Leicester City Council

Leicester Safeguarding Children Board

Annual Report

2015-2016

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Report Author & LSCB Interim Manager

Version	Date	Author	Changes
V0.8	27/10/2016	JR	Incorporated suggested changes from LSCB & Ratified 08/09/2016
V0.9	03/11/2016	JR	Incorporate changes from SMT 31/10/2016

LSCB ANNUAL REPORT 2015-2016

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Jenny Myers MA CQSW ASW
Independent Chair Leicester City LSCB

Welcome to the Annual Report of Leicester City LSCB. As the new chair of the Safeguarding Children Board, it is my privilege to have taken over responsibility for chairing the LSCB and to continue the journey of improvement work to ensure that the children of Leicester are effectively safeguarded.

The report presents a summary of the key achievements, challenges and reflections on the work of the Safeguarding Board and wider partnership under the previous chair Dr Jones and ends with a summary of those challenges and revised strategic key priorities that we will be working to over the next year.

1. Foreword

Dr David N Jones
Former Independent Chair, LSCB Leicester

This 2015-16 report is my final annual report; I handed over the Chair in May 2016 having completed two terms of three years. This foreword and report is mainly concerned with the past 12 months, whilst my successor, Jenny Myers, provides the forward view.

The 2014-15 report covered the year which concluded with publication of the Ofsted inspection which judged the LSCB to be 'inadequate'. Have there been significant improvements in 2015-16? Over the 12 months of this report, the LSCB worked closely with the Improvement Board, set up by the Department for Education and chaired by Tony Crane, to monitor and support improvements in multi-agency working in general and Children's Services in particular. I am pleased that we can point to significant service improvements, whilst recognising that there is further to go.

The LSCB did not challenge the judgement of the Ofsted inspection. The main reason for the 'inadequate' judgement was that the LSCB partners had not developed sufficiently robust arrangements for monitoring the quality of safeguarding work across the partnership. The inspection report also noted significant staffing challenges in Children's Services, which contributed to inconsistent and frequently poor assessments and highly inconsistent service quality, and was critical of the lack of engagement with children and young people and with front-line staff. The inspection was complimentary about a number of other elements of the work of the Board, including up-to-date procedures, multi-agency training and good working relationships between Board members and with the Leicestershire and Rutland LSCB.

Some of the weaknesses in service delivery were confirmed in findings of Serious Case Reviews undertaken during the past year, two of which were published in May 2016. Other reports are awaiting the outcome of criminal proceedings. These cases all dated from the period before the inspection. The SCRs highlight the need to strengthen pre-birth assessments; new guidance about this was launched at a multi-agency staff conference in April 2016 and further training is being provided.

As reported last year, the LSCB had identified most of the problems highlighted in the inspection during the months before the inspection, had already reviewed its internal workings and was implementing a work plan to strengthen performance monitoring, but it was too early to be able to demonstrate impact during the inspection. The agencies, which make up the Board were therefore well placed to take up the challenge from the inspection during the early part of 2015. The Board engaged nationally respected consultants to work with us to improve performance monitoring, agreed a new performance monitoring framework and established working groups to promote improved multi-agency working in a number of areas, including cases of neglect, child sexual exploitation, female genital mutilation and assessment of mothers and young babies at risk.

National and international research clearly shows that re-establishing high quality, multi-agency services after significant service problems takes time (Barnes 2003; Barnes and Gurney 2004; Association 2013; Bryant, Parish et al. 2016; Wajzer, Ilott et al. 2016). This requires strong leadership and determined work within each of the individual agencies as well as jointly across the partnership. Over the past year evidence shows that the leadership has been evident and the quality of services for families has improved, but we know that work with families and children is not consistently good and there is more to do, including building a stable and well supported workforce.

The LSCB and its member agencies remain committed to developing the best possible services for children and families in the city. We cannot guarantee that there will never be problems - managing risk in safeguarding services is not a science. Ultimately parents and those caring for children are responsible for keeping them safe, supported by local services when necessary. I have seen that Board members are determined to support continued improvements in services, to do all they can to support Leicester parents to provide good care for their children and to make Leicester a safe city for all.

This report marks the end of my six years of service to the city and people of Leicester. It has not been an easy journey and this report illustrates progress made and the tough challenges still to be overcome. I am grateful for the support provided to me by the City Mayor, the former PCC, the Director of Children's Services alongside chief officers in all the partner agencies and by the two Board Managers with whom I have worked and the staff of the LSCB office. I recognise the commitment of all those working with children and young people in the city who take their safeguarding responsibilities seriously and work round the clock to protect children. Above all, I have been encouraged to see the growing confidence of the young people on the shadow LSCB and supporting the work of the Board in other ways. The strong voice of children and young people is essential to keep the Board focussed and effective. I wish them well, as well as the thousands of people working with children and families across the city.

2. Governance and Accountability Arrangements

The LSCB is a statutory 'partnership arrangement' involving most of the local agencies working in different ways with children and their families. Board members are senior representatives of these organisations and agencies.

The role of the LSCB is to co-ordinate the activity of all agencies in the City aiming to keep children safe in Leicester and monitoring and evaluating how effective this has been. The Board achieves this through: writing, and reviewing policy and procedures and ensuring that these are followed in practice by all those working with children and families in the city; evaluating the work that is undertaken on a single and multiagency basis through quality audits and case reviews as well as gathering statistics and other data within an overarching performance monitoring framework; providing and commissioning multi-agency training; reviewing all child deaths including those where appear to be concerns about practice and providing information for the public. The formal functions of the LSCB are set out in statutory guidance: Working Together to Safeguard Children 2015 (HM Government 2015).

The LSCB is required to publish an annual report to inform the public about the effectiveness of the multi-agency safeguarding arrangements for children in Leicester.

LSCB Independent Chair

The Independent Chair is accountable to the Chief Operating Officer (COO) of Leicester City Council, acting on behalf of and in consultation with the statutory partners. The Chair held regular meetings with the COO, the Assistant Mayor for children and also the Strategic Director of Children's Services, and senior officers from member agencies. The Chair has access to and can hold to account chief officers and strategic leads from all partner agencies as and when this is required.

In March 2015, following the OFSTED inspection, Leicester City Council (LCC) and the LSCB became subject to improvement measures. The Independent Chair is a member of LCC Improvement Board (LCCIB). The LSCB Chair has had regular consultation with the Chair of the LCCIB. The LCCIB received monthly reports on progress from the LSCB.

LSCB Partner Agencies

The statutory and non-statutory agencies represented on the LSCB include City Council representatives from relevant departments, Police, NHS England, Clinical Commissioning Group (NHS), Leicestershire Partnership Trust (NHS), University Hospitals Leicester (NHS), schools and colleges, National Probation Service, CAFCASS, Voluntary and Community Sector representatives and a statutory Lay Member *(See Appendix 1)*. LSCB Members are required to:

- consult with and speak for their organisation with authority
- disseminate information and commit their organisation on policy and practice matters
- hold their organisation to account
- challenge their own and other agency on any issues that impact on the performance of children's safeguarding
- make the LSCB's assessment of performance as objective as possible

Lay Member

The LCC Lay Member is a full member of the LSCB, participating in Board meetings and serving on relevant sub-groups. The Lay Member should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. In the past year, the Lay Member served on the Safeguarding Effectiveness Group as a Non-Executive member.

Joint Working Arrangements

The Leicester City and the Leicestershire and Rutland LSCBs (LLR) continue to work closely on policy, procedures, training and development and work that affect services and practice across the three authorities and the children's workforce. The LLR partnership maintains the development/revision of the multi-agency safeguarding procedures and last year successfully progressed work relating to female genital mutilation, child neglect and child sexual exploitation (CSE) and the views of children and young people. Closer joint working on performance monitoring, assurance and communications was also developed during the year.

Relationship with other Partnership Structures

The LSCB has links and formal protocols with other partnership structures, including the **Children's Trust**, **Health and Wellbeing Board**, **Local Safeguarding Adults Board, Family Justice Board, Young Offender Management Board, Corporate Parenting Board** and **Safer Leicester Partnership** in order to:

- Contribute a safeguarding perspective to the work of that partnership
- Strengthen the effectiveness of the arrangements made by that partnership to safeguard and promote the welfare of children.
- Identify any crossover issues which should be jointly addressed

On the following page you will see a chart which illustrates the LSCBs relationship with other Strategic Partnership Boards in Leicester.

LSCB Relationship with other Strategic Partnership Boards

CHILDREN'S TRUST BOARD

Set the strategic direction for improving outcomes for children and young people. This Board oversee the delivery of the Children & Young People's Plan.

LOCAL SAFEGUARDING ADULT BOARD

Co-ordinate the safeguarding activities of its partner agencies and evaluate what they do

HEALTH & WELLBEING BOARD

Key leaders from health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities

FAMILY JUSTICE BOARD

The FJB aims to work collaboratively to improve performance and efficiency within the local family justice system and beyond

YOUNG OFFENDER MANAGEMENT BOARD

The YOMB is responsible for ensuring that the local YOS partnership fulfils its statutory duties including its Safeguarding responsibilities and any lessons arising from serious incidents involving for children and young people in the criminal justice system.

CORPORATE PARENTING BOARD

Corporate Parenting refers to the partnerships between the local authority departments, services and associated agencies who are collectively responsible for meeting the needs of looked after children, young people and care leavers.

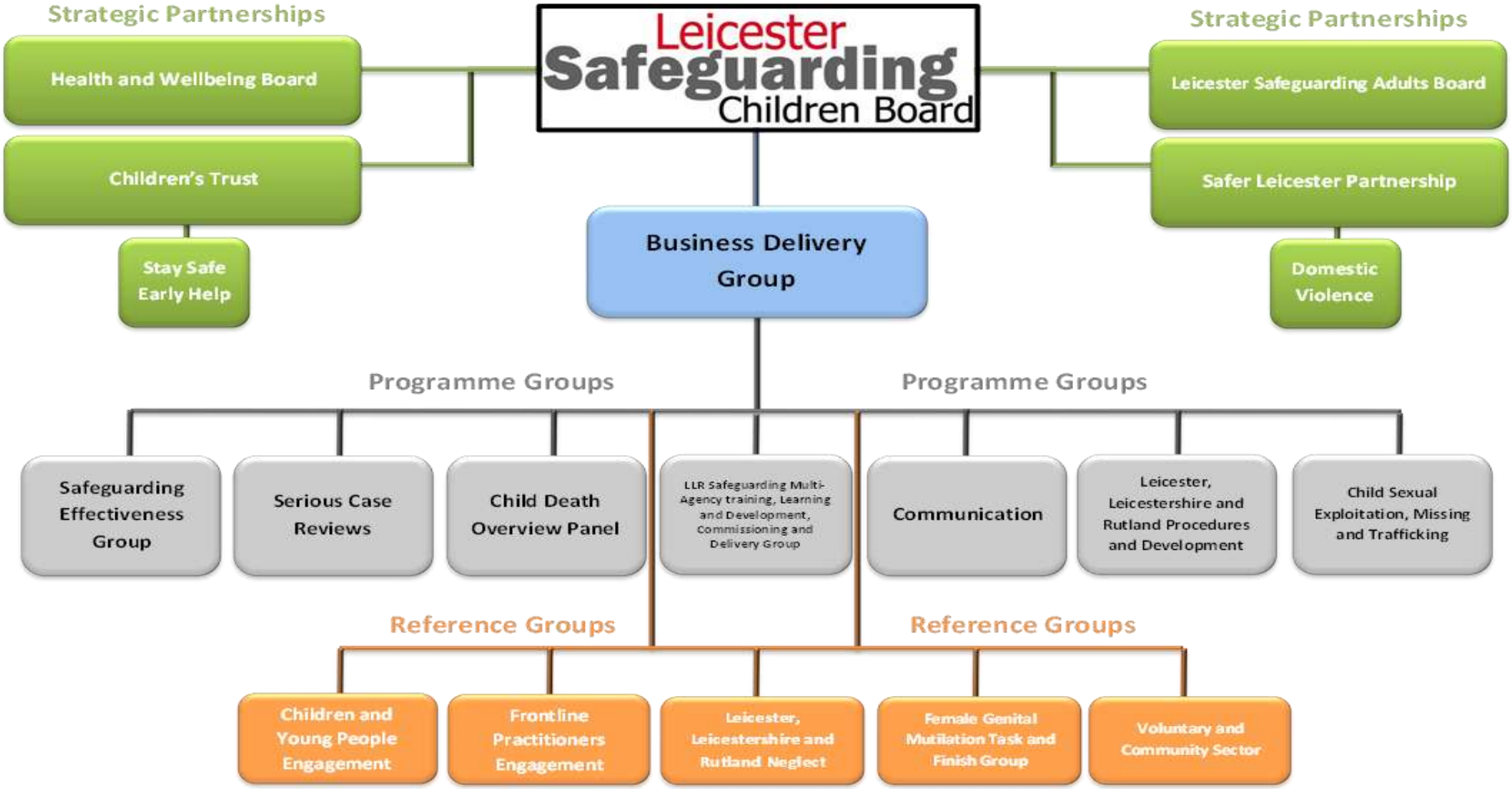
SAFER LEICESTER PARTNERSHIP

Brings together a number of agencies and organisations; its objectives and priorities are to reduce crime and antisocial behaviour, reduce alcohol related harm, domestic violence and sexual abuse and reduce adults and children's re-offending

LEICESTER SAFEGUARDING CHILDREN BOARD

Ensures that all partnership structures work together to safeguard and promote the welfare of children & young people

3. LSCB 2015 - 2016 Structure



4. LSCB Budget 2015 - 2016

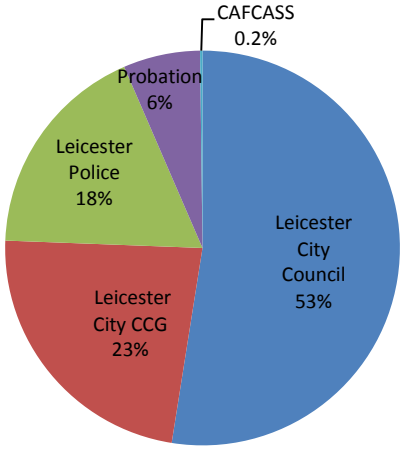
Working Together (2015) details that the budget for each LSCB and the contribution made by each member organisation, should be agreed locally. The member organisations' in Leicester shared responsibility for the discharge of the LSCB's functions includes shared responsibility for determining how the necessary resources are to be provided to support it.

The LSCB requires an annual budget to include the cost of training and development on a multi-agency basis, to enable it to carry out its agreed business plan objectives, which also includes the cost of Serious Case Reviews, where necessary.

The financial year commences on 1st April until 31st March each year.
Leicester City Council is the accounting body for the LSCB Budget
The LCC, Head of Service, Safeguarding Unit is the Cost Centre and Budget holder.

Partner agencies' contributions 2015/2016

	£	%
Leicester City Council	129,030	52.5
Leicester City Clinical Commissioning Group	56,759	23.1
Leicestershire Police Force	43,944	17.9
National Probation Service	15,556	6.3
CAFCASS	550	0.2
TOTAL	**245,839**	



Partner agencies also provide significant support to the LSCB
through contributions in kind, in particular the release of a significant amount of staff time, without which it could not operate.

Expenditure exceeded income for the first time since the City LSCB was formed in 2010.

The overspend was largely funded from accumulated underspends from previous years and additional contributions. The additional expenditure was the result of three main factors. 1) The partners supported five Serious Case Reviews (SCRs) during the year, some of which will be published in 2016-17 (see Section Strategic Priority 5). The need for SCRs is unpredictable and the Board had therefore accumulated reserves to meet additional costs. 2) The Interim Board Manager was appointed in January 2015 and recruitment to a permanent post was delayed to avoid disruption during the early phase of the Improvement programme. It then proved difficult to recruit a suitable candidate, resulting in several months of unplanned additional staffing costs. 3) A small number of consultancy days were commissioned to support the improvement in performance monitoring.

5. What does Leicester look like?

Leicester is the largest city in the East Midlands and the tenth largest in the country. It has a population of 330,000 (509,000 living within the wider urban area). Leicester also has the largest proportion of under 18 year olds in the East Midlands compared to neighbouring cities. There are approximately 80,750 children and young people under the age of 18 years (24% of the total population).

Leicester is an exciting, vibrant and forward looking city with a diverse population and a large and growing number of children and young people. The city and metropolitan area is culturally diverse, 59% of the city population comes from minority ethnic groups, with well-established South Asian and African Caribbean communities, in addition to more recent arrivals from European Community countries, amongst others.

Leicester is the 20th most deprived local authority in England, with almost half of the population living in areas of very high deprivation.

Leicester is a major centre of learning: the University of Leicester is recognised for the quality of its teaching and research; De Montfort University is very well regarded in many of its specialist fields and has worked together with the LSCB and other strategic partnerships to promote partnership working and a whole family approach to the safeguarding agenda.

Sir Peter Soulsby became the first directly elected Mayor of Leicester on 5 May 2011; he was re-elected for a second term in May 2015. Sir Peter Soulsby appointed Rory Palmer as Deputy Mayor and Sarah Russell as Assistant City Mayor for Children.

There are 54 councillors represent 21 wards across the city: they were voted in at local elections. The council is controlled by the Labour Party, which has 52 seats.

Leicestershire Police provides the policing service to the people of Leicester, Leicestershire and Rutland, covering over 2,500 square kilometres (over 965 square miles) and a population of nearly one million. Sir Clive Loader stood down at the end of his four year term as Police and Crime Commissioner in May 2016, having worked with the LSCB to strengthen the response to child sexual exploitation and other aspects of safeguarding.

Health services in the city are commissioned by the Leicester Clinical Commissioning Group with some specialist services commissioned by NHS England. During this period commissioning of health visiting and school nursing transferred from the CCG to the City Council public health service. The main health care providers are Leicestershire Partnership NHS Trust (community services) and University Hospitals of Leicester NHS Trust, all of whom are represented on the LSCB.

A new probation service structure came into being during the year. The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community; it is represented on the LSCB. Community rehabilitation companies (CRCs) manage low and medium risk offenders; the Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company is based in Birmingham and was not represented on the LSCB during the year.

6. How did we make a difference to the children and young people of Leicester during 2015/2016?

This is the second annual report since the OFSTED inspection 2015. The LSCB annual report reflects on the ongoing developments relating to core business, priorities identified from the LSCB development day held in September 2014 and the outcome of the OFSTED inspection.

The LSCB Annual Report 2014/2015 outlined six strategic priorities. The LSCB Business and Delivery Plan 2015-2018 incorporates both the recommendations from the OFSTED inspection report and the LSCB strategic priorities.

OFSTED
Priority and immediate actions for the LSCB

1. Establish and implement a robust performance management framework and dataset that can enable the Board to exercise scrutiny of service effectiveness and outcomes for children.
2. Monitor the effectiveness of statutory services and practice provided to children in need of help and protection.
3. Establish a clear line of sight and reporting from front line practice to the Board

LSCB Strategic Priority Areas
The key priority areas for 2015–17 are:
1. Post Ofsted Improvement Plan
2. Core Business and Governance

Areas for improvement
Scrutiny, awareness and challenge
4. Ensure that the information reported to the Board contains challenging analysis that enables members to identify the key priority areas for improvement and generate an effective Business Plan.
5. Increase the number frequency and range of multi-agency audits initiated by the Board.
6. Produce and implement a plan to engage with children and young people in order to hear and act upon their voice.

The strategic priority areas for 2015–17 cont/d

3. LSCB Identified Themed Priorities
   a. Evaluating Early Help
   b. Strengthening CSE
   c. Female Genital Mutilation
   d. Neglect
   e. Voice of the Child
   f. Domestic violence

Areas for improvement
Quality and evaluation

7. Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013).
8. Evaluate the current operation of the early help offer, including partners understanding and implementation of their early help responsibilities and the understanding and application of service thresholds.
9. Ensure that an evaluation of the impact of recent CSE initiatives relating to prevention, protection, prosecution and disruption is undertaken and that the right support is being made available to victims.

The strategic priority areas for 2015–17 cont/d

4. Participations and Engagement
   a. Voice of the Child
   b. Engagement with Frontline Practice

5. Effectiveness of Multi-agency Practice
6. Children's Workforce Development Issues

6.1
STRATEGIC PRIORITY 1

The themes emerging from the Ofsted inspection identified 5 key areas for improvement. They are:

1. **Governance and Board Functions**
2. **Engagement of Children, young people and families/carers**
3. **Engagement with frontline practice**
4. **Early Help**
5. **Performance Management**

The LSCB reviewed its work priorities to ensure that effective oversight of core child protection business was in place and that regular oversight is maintained of the areas for improvement identified by inspection so as to ensure good and timely progress in all areas for improvement.

The priority improvement areas were embedded within the LSCB business plan as well as being subject to a separate improvement plan which was overseen by the Leicester City Council Improvement Board.

6.2
STRATEGIC PRIORITY 2

The core business of the LSCB supports and sustains the strategic priorities which are focussed on the needs of Leicester's children and young people. This section reports on activity to sustain the infrastructure.

An effective LSCB is one where all partner agencies feel able to fully participate and engage in the business of the Board. Following the Ofsted Inspection LSCB Partners has remained committed and motivated to improving the partnerships strategic position and has focussed on improving its challenge and scrutiny of the single and multi-agency response to safeguarding children.

The core business is supported by chairs of sub-groups, key staff from different agencies and the LSCB office staff. The number of sub-groups and project groups which need sustained support is evident in this report; the activity reflects the need to deal with local priorities whilst also responding to emerging national priorities such as FGM. Contributions of senior officer time and the time of safeguarding specialists from all agencies is becoming more difficult as financial pressures and reductions in management severely reduce the capacity of all agencies to contribute to multi-agency working. Partnerships depend on the time of individuals to build relationships and sustain joint work. Effective safeguarding depends on sustained partnership working at all levels and is therefore jeopardised by the reductions in management capacity in all agencies.

The Interim Board Manager was appointed at the beginning of 2015 and continued in post throughout this year. Janet Russell provided knowledgeable, reliable and consistent support to the Board and the Chair. It was judged prudent for her to remain in post for the early part of the post-inspection improvement plan. An attempt to recruit to the permanent post towards the end of the year was not successful. This has had a financial impact on the Board. There were a number of other changes in staffing in the Board office. The LSCB appointed independent consultants who provided helpful assistance with developing the performance monitoring framework and indicator set.

A LSCB Induction Booklet was produced for members and practitioners to ensure that the role and function of the LSCB and expectations on members was fully understood.

The Board has ensured that there is the right representation within the LSCB and its associated sub-groups. The sub-group developments have ensured that there was an improved throughput of delivery on the LSCB Business Plan.

The Board partners have worked closely with the LCC Improvement Board to ensure there is robust oversight and progression of its improvement plan. The LSCB had produced an Improvement and Business Plan which incorporates the OFSTED recommendations.

LSCB Partners have given a particular focus to strengthening the arrangements relating to the 'Performance Management and Quality Assurance Framework. Partners agreed the set of indicators which would be used to measure progress and best suit and inform the identified priorities. A golden thread in this framework is the emphasis on the participation and engagement of Children Young People and their Families and that of Frontline Practitioners.

The Safeguarding Effectiveness Group was chaired by a senior officer from the CCG and was well represented by key statutory partners including Children's Services, Police, Leicester Partnership Trust, CAFCASS and Probation with the full Board being informed of any issues which have arisen.

With reducing budgets, staff instability one of the greatest challenges to LSCB partners is to assure themselves that what they are doing is done well and is really making a positive difference to children's lives.

6.3
STRATEGIC PRIORITY 3

This section provides an overview of information that relates to all children in Leicester. Some of these children and young people will have multiple needs and vulnerabilities, those worth noting will be highlighted below. In addition these children may feature amongst the cohort of children of which the LSCB as identified as a themed priority.

The priorities include focus on the themes stated below which have been identified from a range of sources, such as 'National' agendas, learning from reviews, local practice issues and local performance and assurance data.

a. Evaluating Early Help
b. Strengthening CSE
c. Female Genital Mutilation
d. Neglect
e. Voice of the Child
f. Domestic violence

Overview

The Office for National Statistics mid-year population estimate (2014) for 0-17 year-olds in Leicester was 80,750.

The January 2016 school census identified around 55,900 pupils in schools.

Around 17% in primary were eligible for free school meals and 52% had a primary language other than English. Corresponding figures for secondary were 18% and 50%.

2.6% of all pupils had a statement of special educational need or an Education, Health and Care plan, slightly higher than the regional average but comparable to the level in statistical neighbours.
17.7 % of children are in receipt of free school meals
51% of children have English as an additional language
10.5% of reception children are identified as being obese
22.1% of year 6 children are identified as being obese

Levels of young people not in education, employment or training (NEET) 6.3% were higher than national, regional and statistical neighbours.

413 children and young people were identified as being disabled during this period.

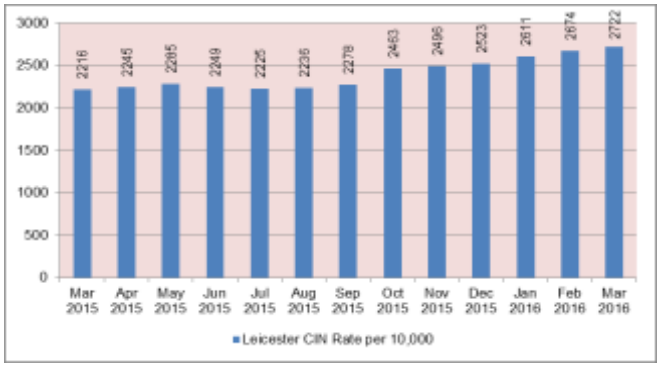
Vulnerable Children and Young People

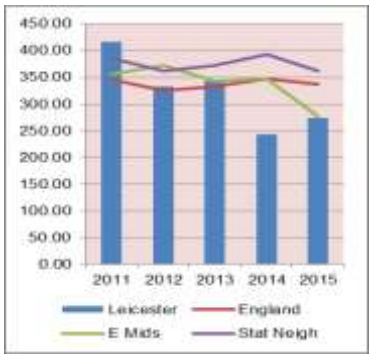
Working with the most vulnerable children - tracking the experiences of children through the journey of safeguarding systems and processes, beginning from Early Help, Child in Need, Child Protection, Looked After Children (LAC), leaving care and post care support.

Children in Need

Internal figures showed that there were 2,722 children in need at the end of March 2016. In addition to children being supported through a CIN plan, this includes children on child protection plans, looked after children, care leavers and those working with the Disabled Children's Service. The year-on-year change of 500 showed a 23% increase. The end of March figure is equivalent to 337 per 10,000 children.

Levels have risen throughout the year after DfE validated figures showing a downward trend between 2011 and 2015. 2016 comparable rates are not yet available.





Over the year the cohort included 5,372 children and young people. There were over 3,200 starts and around 2,650 episodes ended during the year. Some of these were multiple starts/ends for the same child.

Children subject to Child Protection Plan (CPP)

Children who have a Child Protection Plan (CPP) are considered by Partner Agencies to be in need of protection from either neglect, physical, sexual or emotional abuse, or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken by the family, social worker and supporting agencies to reduce these concerns and, how we will know when progress is being made.

At the end of March 2016, 518 children and young people were the subject of a child protection plan. This is an increase of 19.9% from 432 at 31 March 2015.

Whilst being volatile, levels in Leicester were previously on a slight downwards trend since 2011. 2015 rates were higher than national, regional and statistical neighbour levels. 2016 comparable rates are not yet available.

Neglect (43%) remained the most prevalent category of abuse for all 949 cases open over the year, followed by emotional (32%) and physical (22%).

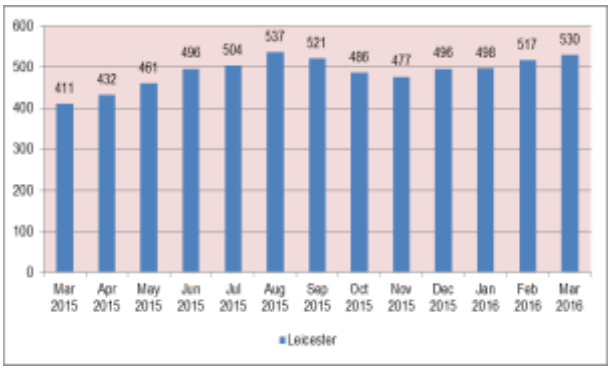
Between April 01 2015 and March 31 2016 521 child protection plans were started, with just under 22% for children previously on a plan and just over 4% for children previously subject to a plan within the last 12 months. Each group of those aged 1-4, 5-9 and 10-15 contributed around a quarter of all started plans. Girls (53%) were more likely to have a plan started than boys.

Between April 01 2015 and March 31 2016 431 child protection plans were ended. The average length of ended plan was 270 days. Girls (49%) were less likely to have plans ended than boys.

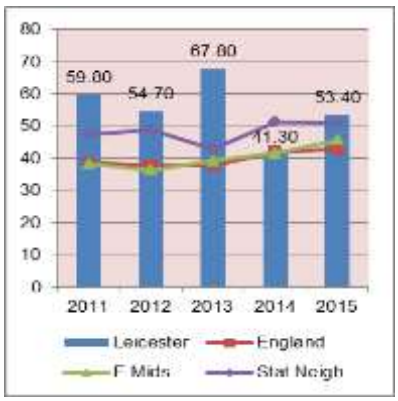
Looked After Children (LAC)

Looked After Children are those looked after by the Local Authority. Only after exploring every possibility of protecting a child at home will the Local Authority seek a parent's consent or a Court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

Internal figures showed that there were 638 Looked After Children at the end of March 2016. This is up by 73 from the DfE validated figure of 565 on March 31 2015; an increase of nearly 13%. The final figure is equivalent to 79 LAC per 10,000 children.



Levels have risen consistently over the year after DfE validated figures being relatively stable between 2011 and 2014. 2016 comparable rates are not yet available.



There has been a rise in the numbers of Looked After Children. Reasons include the Local Authority continuing to applying for more Care Orders and the number of children and young people leaving care decreasing. There a high numbers coming into care between 12 and 16 years. This mirrors the national trend. External inspection, the courts and our own audit have concluded that the threshold applied for care is correct at the time of children and young people becoming Looked After.

Children Leaving Care

From 1st April 2015 to 31st March 2016:

- 42 children were adopted
- 26 children became subjects of special guardianship orders
- 205 children ceased to be looked after, of whom 11 (5%) subsequently returned to be looked after
- 103 children and young people ceased to be looked after and
- moved on to independent living
- four children and young people ceased to be looked after and are now living in houses of multiple occupation.

Privately Fostered Children

Despite efforts by the Local authority and LSCB to raise awareness of the need to notify children's services of when these arrangements are in place the reported numbers remain low. In total there have been 18 private fostering arrangements known to the Local Authority in the year 2015/2016. There remains a need to consider how to increase the reporting of private fostering arrangements as these children are living in unregulated placements and are potentially open to exploitation and subject to risk. Increasing the reporting of private fostering arrangements remains a key focus for the Local Authority and this will continue to require a multi-agency approach.

Partners are reminded that parents may make their own arrangements for their children to live away from home.

A privately fostered child is a child under 16 (or under 18 if the child has a disability) who is being cared for and is living with someone else.

The carer for the child is someone who is not:

- A parent, or other person who holds parental responsibility for the child
- A close relative; for example, a grandparent, step-parent, brother or sister, uncle or aunt. (This includes relatives who are half blood, full blood or by marriage.)

Private Fostering is an arrangement where care is intended to last more than **27 days**.

Any person who is looking after someone else's child, or knows of someone who does should talk to Children's Services.

Children with Poor Emotional and Mental Health

The Child and Adolescent Mental Health Services (CAMHS) offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

CAMHS can diagnose and treat conditions as indicated:

- Depression in children and young people (NICE guidance CG28)
- Eating Disorders (NICE guidance CG9)
- Self-harm(NICE guidance CG16)
- Post-Traumatic Stress disorder (NICE guidance CG26)
- Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD) (NICE guidance CG31)
- Bipolar Disorder (NICE guidance CG38)
- Attention Deficit Hyperactivity Disorder (ADHD) (NICE guidance CG72)
- Anxiety (NICE guidance CG11)
- Social and emotional wellbeing in primary schools PH12
- Social and emotional wellbeing in secondary schools PH20
- CAMHS can also diagnose and treat serious mental health problems such as bipolar disorder and schizophrenia.

There are different ways to get an appointment with CAMHS. The most common is by referral from the child's GP. Others who may be able to make a referral to CAMHS include:

- Health visitors - following discussion with GP
- School nurses - following incidents of self-harm or discussion with GP
- Social workers

CAMHs has, from the 1st June 2016, a single point of access (SPA) called 'Access' for all referrals. The centralised system has rationalised the point of access to enable improvements in multi-disciplinary, multi-agency facing hub for the management, processing and assessing of needs of children and young people.

6.3.1 Evaluation of Early Help

Interaction between early help services, child protection investigations (Section 47) and admissions to care

The LSCB has recognised the following inter-related elements from performance and assurance data:

i. Very low proportion of early help lead practitioners from agencies other than the City Council - this has remained the case for several quarters
ii. Number of Section 47 investigations – these continue to be above the average for similar areas
iii. Looked after children rate per 10,000 – there is a very significant increase in the number of looked after children and new admissions to care, with concern about the number of those aged 0-3.
iv. Pre-Birth Assessments – concerns about weaknesses in arrangements for these assessments have been identified in an audit of pre-birth assessments, a number of Serious Case Reviews and in feedback from frontline staff. Evidence from assessments shows that there are greater numbers of children requiring specialist intervention and lesser number requiring minimum intervention.

This suggests a need for more effective support to families and children at an earlier stage to prevent the escalation of problems which result in Section 47 investigations. The internal audit evidence and judicial feedback suggests that those cases which do go to court are appropriate, but that more effective intervention at an earlier stage might have reduced the risk and would probably have enabled more children to remain at home. This hypothesis requires further testing but is a sufficient basis for planning multi-agency service improvement.

The need to strengthen multi-agency understanding of and engagement with the integrated delivery of early help to families is accepted by all agencies. The City Council is engaged in active discussions with partner agencies and there have been specific discussions among head teachers and within Leicester Partnership Trust about how best to engage with this priority and the implications for service delivery.

The LSCB evaluates that there is evidence of service weaknesses in relation to early help across the partnership; this has also been identified in the LCC Improvement Board. This themed priority needs continued attention and must be addressed on a multi-agency basis.

Children's Social Care Early Help

The Council's Early Help Targeted service (Children centres, Family Support and oversees the Early Help Assessment process) monitors performance and outputs in the following ways:

a) Numbers of service users accessing the Early Help Targeted Service via the CYP&F Centres. This includes

- contacts (numbers of times the Early Help Targeted service is contacted by service users once in a set period, e.g. 12 months);
- reach (numbers of service users that made at least one contact with the service); and
- engagement (numbers of service users that have made at least 3 meaningful contacts which would result in a positive impact).

b) Numbers of short term (e.g. Home Learning/Family Support) and long term (e.g. Early Help Assessment) casework involving families who are at risk of requiring a statutory social care intervention.

c) Quantitative and qualitative data evidencing the outcomes achieved by families who have had their needs met through the early help service.

Numbers of contacts made to the Advice Point and what happened to them

Numbers of contacts made to the Advice Point and what happened to them[1]

	Numbers of contacts to the Council's Advice Point in the Early Help Targeted service	**2014/15**	**Numbers of contacts 2015/16**	**Notes**
1	Total numbers of contacts to the advice point (telephone, drop in, outreach for up to 2 sessions)	Not collected	20,236	Equates to 4,780 families 24% of contacts were made by professionals
2	Of total contacts to the Advice Point, number and percentage of total contacts resulting in no further action (NFA) Number and percentage of contacts dealt with by the Advice Point	Not collected	3,175	Equates to 791 families NFA is determined as not a relevant query or meets threshold for service e.g.) adults only, no children involved or no service required
3	Of total contacts to the Advice Point Numbers and percentage of total contacts resulting in some form of action by Advice Point (low level advice, short term work without it becoming a case)	Not collected	11,097	Equates to 2,606 families e.g. supporting with housing applications, accessing foodbank, one off session in the home on parenting techniques.

The creation of the **'Advice Points'** has been very successful for the service and popular for professionals who want to access information or gain advice about how to support a family or refer for targeted early help support. Of the **20,236** contacts made to the service via the Advice Point:

a) **50%** of families were dealt with by the Advice Point enabling families to access support at an earlier stage to **stop issues from escalating or require further support,** helping them to meet their own needs independently.
b) **16%** resulted in **no further action** due to a variety of reasons, e.g. family did not meet the Priority List criteria (refer to Appendix E) or there were no children involved in the case.

[1] Contacts refer to individual contacts but some of these could have been made by the same person a number of times.

Contacts resulting in casework and what happened to them 2015-16

	Casework Files	Individual children	Equates to no of Families	Notes
1	Total numbers of **individuals** and **families** subject to casework	5,964	1,098	
2	Numbers of individuals and families supported by **Early Help Response** (short term casework files - 6 weeks)	1,572 (26%)	376 (34%)	Of the total numbers identified in row 1.
3	Numbers of casework files **stepped up to Children's Social Care**	67 (1.12%)	20 (1.82%)	Of the total numbers identified in row 1.
4	Numbers of **Single Agency** casework files (short term casework files - 12 weeks)	3,927 (66%)	604 (55%)	Of the total numbers identified in row 1.
5	Numbers of open **multi agency Early Help Assessments** (long term casework files - 9 months +)	398 (6.7%)	98 (9%)	Of the total numbers identified in row 1.
6	Of the cases closed **(605)** by the Early Help Targeted service, percentage of families evidencing their needs were met.	n/a	454 (75%)	Families identified their needs at the start of intervention and measured distance travelled at closure.

The table above provides a range of information about **case work files** and the key points are highlighted below:

a) **Case work files can refer to three different types of work:**

- **(Refer to 2 above):** Supported by **Early Help Response** to complete a very short piece of work (less than 6 weeks), for a case stepped down from social care that requires a brief intervention, directed from the court or for young people who are missing and at risk of exploitation.

- **(Refer to 4 above): Single Agency** – 1 or 2 issues that can be supported by one worker for a short period of time (no more than 12 weeks)

- **(Refer to 5 above): Early Help Assessment**, 3 issues or more, requiring longer term support, more than one agency involved and requiring someone to be the named contact for the family to co-ordinate the support plan.

b) **29%** of all contacts to this service (as outlined in table 6, page 12) resulted in a single agency response of short term (12 weeks) or long term (9 months+) Early Help Assessment.

c) Only 67 individuals (**1.12%** of all individuals subject to casework) were **stepped up to Children's Social Care.** This suggests that the Early Help Targeted service is managing

thresholds well and that its support of families is preventing the escalation of need and the requirement for a statutory social care intervention.

d) In reviewing all case work files open to the Early Help Targeted Service, 16% came from Children's Social Care, which suggests confidence in the Early Help Targeted service to support families transitioning from social care to universal services and targeted support. This results in cases being closed by Children's Social Care.

e) **66%** of individuals subject to casework were supported through **short term work** with the minority of families being supported by a **longer term** multi agency intervention lasting approx. 9 months or more.

f) Of the **605 cases closed** to early help services, **75%** of families stated that their **needs had been met**. Data is not available to determine if any of these closed cases were subsequently **re-referred** to the Early Help Targeted service or Children's Social Care.

Interface between Early Help and Social Care

	Direct impact on Children's Social Care	2015-16	Decrease or increase[2]	Comment
1	Number of cases stepped down from social care to early help services (for either casework or centre services).	934	↑	73% increase on 2014-15 16% of all cases open to early help are from social care.
2	Percentage of all single assessments undertaken by social care that were stepped down to early help services.	12%	↑	Equates to 272 statutory single assessments which required action and support to prevent escalation to statutory CIN, CP, LAC plans.
3	Percentage decrease in the number of contacts made to Children's Social Care.	5%	↓	Equates to 600 contacts
4	Percentage increase in the numbers of children subject to a statutory social care plan.	23% (av)	↑	Equates to 546 children. However, in reviewing the data more closely, 300 children are from the Disabled Children's Service who have not been included in previous datasets and reflects national trend.
5	Percentage decrease in repeat referrals to Children's Social Care	9.6%	↓	In looking at re-referrals data, there were 712 cases closed by social care where issues escalated but they were supported by targeted EH services rather than escalated to social care.

Significant progress has been made over the past 12 months in responding to Ofsted's feedback on where the Early Help Targeted service could do better. Whilst work had already started to review the current early help offer, the Ofsted inspection provided leverage to transform the current delivery model and accountability arrangements. The Early Help and Prevention Strategy & Protocol was refreshed in consultation with the LSCB, Children's Trust and Early Help Strategy Board, which resulted in the changes outlined in table below.

[2] Green = favourable increase/decrease, Red = unfavourable increase/decrease.

Work undertaken as part of the refresh of the Early Help and Prevention Strategy & Protocol

	What we did	What has been the impact and how does it support remodelling of services?
1	**Merging of workforce development budgets** to develop one annual multi-agency workforce plan. Voluntary Action Leicestershire plans and co-ordinates delivery and evaluates learning and impact.	• Quarterly evaluation demonstrates the impact of knowledge gained, shared understanding and standardised processes on improving the quality of service provision. • External partners have improved their knowledge and skills enabling them to support families and prevent escalation of need for local authority services.
2	**Implementation of the new Early Help Assessment (EHA)**; new eligibility criteria and definitions agreed by partners. Supported by a full day training course and e-learning module for staff and partners.	• Clearer pathway to access support and ensure multi agency working. • Improved understanding of early help and how to access services, reduction of duplication and inappropriate referrals to both early help and social care.
3	**Development of 'Advice Points'** in each cluster across the city to provide low level advice, signposting or one off interventions without becoming a case.	• Decrease in inappropriate referrals to early help and social care and a reduction in issues escalating or requiring longer term, high cost interventions. • Learning and outcomes from this work can be applied to the creation of the single Advice Point, proposed in the models described in this report.
4	**A partnership communication strategy** with a new website, e-newsletter and regular evaluation with staff and partners re :'Early Help'	• Over 600 individuals are registered for the Early Help Newsletter; over 800 individuals access the Early Help website per quarter resulting in 1,300 page views. • Improved communication and knowledge for external partners allowing them to facilitate a range of support for families. • Established media network supports the Early Help Targeted service to communicate with its partners and will facilitate service transformation in the future.
5	**Updated key protocols/thresholds aligned to the new offer**	• Robust process in place for step up/step down of cases between early help and social care. • Review of thresholds from 4 to 3 levels to reflect the work of early help services with complex families. • Clear pathway for cases transferring between social care and early help leading to a direct reduction in the number of cases being open to social care. Staff and partners' increased understanding of thresholds is leading to a reduction in inappropriate referrals to both early help and social care.
6	**Merging of referral and assessment paperwork,** incorporating '**Troubled Families'** objectives and a focus on evidencing outcomes	• Reduction of 4 referral forms into one form; a clearer focus on reflecting the voice of the child; the difference made by early help interventions now evidenced by outcomes. • Robust process allows early help to demonstrate impact and as a result make successful payment by results claims for TF funding.
7	**The creation of the 'Early Help Response Team'** collocated with Social Care, screening all requests for targeted early help, allocation of casework, managing step up step down and completion of returning from missing interviews.	• All requests for early help support come to one team, rather than 6 teams based out in localities. • Smoother process for referrals and interface with social care, which supports step down of cases and joint working. Weekly surgeries to discuss potential early help support. This process has ensured that we have accurate performance data, can prevent cases from 'drifting' and can provide standardised, effective advice. Reduction from 6 teams to 1 has improved service consistency and efficiency (i.e. the new team is less resource intensive).

	What we did	What has been the impact and how does it support remodelling of services?
8	**Roll out of the 'Rickter Scale' (RS)** outcomes tool which resulted in a major investment of RS training for all staff and partners delivering early help services to evidence impact and distance travelled through the 'Families Outcome Plan' - for all families and not just those identified as 'TF'.	• Families Outcomes Plan in place to clearly outline expectations and measure outcomes. The use of one main user friendly evidenced based tool has enabled early help services to effectively demonstrate service user progress and the impact of interventions. • Analysis of Q1 2016-17 data showed that of the 81 Rickter scale evaluations completed, there has been a 94% improvement in distance travelled for improved parenting.
9	**A new electronic case recording system** 'Liquid Logic' Early Help Module, which is accessed by all LCC staff to record their single agency and EHA work, and partners who are Lead Practitioners on EHA's. The system is also shared with Children's Social Care operating a one record per child model.	• A single entry for each child and family has improved information sharing between early help and social care and improved data accuracy. • The Council's Partners can now view information about children and lead and/or contribute to 'team around the family action plans' • Early help, social care and partners now have a clear 'whole view of each family' allowing them to better identify and address needs. • Time is saved by reducing manual paperwork and ending the recording of information on multiple information management systems. • Information is now easily accessed through a secure internet connection, speeding up assessments and support. • A feeling of shared ownership between the Council and its partners has been developed and will assist the council to develop partner involvement in taking on the lead practitioner role in early help assessments.
10	**Development of a 'Step up Step down protocol** for all open cases between early help and social care.	• As a result of a clear protocol and pathway there has been a 73% increase in social care cases stepping down to early help.
11	**Stakeholder Analysis** with staff and partners to assess the development of the early help offer and a full 'Health Check' completed with families, staff and partners, which resulted in an action plan that is currently being implemented.	• This action plan resulted in the development and approval of a charging policy for partners using CYP&F centres, enabling Early Help Targeted to generate additional income. Actions completed included a staff health and wellbeing survey, which had a 64% response rate, and a user and partner survey, which informed service development.

12	**Development of a multi-agency response** at a senior management level to any open case that is stuck, high cost or escalating across early help and social care services.	• 49 cases were presented to the Multi Agency Support Panel (MASP). Of these cases, 20% were escalated to social care for a single assessment resulting in a statutory social care plan. This panel has enabled a partnership response to presented cases, a pooling of resources and robust decision making. There is now an opportunity for practitioners to flag and present cases that they are concerned about at an earlier stage to prevent children and young people coming into care. • There are also 6 early help locality partnerships across the city supported by the council and represented by operational leads in services located in clusters. These partnership boards have become established demonstrating a localised response of joint initiatives responding to demand and priorities eg) breakfast clubs, summer programmes, reduction of asb.
13	**Robust governance arrangements** through the Early Help Strategy Board reporting to the Children's Trust.	• Strong partnership engagement representing the majority of key partners from across the City. This has improved joint working, increased understanding and resulted in the development of the first early help partnership quarterly performance report and 3 year strategy.

6.3.2 *Child Sexual Exploitation (CSE), Trafficked and Missing*

Why did we do it? How did we know there was a need to do it?

CSE remains a key strategic priority for the Local Safeguarding Children Board (LSCB) reflecting its national and local status. The government has elevated CSE to the level of a national threat and established an Independent Inquiry into Child Sexual Abuse which will investigate whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse including CSE. CSE is deemed to be a local threat evidenced through high profile cases across Leicester, Leicestershire and Rutland and also demonstrated in the Leicestershire Police problem profile (using 2014-15 data) for CSE, Missing from Home and the Paedophile & Online Line Investigation Team that highlights a number of threat and risk areas.

How much have we done in the last 12 months up to March 2016?

A joint LSCB CSE, Missing and Trafficking Subgroup covering Leicester, Leicestershire and Rutland, established in August 2012, is tasked with coordinating the local response.

During this business year key principles established last year to strengthen the local response have been progressed:

- Consolidation of a single Leicester, Leicestershire and Rutland (LLR) approach to tackling the issues of CSE, trafficked and missing children
- Sharing, pooling and an equitable distribution of resources within a single multi-agency specialist CSE team in line with emerging threat and need

In June 2015 a CSE Coordinator for Leicester, Leicestershire and Rutland was appointed to support the work of the LSCB subgroup and focus on a number of identified priorities:

- Support the implementation of the local action plan
- Ensure protocols, policies and procedures are up to date and effective
- Co-ordinate partnership activity with the aim of creating an accurate and up to date multi-agency CSE problem profile
- Monitor the effectiveness of practice, to protect and support children and young people at risk of CSE and make recommendations for improvement
- Ensure effective information sharing between partners and at a local level

Progress has been made on a number of the identified priorities:

- A local authority data set has been established and key information is emerging. It has resulted in improved profiling of victims and those at risk of CSE and risky persons and peers. The appointment of a multi-agency intelligence analyst through the Strategic Partnership Development Fund (SPDF) CSE Project (see below) will bolster this area of work and support the development of a comprehensive multi-agency data set
- Children and young people at risk of or subjected to CSE are now flagged on their health records and available to front line health services
- Frontline police officers are now using a CSE checklist when completing a Vulnerable Children's Report to support identification, prevention and timely referrals

- An operating protocol for the multi-agency specialist CSE team has been developed

The growth and development of the specialist multi-agency team response to CSE has continued apace with confirmation of investment from the NHS and Leicester City Council to add to the existing contributions from Leicestershire Police, Leicestershire County Council and Rutland County Council.

The development has been further bolstered by a successful partnership bid of £1.23 million to the Strategic Partnership Development Fund (SPDF) of the Police and Crime Commissioner aimed at funding provision over the next two financial years. The aim is to utilise the funding to build capacity, capability and improve the effectiveness of the partnership in preventing, identifying and tackling CSE. The SPDF CSE Project is intended to fund both one-off and non-recurring initiatives, as well as extending existing initiatives and good practice. In addition, it will provide a temporary increase in structures and staffing. Planned initiatives include the extension of Warning Zone provision to include an innovative e-Safety programme and the development of a comprehensive school prevention activity programme including re-commissioning 'Chelsea's Choice'. Additional posts include the recruitment of a multi-agency CSE analyst, a forensic psychologist, parenting support coordinator and specialist health professionals into the multi-agency team. The CSE Coordinator is the nominated project manager for the SPDF CSE Project.

One of the initiatives C.E.A.S.E. (Commitment to Eradicate Abuse and Sexual Exploitation), was launched at an event in February 2016. At the event partner agencies publicly pledged their commitment to tackle CSE by signing-up to C.E.A.S.E. This marked the start of an internal and external awareness raising campaign designed to complement the communications activity already being delivered under phase three of the wider 'Spot the Signs' campaign led by the LSCB Subgroup. Phase two of C.E.A.S.E. includes the launch of an educational film focusing on e-Safety based on a recent local case.

Multi-agency work to identify children and young people who may be at risk of Child Sexual Exploitation (CSE) in Leicester is jointly coordinated with Leicestershire and Rutland (LLR).
During the year, 362 children in total across LLR were identified as at risk of or subjected to abuse through sexual exploitation

- (125) Leicester City, 34%
- (233) Leicestershire, 65%
- (4) 1% Rutland
- 12% (44) of referrals are for boys (for the City 15 boys)
- 18% (67) are LAC children (for the City 7 LAC)

This was a significant increase from the previous year's figures and is most likely owing to the awareness raising and targeted communications campaign across LLR.

How well did we do it? Is anyone better off? How do we know they are better off? What is the evidence for that?

Leicestershire agreed to participate in trialling the development of a new inspection regime. The two day Joint Targeted Area Inspection trial held in September 2015 involved the inspectorates for children's services (Ofsted), police (HMIC) , health (CQC) and probation (HMIP) - combining their resources to undertake a multi-agency inspection focusing on the theme of CSE and missing children. Following feedback provided by the inspectors a number of actions have been progressed through the LLR LSCB CSE subgroup. This includes ensuring CSE concerns are flagged on health records.
A seminar hosted by the East Midlands Assistant Directors of Children's Services (ADCS) Group was held in October 2015 involving senior leaders from a wide range of agencies from across the region.

Keynote contributors included Ofsted and Crown Prosecution Service. The event provided an opportunity to reflect on CSE practice and critical issues, highlighted improvement themes and engaged delegates in a discussion about regional approaches. The local approach in achieving a unified approach to tackling CSE across three local authorities and two LSCBs was cited as an example of good practice. A regional CSE framework, encompassing a range of regional principles and standards, has been finalised and endorsed by the regional ADCS group.

Work of the Subgroup

In order to effectively respond to the developments outlined above the pace and trajectory of the work of the Subgroup has been increased and accelerated during this business year. A wider range of agencies are now represented on the Subgroup reflecting the increased scope and breadth of the agenda.

What are the priorities for the work over the next 12 months from April 2016?

A development day took place in February 2016 to focus on development and delivery of the business plan for 2016-17. A member of the National Working Group (for Sexually Exploited Children) attended to help inform the discussion. Priorities identified included:

- Developing our response to online CSE
- Developing our approach to risky persons offenders and serious and organised crime groups
- Broadening awareness raising activity in relation to CSE, trafficking and missing whilst targeting identified underrepresented groups
- Seeking assurance that the implementation of the Strategic Partnership Development Fund CSE Project leads to enhanced safeguarding outcomes for children

Missing Children

Missing – Ofsted found that many children known to children's services do not benefit from return interviews when they go missing. As a result, plans to reduce further missing episodes and tackle risks associated with and reasons for going missing are not in place. When young people are known to be at risk of child sexual exploitation, robust multi-agency action occurs to reduce these risks. However, for other young people, opportunities are missed or intervention does not always happen when potential risks are first identified, and concerns escalate.

6.3.3 Female Genital Mutilation

Why did we do it? How did we know there was a need to do it?

In the UK FGM is more common among communities from Kenya, Somalia, northern Nigeria, Sierra Leone, and Egypt. Over 100,000 women are living with the consequences of FGM in the UK, with 60,000 girls are at risk.[3]

A report[4] on FGM prevalence in England and Wales showed areas such as Manchester, Slough, Bristol, Leicester and Birmingham have rates ranging from 12 to 16 per 1000 women. The report found the communities in which FGM is practiced in the UK tend to be urban, but that it is likely to affect women and girls from every local authority including Leicestershire and Rutland.

Although FGM is illegal in the UK,[5] it is unlikely to be reported to the Police. This is likely to change, especially as since November 2015 the Serious Crime Act for England and Wales, requires teachers and regulated health and social care professionals to report to the police cases of FGM in females aged less than 18 years. In addition, collection and submission of a new FGM Enhanced Dataset became mandatory for all NHS acute trusts from July 2015, and all Mental Health Trusts and General Practices from October 2015. This will improve the NHS response to FGM and facilitate better commissioned services to safeguard and support women and girls.

Local

The demographics In Leicester, Leicestershire and Rutland indicate that there is a substantial representation of the communities identified in at least three of the communities identified in the national overview. Despite the requirement for social workers, teachers, doctors, nurse and midwives to report FGM, many cases are continuing to go unnoticed because FGM happened at a young age and/or abroad.

The experimental statistics released by the Health and Social Care Information Centre on 21 July 2016 show 30 newly identified FGM cases in Leicester City. 25 of the 30 were advised of the health implications and the illegality of FGM.

There is a need for more community engagement on FGM to ensure it is understood as child abuse, to improve parental understanding of FGM as a harmful practice and the need to prevent it and to better educate communities on the health implications of FGM.

How much have we done in the last 12 months up to March 2016?

The LSCB FGM Task and Finish Group commenced work in September 2014. In accordance with the Terms of Reference the group has ensured the delivery of refreshed LSCB FGM Procedures and opportunities for frontline practitioner to access training in recognising and responding to FGM.

This has been achieved by:

- The completion of refreshed LSCB FGM Safeguarding Procedures and disseminated to frontline practitioners and launch in September 2015
- FGM Training and briefings to frontline practitioners

[3] Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates, City University London, 2013

[4] MacFarlane et al. (2015). Prevalence of Female Genital Mutilation in England and Wales. National and Local estimates. Available at: http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf

[5] Female Genital Mutilation Act (2003) http://www.legislation.gov.uk/ukpga/2003/31/contents

- Supporting the July 2015 FGM awareness communications to all LLR schools pre summer holiday

- Supporting a You Tube FGM awareness video

- Bespoke FGM web pages/areas created on each of the two LSCB websites linking to procedures and media articles and signposting to reporting http://lrsb.org.uk/fgm-female-genital-mutilation

- Creation of a new LLR leaflet http://lrsb.org.uk/uploads/fgm-leaflet.pdf

A successful mini 'Engagement Summit' involving member of the Somali community took place on 14th October 2015. It is the hoped that further development work involving community champions in the design and development of resources to inform their own community about FGM. This model of community engagement could be replicated across relevant communities.

How well did we do it? Is anyone better off? How do we know they are better off? What is the evidence for that?

Impact of the LSCB FGM Procedures and Training

The impact of the work undertaken to raise awareness of FGM by the refreshed LSCB FGM Procedures and Training to frontline staff will be evidenced by:

- The number of FGM cases reported to 101 by practitioners included in the October 2015 Mandatory reporting arrangements

- The number of FGM cases reported by the public or professionals not included in the Mandatory reporting arrangements

- Clear referral pathways have been established and a flow chart jointly devised with Social Care, Police and Early Help to provide practitioners with clear direction on roles and responsibilities from initial reporting to intervention

- There has been some analysis to identify the number of women in the county that have had FGM and to identify those most at risk

The current LLR LSCB FGM Task and Finish Group has been discontinued in its current format as the core tasks identified have been completed. A key area of work which remained outstanding related to the operational delivery of messages into communities affected by FGM through a sensitive communication and engagement plan.

The LLR LSCB FGM Task and Finish Group has recommended that there is a development of a FGM Community Engagement Group and FGM Community Engagement Plan. The intention would be to sensitively raise the awareness of the refreshed FGM Procedures and new legislative frameworks in communities affected by FGM and there is a proposal that this work should be undertaken within another strategic partnerships which has a greater expertise in the management of potentially sensitive communications and awareness raising of the legislative requirements of FGM in affected communities across Leicester, Leicestershire and Rutland.

The FGM Group also recognise the role of Public Health to enable data and scoping of the potential number of girls and women in additional communities, other than the Somali community, who are likely to be affected by FGM.

What are the priorities for the work over the next 12 months from April 2016?

Ensure a comprehensive community awareness and communications campaign is in place that links in with opportunities to work locally to compliment national campaigns.
Continue to map FGM, use partner to develop a local profile to inform targeted work with public and practitioners and inform service development across the LLR.

6.3.4 Neglect

Why did we do it? How did we know there was a need to do it?

Neglect had been identified as a feature in national and local SCRs, and locally in learning reviews and multi-agency audits, resulting in neglect being identified as a priority by the Leicester LSCB and the Leicestershire & Rutland LSCB.

Neglect may be a factor or a direct cause of death or severe injury in children and young people, and it has been identified as a prevailing or risk factor when there is hidden harm relating to physical and sexual abuse. Current evidence strongly suggests that all forms of neglect are particularly associated with damage to the child's lived experience and their physical and emotional wellbeing.

It is important that professionals/practitioners understand that neglect is a safeguarding issue as every child has the right to develop healthily, and to do this their basic needs must be met. A link can be made between impairment of the child's health and development and neglect of aspects of their care provided by their parents or carers. A pre-requisite in recognising neglect in general terms, is a knowledge and understanding of children's development, of their families, their life events and experiences. This does not initially imply 'expert knowledge', although in some instances urgent expert assessment may be needed.

The Department for Education, National Statistics - Characteristics of children in need in England, 2013-14, show that nationally (in England) “abuse or neglect” was again the most common primary need at first assessment with 47.2% of cases recorded “abuse or neglect” as the child’s primary need. The proportion of cases with “abuse or neglect” as their primary need is broadly similar to last year (however, as earlier years contain missing or unknown values it makes it difficult to draw conclusions from the longer time series).
Locally, the numbers of children in need recorded as ‘abuse or neglect’ show that in Rutland and Leicestershire there has been a decrease in the numbers recorded from 2014 to 2015 whilst there has been an increase in Leicester City. In Leicester City the number recorded in 2013 was 1398, decreasing to 1011 in 2014 and increasing to 1,256 in 2015. In Rutland County the number recorded in 2013 was 92, increasing to 99 in 2014 and decreasing to 76 in 2015. In Leicestershire County the number in 2013 was 1503, increasing to 2088 and decreasing significantly to 876 in 2015.

In December 2015, a survey to ascertain practitioners’ knowledge and confidence in identifying and assessing neglect was conducted to inform the development of the neglect strategy and toolkit, found that out of the 96 surveys that were completed across Leicester, Leicestershire and Rutland, 75% were completed by frontline workers. Confidence in identifying neglect was at 81%, but assessing levels of neglect was at 51%. A wide range of tools and guidance were used to inform assessments, but practitioners wanted a universal cross-agency toolkit and guidance. Over half of those who responded to the survey were unware of the LLR LSCB multi-agency Threshold document and over three quarters did not use it.

How much have we done in the last 12 months up to March 2016?

The LLR LSCBs commissioned a reference group in June 2015 in order to understand the scale of, and improve the multi-agency response to neglect of children across Leicester, Leicestershire and Rutland.

The LLR LSCB Neglect Reference group created an action plan of the tasks that need completing in order to take forward the work around neglect. Several task and finish groups were set up to take forward the following: :

- Development of the LLR LSCB neglect strategy.

- Development LLR LSCB neglect tool kit.
- Update of the LLR LSCB neglect procedure.
- Communication of the neglect documents at the safeguarding learning event on 4th May and a further launch of the strategy, tool kit and updated procedure on 7th July.
- Practitioner survey on neglect.
- Inclusion of children and young people's views (by the NSPCC) about neglect in the neglect strategy.
- LSCB neglect audit: a dip-test and deep dive audit tool place during 2015

How well did we do it?

The LLR neglect reference group was established with representation from key agencies/services across LLR, including the Voluntary and Independent Sector. The group met from June 2015-May 2016 and during this period a number task and finish groups were set up to develop the strategy, toolkit and update the practice guidance.

The views of children and young people as well as practitioners were also sought and incorporated into the development of the resources on neglect.

Neglect was an aspect that was covered in the safeguarding learning event that took place on 4th May 2016, which was attended by 240 people from agencies/services across Leicester, Leicestershire and Rutland. The toolkit was particularly welcomed by practitioners who attend the event as shown by the evaluation of the event.

An event to launch the LLR LSCB neglect strategy and toolkit will take place on 7th July 2016, and the resources developed on neglect include a briefing paper on neglect. Three further workshops on neglect for staff across Leicester, Leicestershire and Rutland have been organised to take place during 2016.

Is anyone better off? How do we know they are better off?

Practitioners working across Leicester, Leicestershire and Rutland are better informed about neglect impact of neglect on children and the resources that are available to support staff working with children. The intended outcome of that is through practitioners' improved understanding of neglect the outcomes of children at risk of neglect are better understood and actions taken to address this.

What is the evidence for that?

The implementation plan for the work on neglect includes evaluation of the neglect tool kit and an online survey is planned for the end of the year which should evidence use of the toolkit and improvement in practice.

What are the priorities for the work over the next 12 months from April 2016?

During the next 12 months the LLR neglect strategy and toolkit will be launched and implemented. The use of the toolkit will be evaluated and will include an online survey of practitioners across Leicester, Leicestershire and Rutland. There will be a further audit to assure the quality of multi-agency practice.

6.3.5 Domestic Violence

Why did we do it? How did we know there was a need to do it?

Domestic violence is a high volume and high harm issue, with significant cross over for child protection;

- 66% of adult victims known to our services have children
- Domestic violence continues to be a feature of local and national serious case reviews

How much have we done in the last 12 months up to March 2016?

Consulted, procured and implemented a new service model for specialist sexual and domestic violence services, with a specific view to increase the access of young people and to broaden the support available

- Established a service user scrutiny and reference group
- Started a health led working group to increase GP engagement
- Built on established research partnerships with DMU and Leicester University to expand the evidence base
- Opened a new sexual assault referral centre (over 50% of rapes occur within a domestic violence context)

How well did we do it?

120 perpetrators were referred to the perpetrator interventions service

- 875 people accessed support from the safe home service
- 43 people had additional security at home to prevent repeated moves
- 470 children and young people were referred to the family service
- 649 support cases were opened for adult victims
- 6002 helpline calls were received

Is anyone better off? How do we know they are better off?

- 80% of adult victims felt safer following intervention
- 94% of children felt safer following intervention
- 86% of children and young people supported improved attendance and performance in education

What is the evidence for that?

- Provider returns; helpline data sheets; case files
- Insights monitoring data

What are the priorities for the work over the next 12 months from April 2016?

- Be able to identify priority and serial domestic violence perpetrators
- Embed the new services and ensure local practitioners and families know of their existence and how they can help
- Learn more about the families who do not successfully secure support
- Review and re-profile the training package for local practitioners
- Embed Children's Insights dataset to have more child specific information and to compare performance against other similar services

6.3.6 Voice of Children

What did children and young people tell us?

The Leicester Safeguarding Children Board (LSCB) had within its 2015/16 Business Plan a strategic priority to increase children and young people's participation. The purpose of this was to ensure that CYP were listened to and consulted on safeguarding issues, and that their views and opinions were taken into account.

Through 2015/2016 the LSCB has maintained a focus on driving children and young people's voices in the work of the Board. The LSCB had identified the need to incorporate children and young people's views in all areas of its work. LSCB Partners have worked hard to develop the CYP Participation and Engagement Strategy and ensure that all agencies/organisations are mindful to implement and sustain the strategy and a vehicle for CYP to share their views and more importantly that those views are used to inform the way in which services are delivered and improved upon.

The Voice of Children and Young People

The LSCB is committed to developing a safeguarding system that supports children and young people to be engaged participants in intervention and decisions that affects their own lives. Participation is viewed as a right, not an option and children report that we could do it better. Although it can be a challenge to balance children's and young people's protective needs with their need to have a say, it is crucial that the voice of the child is central in Board business and safeguarding practice.

The LSCB has commenced work to progress on bringing together a sub-group to deliver on the Voice of the Child, which will develop a joint working approach to engagement and participation with Children, Young Persons and Families and to develop a methodology which is consistent in capturing the voice of the child across the partnership.

The Young Advisors Group was commissioned to deliver a Shadow Board made up of Children and Young Persons. The group has recruited young people through various methods including contacting several organisations that they work closely with such as the Young People's Council, The Big Mouth Forum, The Children in Care Council and active and enthusiastic young people in youth centres across the city. Work has been undertaken to ensure the shadow board members are aware of what their roles are as well as what the role of the organisation. A key task for the shadow board members is to identify what their priorities are and understand the local agenda and priorities of the LSCB. The Young Advisers Group is engaged with safeguarding issues and will support the CYP Shadow Board to undertake specific commissions on behalf of the LSCB.

Hate Crime Conference and Consultation on the LSCB Multi-Agency Participation and Engagement Strategy

The Participation Federation and the LSCB hosted an event for children and young people across the city. The aims of the event was twofold; to facilitate consultation with them about hate crime and to provide young people with an introduction to the work of the LSCB. Of the latter aim the role of the LSCB was explained to CYP delegates and they then were asked to take part in an interactive session (participated in a mock auction to give them a real understanding of the Board's work, defining the makeup of the Board and its business). The children and young persons were hugely enthusiastic and demonstrated that the most important value to them from the Boards work was, 'to be heard'; the voice of the child was an auction item and sold at a price of £26k.

The children and Young Persons also gave views in regards to the draft LSCB Participation and Engagement Strategy which had subsequently been taken into consideration when finalising the document.

Following the HATE crime conference the young persons who were instrumental in the design and delivery of the event were nominated for awards at the National Young Advisors conference event in August 2015. The young advisors won the best partnership award in recognition of their work.

LADO Arrangements Children's feedback

The Children's Rights and Participation Service were requested to consult with young people who have made allegations and been investigated by the Local Authority Designated Officer. The purpose of this consultation was to ensure that young people have confidence to raise concerns about adults working around them if they feel unsafe. It is also to identify young people's views and understanding of the LADO role.

From the list of 51 referrals made to the LADO service (8.12.14 – 3.12.15), many were unsuitable to engage in this consultation due to a very young age, young person being unidentified and a young person having a complex learning disability. There were some young people who it was felt the consultation would be inappropriate due to their current circumstances.

There were two young people who were consulted with. One male (JB) and one female (US). One aged 12 and the other aged 16, one lives in foster care and the other has recently moved from foster care to a residential placement.

Both young people were unaware of the LADO role or that the investigations into their concerns were managed by someone independent. Both of the young people thought that other LAC young people should be aware of this role whether they had raised concerns or not. One young person suggested that an information leaflet should be made available which would inform them of the LADO role and how their concerns would be looked into. I discussed this suggestion with the second young person and they agreed that this would be a good idea.

Both young people felt listened to, that their concerns were taken seriously and dealt with. Both young people felt confident that they would raise concerns again about adults working with them if they felt unsafe. Both young people also said that they currently feel safe in their placements.

Both young people were asked if they were given feedback. One young person didn't answer, choosing to change the subject and the other young person said they didn't. The young person who didn't receive feedback didn't feel that he needed or wanted feedback as he was moved as a result of raising concerns and now felt safe.

6.4
STRATEGIC PRIORITY 4

One of the LSCB's statutory functions is to communicate to persons and bodies in Leicester 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.
The LSCB through 2015/2016 continued to develop on the partnerships communications pathways, this included.

- The ongoing development of the LSCB website to make the work of the Board more transparent and accessible to all partners, parents/carers, communities and children and young people
- Bespoke website pages linking to key procedures and media articles relating to CSE, Trafficked and Missing's
- Multiagency meeting to engage community and faith leads in the multi-agency response to CSE
- Promotional material relating to Female Genital Mutilation (FGM to support the FGM annual 'Schools Out for Summer' campaign, to alert education staff to identify pre and post-holiday children who are most at risk of FGM) and including publication information 'You-tube' video
- A mini 'Engagement Summit' involving members of the Somali community work took place in October 2015

Views of Frontline Practitioners

The OFSTED inspection outcome identified the LSCB needed to "Establish a clear line of sight and reporting from frontline practice to the Board". Partners accepted the LSCB work collectively and as individual agencies was not well sighted on the views of frontline practitioners consistently in order to inform the development of safeguarding services.

A new multi-agency group was set up in response to the Ofsted outcome with representation from agencies across Leicester. The group was originally chaired by an Independent Reviewing Officer, Janice Bryan and now is chaired by the Councils Principle Social Worker.

6.5
STRATEGIC PRIORITY 5

Safeguarding Effectiveness Group (SEG)

Why did we do it? How did we know there was a need to do it?

LSCBs have a duty to monitor and challenge the effectiveness of local safeguarding arrangements (Working Together 2015). This work was undertaken in Leicester by the Safeguarding Effectiveness Group (SEG), which is responsible for monitoring and challenging the effectiveness of safeguarding arrangements of partners of the Leicester Safeguarding Children Board.

The OFTSED inspection found the quarterly monitoring framework was not robust enough and the *"Board had not been receiving adequate performance management data of safeguarding activity from partners and it is therefore unable to hold agencies effectively to account".*

How much have we done in the last 12 months up to March 2016?

The activity of the Safeguarding Effectiveness Group (SEG) through partner agencies and with support from the Board for 2015-2016 included:

Quality Assurance and performance Framework (QAPMF)

- The review of the LSCB Quality Assurance and Performance Monitoring Framework (QAPMF) following the Ofsted's judgement that the LSCB performance framework (Indicators report) was rich in data but lacking in analysis. The revised QAPMF was implemented for quarterly performance monitoring of data from for Q1 to Q4. During the year the data set and analysis from partner agencies was further refined. There was an increased commitment to this area of work from partner agencies with submission of data within the given timeframes however, the quality of analysis and appropriate commentary still require improvement.

- A revised performance quality assurance process based on Results Based Accountability/Outcomes Based Accountability was introduced for considering the performance monitoring data and analysis.

- The process for obtaining performance data and analysis from partner agencies on a quarterly basis was reconsidered and support with obtaining the data/analysis and producing a dash book was provided by the Local Authority Performance Team. This support is intended to be on-going.

- For the data and analysis provided by partner agencies to both the City and Leicestershire & Rutland LSCBs there were discussions and negotiations with LSCB Partners to amalgamate the collection of partner agency LSCB performance data from 2016-2017.

Audits

- Section 11 audit was conducted. A joint Leicester, Leicestershire and Rutland (LLR) online audit was also conducted with a sample of frontline and supervisory staff in agencies that are members of the LSCB and had previously responded to the strategic Section 11 2014-2015 audit. 145 returns were completed, 102 (70%) by frontline workers. City council returns came from Children and Family Services, Enforcement and Community Safety Services, Cultural (including leisure) and Neighbourhood Services, Adult Services and Housing Services, with other returns from police, CCG, UHL, LPT Fire and Rescue, probation

and CAFCASS. The findings show that there is high level of awareness amongst staff of what they should do when safeguarding children, particularly in relation to specific issues such as Domestic Violence, CSE, Neglect, FGM, Adult Mental Health and 'Prevent'. The audit also identified that there is a need to improve staff awareness of how to escalate a safeguarding concern and resolve practitioner disagreements, using the escalation procedure, and to disseminate learning from SCRs more widely.

- Single agency audit schedules and outcome of single agency audits undertaken by partner agencies were received. However, it was identified that not all partner agencies had single agency audit schedules and where audits took place these were submitted to the Safeguarding Effectiveness Group for consideration.
- A schedule of multi-agency themed audits on the LSCB priorities areas was created to increase the number and quality of audits undertaken. However, there was a delay in implementing the audit schedule due to the review and implementation of the multi-agency audit process and capacity of auditors to conduct the audits. During 2015-2016 audits were conducted on neglect and Child Sexual Exploitation. The neglect audit involved a dip-test of 42 different cases and a deep-dive audit on 2 of the same cases. The CSE audit comprised of 10 of the same cases and a deep-dive audit on 1 case.

How well did we do it?

Performance data and analysis was provided by partner agencies for Q1 to Q4 in 2015/2016. During the year the data measure and analysis was refined and by Q4 there was timely submission of data. To compliment the data collection and provide assurance to be Board an assurance process was proposed and agreed which entailed partner agencies providing assurance on topics such as neglect and CSE. However, commentary and analysis from the performance monitoring information and also the assurance questions did not fully provide the Board with assurance on the effectiveness of safeguarding children, and it was proposed that the group's structure is reviewed.

The system to collect LSCB performance data and analysis was established by the local authority performance team resulting in the production of a dash book for consideration by SEG.

Is anyone better off? How do we know they are better off?

LSCB Partners are fully committed to the work relating to their own agencies performance and assurance and have worked hard develop systems and processes to inform analytical reporting to the Board. With an improving performance and assurance system the LSCB are in are better placed to scrutinize and challenge the effectiveness of the multiagency safeguarding arrangements across Leicester. For children young people and families this will result in an informed comprehensive picture of service delivery. Children and families should see an improving picture and better experience of agency intervention which is consistent, timely and of improved quality.

What is the evidence for that?

During 2015-2016 the LSCB concentrated on developing and embedding a robust Quality Assurance and Performance Framework, which included confirming and defining the measures included in the LSCB quality monitoring framework, to ensure that the LSCB received consistently good information to prioritise safeguarding activity. Performance data and information is received from partner agencies in a timely way which allows for discussion and identification of what works well and where improvements are required for example there was identification of:

- Open single assessments open beyond 45 days (overdue)
- Looked after children rate per 10,000
- Children in care with three or more placements in the past year
- Initial health Assessments

- Foster Carer reviews overdue
- Social worker sickness rates
- Case work supervision
- LPT-CAMHS/UHL CYP with mental health issues increase in CYP using acute services/referral rates to CAMHS and waiting times

These areas were considered by the LSCB and some of these areas were being considered through the Leicester City Council Improvement Board.

Significant time has been committed by member agencies to developing more robust analysis of and informed understanding about the quality of multi-agency practice, which has been monitored by the Improvement Board and LSCB. The LSCB has been actively supported by the Children's Services data analysts with input from analysts in partner agencies. Quarter 4 returns showed an improvement in the timeliness and completeness of submissions of agency data. The Board, working primarily through the Safeguarding Effectiveness Group, is working to strengthen the integration, analysis and understanding of the data from these different sources across the partnership.

The LSCB has received reports on the deliberations of the Improvement Board, which mirror the remit of the LSCB. Examples include the development of more effective, multi-agency early help services, more timely initial health assessments for children looked after, reduced numbers of repeat child protection plans and strategies to develop a more stable workforce. The Board, through the Safeguarding Effectiveness Group, is also sighted on the rise in the numbers of looked after children, the need to improve the timeliness of return interviews for missing children and the development of more consistent CSE services. There is a need to strengthen connections between the support structures to both Boards to ensure consistency and coherence, especially in respect of the analysis of priority areas of focus for both Boards.

What are the priorities for the work over the next 12 months from April 2016?

The priorities for the work around safeguarding effectiveness for 2016-2017 include:

- Review of SEG arrangements to include review of the name of the group, Terms of Reference, membership and reporting structure.

- Implementation of the aligned partner agency LSCB data set from Q1 and it is intended that improved analysis will be received to provide assurance to the Board.

- Performance returns from partner agencies to include data/analysis in relation to the voice of the child.

- Review the arrangements for multi-agency audits and create a schedule in line with the LSCB priorities for 2016-2017.

LLR Procedure and Development Group

Why did we do it? How did we know there was a need to do it?

The Leicester, Leicestershire and Rutland (LLR) LSCB Development and Procedures Group oversee the development of multi-agency safeguarding procedures and ensure that procedures are up-to-date and compliant with Working Together 2015.
The procedures are available through the Leicester and Leicestershire & Rutland Safeguarding Children Boards website and 'hosted' by Tri-x Child Care Ltd, accessible at:

http://llrscb.proceduresonline.com/chapters/contents.html

The Development and Procedures Group meets four times a year to coordinate the revision and addition of new procedures to ensure that they reflect national and local changes as necessary.
The need for updating procedures or creating new ones is identified through legislative/statutory changes, national and local policy and operational changes and/or from partner agency or practitioner suggestions, learning from Serious Case Reviews, Learning Reviews and audits, and suggestions from Trix on policy issues.
Leicester SCB continues to commission arrangements jointly with Leicestershire and Rutland LSCBs to ensure there is a consistent approach to safeguarding children across LLR. The LSCB identified within its Business Plan has a core business action within Strategic Priority 2 continue to develop and maintain policies and procedures for safeguarding and promoting the welfare of children in the area.
The purpose of the LLR Procedure and Development Group is to:

- Agree the content of the multi-agency LSCB procedures across the agencies
- Ensure their easy access and dissemination amongst organisations / agencies including the private, independent and voluntary sectors.

How much have we done in the last 12 months up to March 2016?

Two updates have taken place in 2015/2016 on procedures that were subject to review and/or development as identified by the sub-group, and these took place in September 2015 and March 2016. Task and finish groups consisting of representatives from relevant partner agencies across LLR were established to assist with updating key procedures and developing new ones, which were consulted upon prior to being signed off by the group.

How well did we do it?

A number of procedures were updated (or developed) with partner agency involvement across Leicester, Leicestershire and Rutland resulting in updated LLR LSCB multiagency safeguarding procedures being made available to staff across Leicester, Leicestershire and Rutland.
A procedure launch event comprising two sessions for practitioners across Leicester, Leicestershire and Rutland was held on 29th September 2015, and attended by approximately 160 people. The sessions focused on the following: Training Competency Framework, Information Sharing, FGM, Resolving Practitioner Disputes & Escalation of concern, and Self-harm and Suicide.
The group agreed that such events should be arranged following the procedure updates (6 monthly).
A safeguarding learning event was planned for 4th May 2016. The event will focus on Neglect (neglect toolkit), Learning from Serious Case Reviews, Managing Allegations Against Professionals (Role of the LADO), Practitioner Forum and Safeguarding Babies.

Is anyone better off? How do we know they are better off?

Updated guidance is available to staff to inform their practice in line with national and local policy so that practice across agencies in safeguarding children is consistent and within expected practice under the relevant statutory framework and guidance.

Children and young people will be better safeguarded as a result of updated multi-agency safeguarding procedures/guidance being available to practitioners so that their practice is in line with national and local policy. This should help achieve consistent practice across the LSCB partnership in safeguarding children. Assurance activity regarding compliance to procedures is a golden thread in the LSCB multi-agency audit process. In addition the Training and Development Group are leading on work to embed the competency framework.

What is the evidence for that?

Google analytical data shows that there has been an increase in 2015-2016 in the sessions, users, and page views compared to 2014-2015. There were 23,182 users, 29, 825 session and 61,367 page views from April 2015-March 2016, in comparison to 17,489 users, 23,067 sessions and 53,798 page views from April 2015-March 2015. There were slightly more retuning visitors (75.2%) and fewer new visitors (24.8%) in 2015-2016 compared to 73.5% and 26.5% in 2014-2015.

There is work underway to promote the use to the LLR LSCB multi-agency procedures as local SCR/Learning reviews and multiagency audits show that whist there is some use of the procedures more work is required for practitioners to be compliant with procedures in their practice. Safeguarding learning events have been planned following procedure updates to promote the use of procedures. Practitioners' compliance to procedures is a 'standing question' in multi-agency case file audits, which should identify whether practice is informed by procedures.

What are the priorities for the work over the next 12 months from April 2016?

Deliver the Safeguarding Learning Event in May 2016.

Launch the LLR LSCB Neglect strategy and toolkit on 7th July 2016. Implement and evaluate the LLR LSCB Neglect strategy and toolkit.

Procedures identified for review or for developing new ones for 2016-2017 include the following:

Bruising and injuries in Babies and Children who are not independently mobile	**Threshold for access to Services for Children & Families in Leicester, Leicestershire & Rutland Social Care**	**Think Family/Whole Family Approach**	**Learning and Improvement Framework**	**Safeguarding Children Vulnerable to Violent Extremism (PREVENT)**
Pre-birth assessments	**Children Using Sexually Abusive Behaviour**	**CSE, trafficked and Missing**	**Neglect guidance**	**Complex (Organised or Multiple) Abuse**

Serious Case Review Group

Why did we do it? How did we know there was a need to do it?

The Serious Case Review programme group is responsible for coordinating serious case reviews and learning reviews.

A Serious Case is one where

(a) abuse or neglect of a child is known or suspected;

and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child.

Where the criteria for a Serious Case Review (SCR) are met, the LSCB always commissions an external independent author to conduct a review. The remit in all cases is to review and analyse the learning from the circumstances that resulted in a SCR, so that all partnerships can jointly own the outcome of the report and deliver improvements.

How much have we done in the last 12 months up to March 2016?

Between 1st April 2015 and 31st March 2016 the SCR Group commissioned four SCRs. The findings from the reviews are considered by all agencies. The SCR group has oversight and monitors the completion the related action plans to address any areas that require improvement to prevent further serious incidents. The SCR outcome findings have resulted in a number of policy, practice and training developments.

Is anyone better off? How do we know they are better off? What is the evidence for that?

The learning from SCRs has led to practice improvements and policy development in a number of key areas; they include:

- Failure to identify persistent re-occurring incidences as Neglectful care
- Pre-birth assessments including issues relating to concealed pregnancy
- Bruising and injuries in non-mobile babies with directive to refer all injuries to babies
- Practitioner compliance with the application of multi-agency procedures
- Improvement to assessment of need and risks and particular focus on
    - Lack of identification of the need for early help services,
    - Information sharing and practitioners taking on the lead practitioner role to coordinate assessment and support planning
    - Fathers and / or reconstituted families
    - Use of chronologies and historical information to inform presenting risks/need assessments
    - Parental capacity and whole family approach
    - Assuring the voice and lived experience of the Child
- Resolving practitioner disagreement and Escalation
- Appetite to give consideration to MASH principles in the development and delivery of safeguarding services.

Child Death Overview Panel

Why did we do it? How did we know there was a need to do it?

The Child Death Overview Panel is a Sub Group of the LLR LSCBs. LLR CDOP is required to review ALL child deaths (from 0 up to 18 years) of any child who is resident within Leicester, Leicestershire and Rutland. It undertakes a systematic review of child deaths to help understand why children die. By focusing on the unexpected deaths of children, it can recommend any interventions it considers appropriate to help improve child safety and welfare to prevent future deaths. When a child dies unexpectedly, a process is set in motion to review the circumstances of the child's death, which includes the support in place for the family.

How much have we done in the last 12 months up to March 2016?

A key objective for CDOP was to undertake and complete a 6 year analysis (from 2009/2010 – 2014/2015) of all completed child death reviews. The findings were presented to the respective LSCBs and the recommendations have been noted. Currently there are no residual issues that have been identified as part of the 6 year analysis. All areas of work have a pathway for progression.
The analysis has allowed key recommendations to be drawn out which were segregated into recommendations for partners and recommendations for CDOP.

Is anyone better off? How do we know they are better off? What is the evidence for that?

In terms of Partners, there was evidence of a disproportionate number of child deaths in the more deprived areas. All partners were asked to assess the work currently in place to target vulnerable groups and develop an action plan to identify how the number of deaths can be reduced.

It is a consistent feature both locally and nationally that children under the age of 1 account for the majority of child deaths. These deaths have common features which include:

- low birth weight,
- prematurity and maternal smoking and associated issues of hypertension,
- Diabetes and obesity and their links to poverty and infant nutrition.

Given that year on year the percentage of deaths remains high, all partners have been asked to ensure that appropriate action plans are in place to address the areas identified.

It was agreed that a community engagement exercise would be commissioned by Public Health to explore certain ethnic Groups' views on consanguinity and access to universal and specialist services.

CDOP have recently submitted their data findings to the Department for Education (DfE) for 2015/2016 – this data has yet to be verified; once verification has been completed the DfE will produce a statistical analysis for circulation.

Data was submitted to the DfE based on the 102 cases that were reviewed. The Panel process identifies factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

Listed below are the modifiable factors identified.

- Smoking by mother in pregnancy
- Smoking by parent/carer in household
- Accessing health care sooner
- Co sleeping
- Substance misuse (by parent)
- Domestic violence
- Consanguinity

All of the factors are considered at panel and a discussion is undertaken in order to ascertain whether they are currently within an ongoing work stream or whether additional work is required.

As well as identifying modifiable factors, CDOP seek to identify learning that has occurred during the review process.

Key areas identified within the cases reviewed related to

- Access to healthcare
- Escalation of care
- Cross site coverage for neonates
- Communication
  - Professional to professional
  - Professional to patient/client

In all cases where panel identify modifiable factors, panel members are asked to consider what action (if any) is required. As part of the decision making process professionals from partner agencies may be asked to provide additional information in order to help form a 'wider picture'.

What are the priorities for the work over the next 12 months from April 2016?

CDOP are currently in the process of producing their annual report. It is recognised that the current timescales do not synchronise with the LSCB reporting timetable and this will be addressed for next year. CDOP now have the support of a public health analyst who is working alongside the CDOP manager in order to use the available data to identify meaningful and achievable work streams for CDOP (and potentially partners) for 2017.

Statutory Complaints, Commendations and Representations

The Complaints Manager is part of the Children's Safeguarding and Quality Assurance Unit of the Children, Young People and Families Division and is responsible for customer feedback and managing the process for children's statutory complaints.

The statutory complaints procedure has three stages

- Stage 1 Local Resolution by Team or Service Manager
- Stage 2 Formal Independent Investigations
- Stage 3 Independent Review Panel

Why did we do it? How did we know there was a need to do it?

It is a statutory responsibility to respond to complaints within 20 working days at stage 1 and 65 working days at stage 2.

How much have we done in the last 12 months up to March 2016?

Responded to 85 Statutory complaints.
84 of which started at stage 1,
1 complaint was accepted at stage 2.
2 of the stage 1 complaints progressed to stage 2.
1 of the stage 2 complaints progressed to stage 3.

How well did we do it?

38 of the 84 stage 1 complaints were responded to within statutory timescales (45%). The average number of days to respond was 34.
Of the 3 complaints responded to a stage 2, one was outside the statutory timescales and 2 within. The average number of days to respond at stage 2 was 58.

Is anyone better off? How do we know they are better off? What is the evidence for that?

85 complaints were responded to, 11 were upheld, 49 were not upheld and 25 were partially upheld.
The majority of complainants were offered, and accepted an apology for any areas upheld.
Learning has been identified that will improve the service in the future. Some examples of practice improvements are:

- The 16+ team have produced a Care leaver's entitlement booklet which workers in the team handout to their young people when the case is allocated and is available on the team's website.
- Social Workers are now fully aware of the timeframes for when a care leaver is proposing to go to university, to ensure that all information is available to this group of young people and to ensure that they have completed the Higher Education financial support paper in time in time with the young person.
- Better use of case summaries so that duty workers can see current situation and update in order to respond to queries in absence of SW.
- Immediate action to be taken with any placement to address our concerns and set an improvement plan
- SW's and TM's to thoroughly check for the accuracy and quality of written work, which is jargon free with acronyms explained.

- Improved communication to ensure that Young people understand even if they don't agree why the LA has followed a particular course of action
- When we ask a parent to leave their home, we should pro-actively engage with Housing/Housing Associations on their behalf to identify alternative accommodation.
- The creation of the Single Assessment Team has addressed a number of complaints made.
- Staff across the service has been given guidance on when a placement with a relative is a Family Arrangement or Regulation24, when the child becomes LAC.
- That as an Organisation, we need to be more mindful of high turnover of staff and recordings need to be monitored closely to ensure that workers do not leave Department without recording all the information regarding their involvement with families.

What are the priorities for the work over the next 12 months from April 2016?

Ensuring new Team Managers and Service Managers fully understand and adhere to the statutory timescales and responsibilities around complaints.
This should result in a higher percentage of complaints being responded to on time and improved learning from complaints identified.

6.6
STRATEGIC PRIORITY 6

Leicester, Leicestershire & Rutland Safeguarding Multi Agency Training, Learning and Development Commissioning & Delivery Group

Overview of the group:

The Multi-Agency Safeguarding Learning, Training and Development Commissioning and Delivery Group supports and encourages safeguarding learning for the children's workforce across Leicester, Leicestershire & Rutland. The group's primary functions are: supporting the implementation of the 2014 Safeguarding Learning Strategy, working to the Leicester City and Leicestershire & Rutland LSCB Business Plans, and developing and supporting multi agency learning (including an Interagency Training Programme) for both Leicester City and Leicestershire and Rutland LSCBs. The group has membership from strategic training and workforce development leads and representatives from agencies across the two LSCB areas.

The work of the Group is driven by the Safeguarding Learning, Development and Training Strategy and the Competency Framework, launched in April 2014, following an eighteen-month period of consultation with partners. The strategy outlines the LSCB minimum standards for expected knowledge and delivery of safeguarding learning and the processes for quality assurance – all of which support the LSCB role and activity around assurance. A **Competency**-based approach has been a change of focus and supports the principle that learning should be **relevant, proportionate and meaningful**, and supports **confident, competent** practitioners, who demonstrate a **commitment** to safeguarding in line with their **role and responsibilities.** *All strategy documents are available on the LSCB website:*

http://lrsb.org.uk/safeguarding-children-learning.

Why did we do it? How did we know there was a need to do it?

The work of the strategic group supports the responsibilities as identified by Working Together 2015 and Regulation 5 of the Local Safeguarding Children Boards Regulations 2006:
The LSCB has a responsibility to develop policies and procedures in relation to:
1 (a)(ii) training of persons who work with children or in services affecting the safety and welfare of children; **(Regulation 5)**

This includes a duty to 'monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.' **Working Together 2015**

The group's work also supports the principles for learning and improvement:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice - **Working Together 2015**

The principles of the 2014 Safeguarding Learning, Development & Training Strategy support this approach, with an increased focus on the impact of learning being transferred into practice to support improved outcomes for children and families.

How much have we done in the last 12 months up to March 2016?

In 2015/16 The LSCB has;

- Continued to promote understanding and application of the revised 2014 strategy and minimum standards for all (single and multi-agency) safeguarding learning, including standards for delivery (Best Practice in Safeguarding Training) and knowledge (LLR LSCB Competency Framework). The LSCB funds briefing sessions on the strategy, (over 800 workforce leads / managers / trainers briefed to date). The LSCB has also funded a package of specialist training to support managers / organisational leads in 'assessing competency and effectiveness' and the website offering information and resources. A range of practical tools and guidance notes is available to support organisations in the application of the strategy.
- Continued to engage with a range of organisations and sectors, applying the strategy and processes. Learning from this process is shared and has assisted review activity. This implementation plan has increased the LSCB 'reach', 'impact' and 'engagement' with partner and non-partner organisations – including private early years and standalone practitioners (eg childminders).
- Increased the emphasis on gaining assurance and evidence of application of use of framework and competency based-approach on an operational level.
- Supported local trainers and commissioners in the delivery of safeguarding learning via a Trainers Network and delivered events and guidance.
- Strengthened links and supported the work of the Procedures group and delivery of large scale awareness-raising and learning events.
- Provided and funded 'essential awareness' training for the Private, Voluntary and Independent Sector.
- Work has also continued with partners from adult services, trainers and the wider workforce, to align training and learning, where possible, to support a whole family approach being embedded into safeguarding learning; this partnership work will continue in 2016/17.
- The group developed a revised process for sharing and embedding learning and key messages, and now provides an auditable process for the LSCB. Following this process brings together the work of the Serious Case Review, Training and Communication groups and will also provide a consistency of message. It allows for training and messages to be targeted and focussed on different areas of the workforce. This process will support Serious Case Review action plans, assurance processes and the training group, and work will be undertaken and supported by the communication group.

Interagency training

The LSCB has continued to deliver a multi-agency programme of Learning, Training and Development, which reflects the requirements of the Business Plan, including the Competency Framework, the findings of Serious Case Reviews and revisions to legislation and guidance.

The Group has adopted a themed programme of multi-agency courses and events, delivered largely by a 'mixed economy' of provision - partner agencies providing training and venues to multi-agency groups at no cost at the point of delivery; each agency aiming to balance the provision and receipt of training by its employees. A brief analysis during the year suggests that this 'balance' is generally maintained. Some specialist provision is brought in, where necessary. A 'Partnership Agreement' underpins this collaborative approach.

In 2015/16 – 1600 delegate spaces were offered, 1,286 people participated in the 46 events in the programme, with an overall attendance rate of 80%. In addition to this there were an extra 140 delegates who attended the L&R LSCB SCR event. These events have offered over 1426 spaces this year. Participation generally reflects the size of the relevant workforce in the partner organisation.

How well did we do it?

The work of the group and continued activity throughout this year, and strengthened links with other strategic groups indicates that the work of the group has been successful in supporting the children's workforce and adult and wider workforce. The continued support to learning across the partnership by commitment of joint resources and the development of work streams is notable, particularly in the current financial climate. The continued positive partnership work within the group has supported LSCB in this process.

Is anyone better off? How do we know they are better off?

The strategy and work of the group aims to support and strengthen practice around safeguarding, and assurance work starts to gather information about this process and activity. It is acknowledged that the training group and strategy will support evidence about improved practice and impact of learning into practice.

The group has access to qualitative and quantitative data, collated and analysed by VAL, which demonstrates the ongoing impact of the group's activity. In addition to this, the group has made requests for more formal data collection by safeguarding effectiveness groups, to look at the use of the strategy and including this in data collection processes and audits (S11 audits and 4 stage evaluation process for the interagency programme.)

What is the evidence for that?

- An increase in awareness in of the training strategy and competency framework – demonstrated by quantitative data and qualitative data from interagency programme and briefing sessions and a survey undertaken by the training group.
- Increased attendance of wider workforce and non-statutory partners on interagency programme.
- The funded essential awareness programme has been consistently oversubscribed, well attended and positively evaluated.
- Continued attendance and positive evaluations on the briefing sessions: The specialist sessions for the competency framework have been well received and positively evaluated. Increased engagement with the non-statutory sector, which has increased the LSCB reach and impact with these smaller organisations. This work has promoted best practice, given advice about standards, policy and procedures and underpinned and strengthened organisational practice.

Interagency programme

There is a four-stage process of pre, post, three-month and six-month course evaluation for the multi-agency programme, the findings from which are incorporated into easily-readable quarterly reports, which the Group considers and uses to refine the programme and feed to strategic leads for safeguarding learning. These reports are now forming the basis for information on improved outcomes for children and young people.

- In 2015/16 – 1600 delegate spaces were offered with, 1,286 people participated in the 46 events in the programme, with an overall attendance rate of 80%. In addition to this there were an extra 140 delegates who attended the L&R LSCB SCR event. These events have offered over 1426 spaces this year. Participation generally reflects the size of the relevant workforce in the partner organisation.
- Levels of satisfaction were high, with participants identifying improvements in knowledge, skill and confidence arising from the programmed events. Details are collated, analysed and included in quarterly update reports produced to the Sub-Group by Voluntary Action Leicester and Leicestershire (VAL).
- An increase was seen in attendance of delegates from the wider workforce

What are the priorities for the work over the next 12 months from April 2016?

The group will have an increased focus on supporting the use of the strategy in the third and final year of implementation, and also focus on assurance; this includes including working alongside other strategic groups and organisations from a range of sectors to see the application of the strategy in practice, and also inform assurance work.

This will include also:

- Supporting learning from reviews being embedded into practice.
- The need to promote and support organisational support for training, development and learning, both to enable people to attend and in providing courses/events for the programme, in line with the training strategy.
- The need for more work to identify and respond to the voice of the child.
- The increased focus and requirement of assurance for partner and non-partner agencies about the application of the strategy and framework. This work will be a priority for LSCB and should begin to provide evidence of how they are applying the strategy in the final year of application.

7. Allegations Against People who work with Children

Why did we do it? How did we know there was a need to do it?

Working Together (2015) refers to local authorities having a Designated Officer or a team of Designated Officers involved in the management and oversight of allegations against people that work with children (LADO).

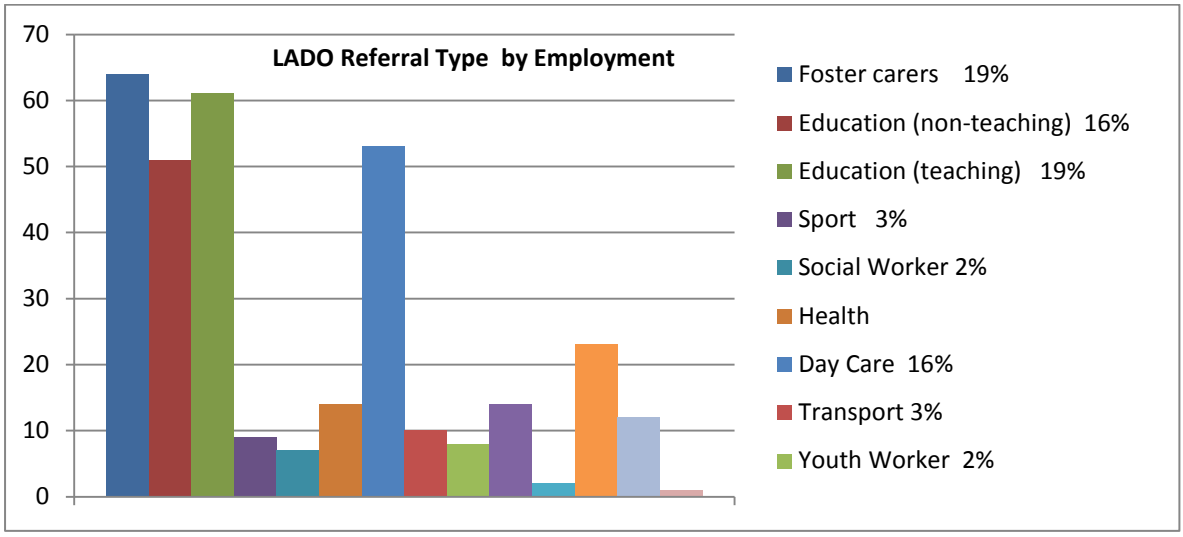
How much have we done in the last 12 months up to March 2016?

The Local Authority collates data which shows us emerging trends, consequently this can lead to targeted support for practitioners including, training, safety actions and improvements in frontline practice and agencies recruitment and supervision practices.

Referrals

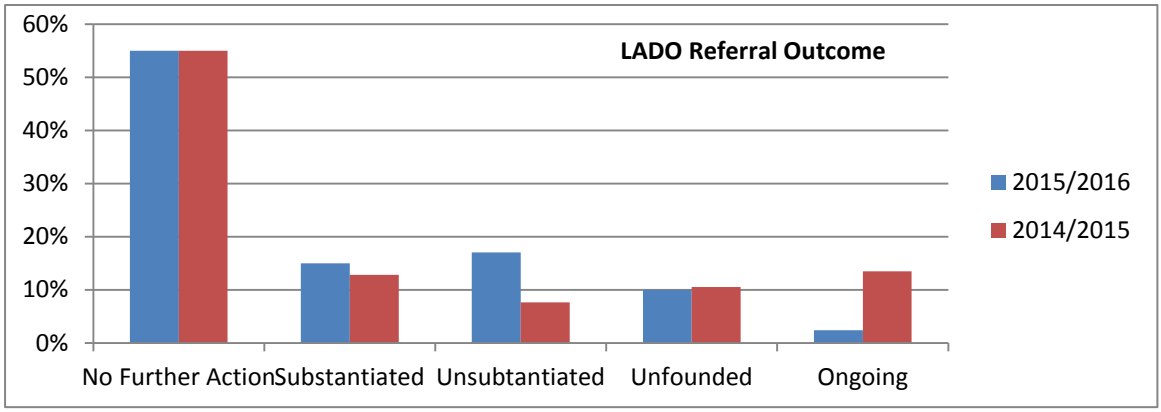
329 referrals have been received during this period; this is an increase of 115 referrals / 53% of the last year's referrals.

Chart 1 Referrals received by employment type



Data in 2015/2016 very similar to last year except for day care provision, with the number of referrals have doubled over the course of the year. During the 2014/2015 nursery provision was a key focus of the LADO training. This could account for the increase of referrals, alongside the awareness raised by the publication and National interest in the Nursery Z serious case review. Given the vulnerability of children in day care this will now lead to a focused piece of work over the next year in relation to a more in depth audit of the allegations in nurseries to identify any actions required.

Chart 2 Referral Outcome



Analysis

- 55% - 181 of referrals resulted in no further action. This is a similar figure to last year and suggests that a consistent threshold is being applied.
- 15% - 51 of referrals were substantiated. In 2014/15 12.8% were substantiated –the definition is that there is sufficient evidence to prove the allegation. This again is a similar figure as that of last year.
- 17% - 56 of referrals were unsubstantiated. In 2014/15 - 7.6% unsubstantiated, the definition is that there is insufficient evidence to either prove or disprove the allegation. It is beneficial for this to be a lower figure so as clearer decision making is reached about risk of harm from adults who work with children.
- 10% - 33 of referrals were unfounded. In 2014/15 10.5 % were unfounded-the definition is that there is sufficient evidence to disprove the allegation
- 2.4% - 8 of referrals were categorised as ongoing. In 2014/15 there were 13.5 % of cases ongoing. A lower figure is good as shows referrals are being progressed timely.

The outcomes from the LADO processes are as seen in the main not resulting in a substantiated concern.15 % resulted in this and the rest were manged by internal processes, advice and guidance, disciplinary measures. Referrals to regulatory bodies and DBS are routinely referred to within the LADO work and are recommendations from meetings when the allegation is substantiated and alongside this the suitability of the person is called into question.

How well did we do it?

- The LSCB has provided feedback to large scale events on LADO activity and provide additional publicity and awareness raising amongst agencies and practitioners. There is a rolling programme for Leicester city agencies of LADO training. This includes embedding the safeguarding principles in the competence framework with an aim to strengthen practice and support safer organisations.

The Fostering Service has strengthened the following areas, in response to the review:

- Fostering Service recognise when Foster Carers manage difficult behaviour, this increases the risk of conflict and allegations of physical harm being made.
  - SSW will be helping Foster Carers identify ways to avoid aggressive confrontations.
  - Foster Carers will be provided with training about managing difficult behaviour.

- The Support Network of the Foster Carer will be a continue area of further assessment in supervision and reviews of the Foster Carers.
- Foster Carers will be provided with work and training about managing their expectations and disappointment when they feel that a child is rejecting them.
- Foster Carers will be provided with training on attachment.

- Where appropriate Foster Carers views will be obtained during the allegations process. Support will also be given to enable them to prepare for related meetings.

Case Example
December 2014, a female young person (CW) aged 17, living in a residential placement, had raised a concern regarding an adult in her placement to the Children's Right's Officer. She didn't feel that her social worker had given her an adequate explanation following the concerns she had raised. With support of the Children's Right's Officer, she requested this from the LADO which was provided. This young person was then satisfied with the response and how her concerns had been addressed.

What is the evidence for that?

Strategy meetings are attended by the Police Child Abuse Investigation Unit, Fostering Supervising Social Worker, Fostering Team Manager, allocated Social Worker to the child and Team Manager for the child. Strategy meetings are always chaired by an Independent Chair or LADO. The meetings are generally well attended with good engagement from professionals.

The evidence is the outcome of the review and actions taken by fostering to show the benefits of using the information to improve service delivery for the benefit of children's safety.

The information from the training events gives a reflection of the learning that individuals take back to their work place to safeguard children. The following are quotes from the feedback from training and actions that delegates would take forward.

8. Challenges and Conclusion 2015-2016

The LSCB has made significant progress over the last year and a summary of that progress was presented to the Leicester City Council Improvement Board in May 2016 by former Independent, Chair Dr David Jones.

All LSCB partners have worked very hard over the last year to support the improvement plan. Progress has been made in a number of key areas, including Neglect, CSE and Missing. We have also actively engaged with front line practitioners and with young people.

Significant challenges remain; partners are working at full capacity in a climate of inspection, austerity cuts and increased pressure but there is a renewed commitment to working together to safeguard children in the most effect and efficient way possible.

As the new LSCB Chair I want to work on continuing to drive improvements. I have undertaken an effectiveness review and made a number of changes to structure *(See Appendix 2 – LSCB Structure Chart from September 2016)*, constitution and processes going forward to ensure we continue to build on the progress made. With partner agency support we have re-defined the LSCB strategic priorities for the next 18 months illustrated below. Our forthcoming LSCB business plan 2016-2018 outlines the detail of this work and can be found on our website - www.lcitylscb.org

I am looking forward to reporting on this further next year.

LSCB Strategic Priority - 1

The LSCB is to be assured that there is evidence to consistently demonstrate that children and young people are effectively safeguarded.

LSCB Strategic Priority – 2

To be assured that 'Early Help' services are accessed and delivered effectively and thresholds are understood and consistently applied.

LSCB Strategic Priority - 3

LSCB is to be assured that there is a culture of continuous system of single and multi-agency learning and Improvement.

LSCB Strategic Priority - 4

LSCB is to continue to improve its governance, performance and quality assurance process and to be assured of the effectiveness of the LSCB.

9. Appendices

Appendix 1 - LSCB Members List 2016
Appendix 2 - LSCB Structure Chart 2016