Children and Young People's Plan (2011-13) and a work stream for the Stay Safe Development Group. The quality and effectiveness of assessment processes comprises a key element of quality assurance activity undertaken by children's social care.

Professor Eileen Munro's review of child protection (2012) recommended that the Government should revise both the statutory guidance, Working Together to Safeguard Children (2010) and the Framework for the Assessment of Children in Need and their Families (2000). This emphasised the importance of social workers using their professional judgement when developing an understanding of children's needs and making and implementing plans to safeguard and promote their welfare. Munro also wanted greater emphasis to be placed on the quality of assessments.

This recommendation was accepted by the Government and in March 2013 Working Together to Safeguard Children was revised and reissued.

This places a requirement on local authorities with their partners on developing and publishing a local protocol for assessment, which is then agreed by the LSCB.

There is also a requirement for the LSCB to publish a threshold document, which should include the process for an early help assessment and the type and level of early help services to be provided, and the criteria for when a case should be referred to children's social care.

The development of a local protocol for assessment and revising the threshold document will be done in partnership with the Leicestershire/Rutland Board in 2013/14.

11. External Inspection findings

Ofsted did not inspect safeguarding/child protection services in 2012/13. The last full inspection was carried out in December 2011, when safeguarding services were judged adequate overall, with good capacity to improve.

The Children's Trust and Leicester Safeguarding Children Board agreed to the creation of an overarching Improving Outcomes Group to integrate and take forward the areas for improvement from the inspection and the recommendations from the Munro Review into Child Protection.

This group was multi-agency and developed an integrated action plan; all the areas for development from the last inspection have been implemented.

In addition, a group comprising of front line social workers and managers from every team in the Children's Social Care and Safeguarding Division was set up in order for some of the changes required to be developed directly by front line staff in a 'bottom-up' approach.

This led to the development of Practice Standards for Children's Social Work in Leicester.

In 2012 a Core Case Inspection of youth offending work in Leicester City was undertaken. The inspection focused exclusively on the work undertaken by Youth Offending Teams with children and young people who have already committed an offence.

Its' purpose was to assess if the work is of a sufficiently high standard to protect both the public from any harm resulting from the child or young person's offending behaviour and the child or young person themselves, whether from their own behaviour or any other source.

The inspection was based on a rigorous examination of a representative sample of cases supervised by the Youth Offending Service (YOS).

Overall, the inspectors concluded that Management and staff had demonstrated their commitment to improving outcomes for children and young people and sustaining these.

The inspectors found examples of effective engagement with children and young people and of thoughtful, sensitive practice.

Performance relating to *Risk of Harm* was identified as an area for improvement, but the inspection report stated: "We are encouraged by the response of the YOS to our findings and are confident that it will take the necessary steps to meet our recommendations for improvement".

At the time of writing, Ofsted are currently developing a new

unannounced integrated safeguarding and looked after children inspection framework which will start from September 2013.

In the interim Ofsted are undertaking unannounced child protection inspections, which follow the child's journey from early help through to statutory intervention from children's social care.

12. Glossary

Acronym Stands for

- CAFCASS Children and Families Court Advisory and Support Service
 - CDOP Child Death Overview Panel
 - CDR Child Death Review
 - CICC Children in Care Council
- HM CORONERS Her Majesty's Coroners Service
 - HSE Health & Safety Executive
 - ISA Information Sharing Agreement
 - L&R LSCB Leicestershire & Rutland LSCB
 - L.A.D.O. Local Authority Designated Officer
 - LCC Leicester City Council
 - LLR Leicester, Leicestershire & Rutland
 - LSCB Local Safeguarding Children Board / Leicester Safeguarding Children Board
 - NHS National Health Service
 - PVI Private, Voluntary and Independent
 - QA Quality Assurance
 - SCRs Serious Case Reviews
 - SDMT Senior Departmental Management Team
 - SDSA Schools Development Support Agency
 - SEG Safeguarding Effectiveness Group
 - STOI Safe Transfer of Information
 - SUDIC Sudden Unexplained Death in Childhood
 - YOS Youth Offending Service

Appendix A: LSCB membership

Agencies/Organisations/Roles represented on the Board are as follows:

Statutory members

Independent Chair
Director of Children's Services
Lead Member for Children Services
Lay Members
Leicester City Council:

Youth Offending Service
Children's Social Care & Safeguarding, Leicester City Council

- Partnerships Planning & Performance
- Adult Social Care & Safeguarding
- Legal services

Leicester City Clinical Commissioning Group

University Hospitals Leicester

Leicestershire Partnership Trust

Leicestershire Constabulary

Children and Family Court Advice and Support Service

Youth Offending Service

Leicestershire & Rutland Probation Trust

Education Improvement Partnership

City Primary Heads

Further Education Colleges

Non statutory members

Leicestershire Fire and Rescue Service

East Midlands Ambulance Service

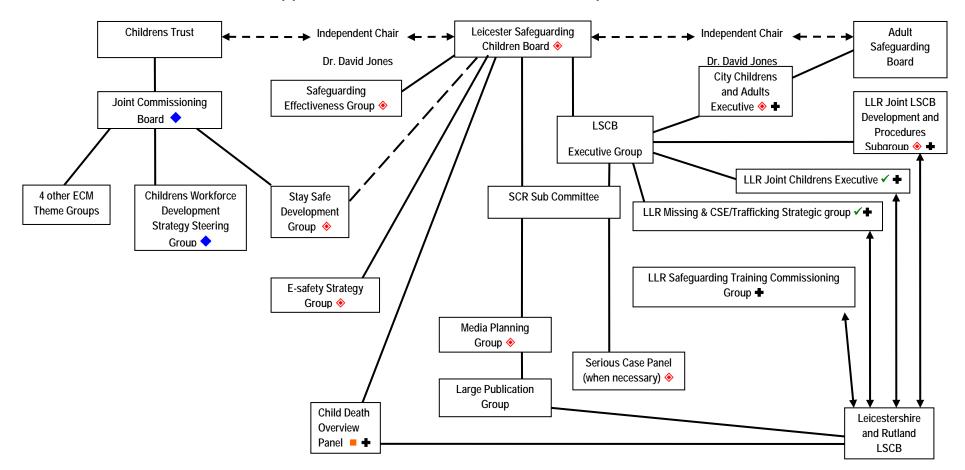
Child Death Overview Panel

Barnardo's CareFree Young Carers Service

National Society for the Prevention of Cruelty to Children

FreeVA

GP consortia, National Health Service



Appendix B: The LSCB and other Partnership Structures

Appendix C: Attendance of statutory members at Board meetings

Organisation (Aganov/ Bala	Record of attendance			
Organisation/Agency/ Role	21.06.12	20.09.12	13.12.12	21.03.13
Independent Chair	\checkmark	\checkmark	\checkmark	\checkmark
Director of Children's Services	\checkmark	\checkmark	\checkmark	\checkmark
Leicester City Council	\checkmark	\checkmark	\checkmark	\checkmark
Leicester Partnership Trust	\checkmark	\checkmark	\checkmark	\checkmark
Clinical Commissioning Group	\checkmark	\checkmark	\checkmark	\checkmark
University Hospitals Leicester	\checkmark	\checkmark	\checkmark	\checkmark
Leicestershire Police	\checkmark	\checkmark	\checkmark	\checkmark
Lay Member	\checkmark	\checkmark	\checkmark	\checkmark
Lead Member for Children's	\checkmark	X		X
Services	v	X	v	Х
Leicestershire & Rutland		Ň		
Probation Trust	Х	X	v	V
CAFCASS	\checkmark	\checkmark	Х	Х
Further Education Colleges	\checkmark	Х	Х	\checkmark
Schools representation	\checkmark	Х	Х	\checkmark
Youth Offending Service	\checkmark	\checkmark	\checkmark	Х



Business Plan

2013 - 2014

Core Business Priority 1: Management, administration and operation of the LSCB and office

Business purpose:	To co-ordinate the work of the Board and its sub-groups
Working Together 2013 reference:	Chapter 3 Page 64 Paragraph 19
Lead:	Mark Fitzgerald, Board Manager
Management arrangements:	LSCB office reports to Executive group on its functioning
Outcome measures:	Office fully staffed
	Operating within set budget
	Sub groups are serviced
Funding from other sources:	LSCB office is hosted by Leicester City Council
Funding from base budget:	£198,700 including staffing, transport, supplies and Independent Chair costs
Funding from the underspend:	None

Core Business Priority 2: Safeguarding Effectiveness

To assure the Board of the effectiveness of local safeguarding arrangements, using the four priorities which are:	
Performance framework	
Embedding learning from review processes	
Coordination of audits	
LSCB effectiveness	
Chapter 3, Page 58	
Adrian Spanswick, Sub Group Chair	
Multi-agency group meets every month to scrutinise reports from topic areas. Reports to Board on a quarterly basis	
To be completed by Adrian	
Nil	
Nil	
Nil	

Core Business Priority 3: E-Safety

Business Purpose: Lead: Management arrangements:	To coordinate e-safety work across member agencies Mark Fitzgerald, Board Manager Multi-agency group meets every two months to progress action from the E-Safety Strategy
Outcome measures:	 LSCB Procedures contain clear guidance for partner agencies about safeguarding and new technologies The group then changes its status into a practitioners group to enable networking and the consideration of new threats to safeguarding
Funding from other sources:	Nil
Funding from Base Budget:	Nil
Funding from the Underspend:	Nil

Core Business Priority 4:	Case review function
Business Purpose:	To consider appropriate responses to reports of serious incidents and to oversee the progress of case review processes
Working Together 2013 reference:	Chapter 4. Pages 65 – 72
Lead:	Andy Smith, Sub Group Chair
Management arrangements:	Multi-agency group meets every 2 months. Reports to Board every quarter
Outcome measures:	 All SCRs/Serious Incidents commissioned by the Board are done in a timely way and are compliant with Working Together 2013 Evidence that strategic and operational recommendations arising from SCRs/Serious Incidents have been implemented and there is evidence of learning and impact Events are run, either on a single or multi-agency basis, on disseminating the learning from SCRs/Serious Incidents and informs the work of SEG Learning and joint working/development takes place as appropriated with the adults' board and the County/Rutland Board on SCRS, DHRs and Serious Incidents
Funding from other sources:	Nil
Funding from Base Budget:	Notional cost of review processes £30,000
Funding from the Underspend:	Nil

Core Business Priority 5: Stay Safe Development

Business purposes:	Deliver improved outcomes in the area of Stay Safe
	 Progress business on LSCB priorities
Lead:	Andy Smith, Sub Group Chair
Management arrangements:	Multi-agency group meets every 2 months to develop and coordinate activity around safeguarding priorities
Outcome measures:	• Evidence of progress and impact against all the priorities in the Stay Safe Action Plan, which contribute to the priorities contained in the Children and Young People's Plan and lessons from SCTs/Serious Incidents
	 Regular attendance and engagement from all partners across adults and children's services in line with the work streams and priorities contained in the Stay Safe Action Plane Progress business on LSCB priorities
Funding from other sources:	Nil
Funding from Base Budget:	Nil
Funding from the Underspend:	£42,000

Core Business Priorit	y 6: Child Death Reviews
Working Together 2013 refere Lead: Management arrangements: Outcome measures:	 hce: Chapter 5. Pages 73 – 84 Dr. Tim Davies, Panel Chair Multi-agency LLR group meets monthly to consider reports of child deaths and report on progress via review process All SCRs/Serious Incidents commissioned by the Board are done in a timely way and are compliant with Working Together 2013; Evidence that strategic and operational recommendations arising from SCRs/Serious Incidents have been implemented and there is evidence of learning and impact; Events are run, either on a single or multi-agency basis, on disseminating the learning from SCRs/Serious Incidents and this informs the work programme of SEG; Learning and joint working/development takes place as appropriate with the adults' board and the County/Rutland Board on SCRS, DHRs and Serious Incidents.
Funding from other sources:	£30,000 from Leicester City Council. Manager and Admin hosted by LPT
Funding from Base Budget:	£5,750
Funding from the Underspend	: Nil

Core Business Priority 7: Training, Learning and Development

Business Purpose:	To co-ordinate the implementation of the LLR Safeguarding training strategy	
Lead:	Caroline Tote	
Management arrangements:	Multi-agency LLR group meets every 2 months to develop, co-ordinate and report on activity around training	
Outcome measures:	A multi-agency Training, Learning and Development programme that:	
	 Reflects the core business of children's services and includes lessons learnt from serious incidents 	
	 Reflects the development and learning needs of the children's workforce 	
	Reflects Think Family	
	 Is embedded into an overarching training, learning and development programme including induction and single agency training 	
	 That impacts of the quality of service delivered 	
Funding from other sources:	Half of the costs of the Project Development Officer are provided by Leicestershire & Rutland LSCB	
Funding from Base Budget:	0	
Funding from the Underspend:	£21,800	

Core Business Priority 8:	Procedures
Business Purposes:	 Develop safeguarding policies and procedures Agree the content of these across the agencies Ensure their easy access and dissemination
Working Together 2013 reference:	Chapter 3, Pages 59
Lead:	Caroline Tote/Chris Nerini
Management arrangements:	Multi-agency LLR group meets every quarter to develop, co- ordinate and report revisions to procedures
Outcome measures:	That Procedures reflect current legislation and guidance
	That Procedures reflect Think Family
	 That Procedures take into consideration procedural changes emerging from serious incidents
	That Procedures enable effective practice
Funding from other sources:	Half of cost of hosting the procedures website is met by Leicestershire & Rutland LSCB
Funding from Base Budget:	£1,900
Funding from the Underspend:	Nil

Core Business Priority 9: Communication and raising awareness

Business Purposes: Working Together 2013 reference: Lead: Management arrangements:	To raise awareness in partner agencies and in the wider community of safeguarding issues Chapter 3, Pages 59 Executive Group Chair/Media Planning Meeting Chair Incorporated into all LSCB activity. Overseen by the Executive group and being developed in the media planning meeting
Outcome measures:	 Coordinated and well managed publication of serious incidents reviews which clearly identify the lessons learnt and actions already taken by agencies Multi-agency communication and awareness raising events on issues relating to lessons from Serious Incident reviews, lessons from CDOP, research and/or priorities for the Board Coordination of key safeguarding messages to the public related to lessons from SCRs/Serious incidents, lessons from CDOP, research and/or priorities for the Board. Aim for at least one major public communication per year Annual LSCB/LSAB Conference on a key theme/s
Funding from other sources:	Nil
Funding from Base Budget:	£6,000 for leaflets and publicity materials
Funding from the Underspend:	Nil

Business Project 1:	Participation
Business Purposes:	 Listening to and consulting children on safeguarding issues Ensuring their views and opinions are taken into account
Lead:	Caroline Tote
Management arrangements:	Task and finish group reporting to the Stay Safe Development Group
Outcome measures:	 That Children and Young People are able to tell up whether they feel safe and are safe That Children and Young People's views and experiences are embedded into services Quality Assurance That Children and Young People are able to help shape service development and delivery
Funding from other sources:	Nil
Funding from Base Budget:	Nil
Funding from the Underspend:	Linked to Stay Safe funding

Business Project 2:	Growing Signs of Safety
Business Purposes: Lead: Management arrangements:	To implement the approach across the partnership and LLR Head of Fieldwork Service (Children's Safeguarding) An LLR group oversees implementation and guides the work of a Project Officer
Outcome measures:	 A consistent method of working with Children and Young People and families that's used across the children's workforce That focusses on improved outcome for Children and Young People That has a common understanding of risk and reduced risk factors That enable the consistent use of risk assessment tools That facilitates improved direct work with Children and Young People
Funding from other sources: Funding from Base Budget: Funding from the Underspend:	Young People, parents and carers From Munro monies allocated to the LSCB Nil Nil

Business Project 3:	Research
Business Purpose:	To look at pressures on the safeguarding system at the point of referral and to develop solutions where necessary
Lead:	Andy Smith as Chair of the Executive Group
Management arrangements:	Regular progress meetings chaired by Andy Smith, working towards a presentation of the findings to the Board in June 2013
Outcome measures:	 Report ready for presentation to the Board with recommendations informed by the work in June 2013 Implementation of any recommendation agreed by the Board within timescales set by the Board
Funding from other sources:	Nil
Funding from Base Budget:	Nil
Funding from the Underspend:	£43,000 (Thorpe research)