Leicester Safeguarding Children Board

ANNUAL REPORT | 2014 - 2015

Dr David Jones
INDEPENDENT CHAIR

Janet Russell
INTERIM LSCB MANAGER

Leicester City Council

Contents

Foreword

I am pleased to present my fifth annual report as Independent Chair of the Leicester Safeguarding Children Board. It is a legal requirement that I publish an annual report which provides 'a rigorous and transparent assessment of the performance and effectiveness of local services'.

This report covers another year of significant challenge for all agencies represented on the Board, including significant reorganisations and management changes in most agencies, ending with publication of the report of the Ofsted inspection in February 2015. This concluded that the LSCB had significant weaknesses and was therefore 'inadequate'. This was a profoundly disappointing outcome, not least for the children and young people of Leicester who deserve nothing but the best. The inspection also delivered a profound challenge to the LSCB itself.

The Board had identified most of the concerns reported by inspectors during the year and was already implementing actions to remedy the weaknesses. Whilst the inspection acknowledged that activity, there was insufficient evidence of improvement when the inspectors visited. All agencies represented on the Board responded positively to the inspection findings and within days were working together to strengthen the improvement work already underway, including a more detailed improvement plan which is already being implemented. That plan is overseen by the Improvement Board, established following the inspection, which is chaired by an independent person and includes senior representatives from all the main partner agencies in the city together with observers from the Department for Education and Ofsted.

This report aims to respond openly and honestly to the inspection judgement, points to the significant improvements which have been put in place in the current year and highlights where further work is still required.

Ofsted identified weaknesses in a number of important areas whilst recognising that the Board itself was aware of the main problems. Key areas for development included the need for a more robust performance monitoring framework, including monitoring of early help for families to prevent the escalation of problems; more effective engagement with children and young people; more open acknowledgement of problems within agencies; and closer links with front-line practitioners, all of which were flagged up in the last annual report. Ofsted pointed to the need for a more analytical annual report, drawing on evidence to provide a more challenging evaluation of performance across the partnership. This report goes some way to meeting that challenge but will be strengthened with the inclusion of more robust performance data in the 2016 report on the current year.

Ofsted also recognised the strengths in the local safeguarding arrangements, including robust governance and a recently revised committee structure; positive joint working by all the agencies; effective joint working with neighbouring authorities; a strong values statement; up-to-date procedures for handling safeguarding cases; a robust policy on access arrangements for social work intervention (thresholds); effective services for the assessment of initial child protection concerns; well managed serious case reviews and good

arrangements for disseminating the learning to practitioners across all agencies; a very effective programme of multi-agency training; and an adequately resourced LSCB office. These provided a foundation for improvement.

Whilst the Ofsted report was very critical of some services, other recent inspections have had a more positive outcome, including the CQC inspection of University Hospitals Leicester.

The Board chose to devote its energy to making rapid progress with the improvement plan and so far has hit all its deadlines to achieve this. It is nevertheless informative to reflect on why the difficulties arose insofar as this supports the work needed to secure improvements. The Board has therefore avoided retrospection but it is relevant to recognise that, during the 9 months prior to the inspection, there had been a significant number of changes of key personnel and reorganisations in a number of agencies. My previous annual reports have included warnings about the risks of organisational upheavals and the inevitable personnel changes which follow. Effective safeguarding relies on good partnership working, which is reliant on tried and trusted relationships. These are being rebuilt. Ensuring stability during this transition has been one of my primary objectives as Chair.

Whilst change offers opportunities, so much change all at once inevitably has a short-term impact at least. Work on key areas such as engagement with young people and the performance monitoring framework was delayed pending the new appointments and the momentum of routine partnership working slowed. The Children's Services reorganisation also had an impact, not least because of the associated turnover of social workers. This has been well rehearsed elsewhere and this report can add nothing new on that matter. The context is now significantly different and progress is being made.

Local developments took place within a challenging national context. The national media has again been full of discussion about child abuse throughout the year. Much of the public debate has focussed on non-recent abuse, often by well-known figures, but some cases well publicised in the national media have involved more recent abuse. High level political and media concern about emerging evidence of child sexual exploitation has required new approaches and additional resources, whilst LSCBs have also been given strengthened responsibilities for tackling extremism within the Government's Prevent programme.

Increasing inequality and growing pressures on families is widely reported and resulting in increasing 'demand' for many services, rising child poverty and reducing budgets. In a city with the profile of Leicester, this is a real concern.

The Board has devoted considerable energy to strengthening its capacity to gather and analyse evidence about multi-agency performance. Most organisations have effective internal monitoring arrangements but the challenge in bringing this together in a coherent framework is formidable. This is, however, essential if we are to have an informed overview of the effectiveness of safeguarding work across the city. The Board has engaged specialists with national reputations and widely acknowledged skills in this area to help speed our improvement and the benefits are already evident.

The new performance framework has been approved but will inevitably take time to become established and informative. Implementation came after the year end for this report which cannot therefore benefit from the new arrangements and more robust data. I will ensure that all agencies will provide all that is necessary to deliver a more robust framework in the current year.

We have already strengthened our engagement with young people. We held a summit for around 100 children and young people in the current year

focusing on their views about vulnerability and hate crime. New arrangements for regular contact with children and young people, linked into the city-wide schools councils, are being established. A group of practitioners from a wide-range of agencies has been set up to review how best to ensure their views and experiences are collected and communicated to the LSCB.

The safety and wellbeing of children and young people is of utmost importance to parents and to the whole community. We therefore welcome public scrutiny of our work and deeply regret the anxiety caused by the problems of the past year.

The Board recognises that there are continuing challenges. We have a professional and legal responsibility to take action to protect children and promote their welfare, but we cannot do this alone. We welcome comments and suggestions from the community about how we tackle those challenges. Safeguarding is everybody's responsibility and we call upon people in Leicester to play their part in helping our children and young people to have the best life we can give them. If you have concerns, please contact the police, children's services or any other agency known to you. We will do our best to listen respectfully and to follow-up your concerns appropriately.

Finally, I would like to thank all the members of the Board and our working groups for their work, especially the united commitment shown to deliver our post-inspection improvement plan.

My own second term of office comes to an end in April 2016. I am confident that the new Independent Chair, when appointed, will inherit a much strengthened Board, a better coordinated partnership and more robust arrangements for keeping a close eye on the effectiveness of practice across all agencies.

I am grateful for the confidence placed in me and reaffirm my commitment to serving the families and people of Leicester to the best of my ability, always preserving my independent scrutiny and judgement.

The children and young people of our city have a right to feel safe, wherever they are. The LSCB is well aware of the many risks they face. We will do our utmost to shape effective safeguarding arrangements. We will also do our best to listen carefully to what children and young people tell us about what needs to be changed to create safe environments for them.

David N. Jones
PhD, MA, BA, CQSW, RSW
Independent Chair

Introduction

Section 14a of the Children Act 2004 and the Apprenticeships, Skills, Children and Learning Act 2009; require the LSCB to publish an annual report on the effectiveness of safeguarding arrangements locally.

"Working Together to Safeguard Children (Dept. for Education, 2015) requires that this report must be submitted to the Chief Executive and Leader of the Local Authority, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

The annual report should "provide a rigorous and transparent assessment of the performance and effectiveness of local services.

This annual report has been structured to a template recommended for national use by the Association of Independent LSCB Chairs (AILC). The intention is to reflect the progress made by the LSCB over the year in question, including an overview of its performance monitoring and quality assurance work, and provide information on the governance and accountability arrangements for the LSCB.

The report details the work Leicester LSCB has undertaken in developing its role as a genuinely independent statutory body and the development of relationships, influence and working arrangements to enhance that role.

The main body of the report provides information on the monitoring and evaluation of the effectiveness of what is done by the LSCB, both individually and collectively, to safeguard and promote the welfare of children and young people.

The report should provide information and challenge to the work of the Leicester Children Trust, Health and Wellbeing Board and other partnership structures and is available on the LSCB website.
www.lcitylscb.org/

Chapter one

Leicester in context

Local Demographics

Local Councils - On 5 May 2011, Sir Peter Soulsby became the first directly elected Mayor of Leicester he was re-elected for a second term in May 2015.

Sir Peter Soulsby has appointed Rory Palmer as his deputy and Sarah Russell as Assistant City Mayor for children, young people and schools.

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

The city is divided into the following council wards: Abbey, Aylestone, Beaumont Leys, Belgrave, Braunstone Park and Rowley Fields, Castle, Charnwood, Coleman, Evington, Eyres Monsell, Fosse, Freemen, Knighton, Latimer, New Parks, Rushey Mead, Spinney Hills, Stoneygate, Thurncourt, Westcotes, and Western Park.

Leicester is the largest city in the East Midlands and the tenth largest in the country. It has an active population of 330,000 and 509,000 living in the wider urban area. Leicester also has the largest number of under 19year olds in the East Midlands compared to neighbouring cities. There are approximately 69,369 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 influxes 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.

Vulnerable Children and Young People

This Annual Report starts by looking at the categories of children and young people in Leicester who have been identified by the Local Authority and other agencies as in need of protection. These categories are not exhaustive and many factors, such as going missing from home and living in households where there is domestic abuse, substance misuse

and/or parents with mental illness, can place children at increased risk of harm from abuse and/or neglect.

Children in Need

At 31 March 2015, 2267 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase of 18% from 1,920 at 31 March 2014.

Caseloads

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 2014, 427 children and young people were the subject of a child protection plan. This is an increase of 31% from 326 at 31 March 2015.

Looked After Children

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.

At March 2015, 559 children were being looked after by the local authority. This is an increase of 5% from 530 at 31 March 2014.

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.

In 2014/2015 Leicester CAMHS received 505 referrals of children for support at the CAMHS Learning Disability Service and CAMHS Paediatric Psychology service. There were 3432 children referred to CAMHS Outpatient & Community and CAMHS Young People Team.

The average waiting time for CAMHS- Outpatient & Community and CAMHS - Young People Team is 11.53 weeks from referral to assessment and 76.42% of referrals are seen seen within 13 weeks. For CAMHS - Learning Disability Service and CAMHS - Paediatric Psychology the average waiting time is 6.2 weeks from referral to assessment and 100% of referrals are seen within 18 weeks.

CAMHS can help with severe depression, eating difficulties, low self-esteem, anxiety, obsessions or compulsions, sleep problems, self-harming and the effects of abuse or traumatic events. 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 - only following incidents of self-harm or discussion with GP
- Social workers

Children Leaving Care

From March 2014 to March 2015:

- 36 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

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.

That carer 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. The relative can be half blood, full blood or by marriage.

It 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.

At March 2015, five children were known to be living in a privately arranged fostering placement. This is a reduction from seven at 31 March 2014. It is thought that many more children are privately fostered but not registered.

Child Sexual Exploitation/ Trafficking and Missing

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

(Under 18's; Leicester City 79,000, Leicestershire 140,000, Rutland 8,000, approx. figures from last census)

- 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.

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.

Local Trends

Referrals have remained high throughout 2014-2015, finishing at 4769, a 7% increase from March 2014.

[1]Public Health England 2013

Chapter two

Governance and Accountability Arrangements

What is the LSCB?

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

Our Objectives

The LSCB co-ordinates and monitors the effectiveness of what is done by each agency on the Board, for the purposes of safeguarding and promoting the welfare of children in Leicester.

Section 14 of the Children Act 2014 sets out the objectives of LSCBs, which are:

[1] Developing policies and procedures.
[2] Ensuring appropriate training is provided.
[3] Communicating and raising awareness of the need to safeguard/promote welfare and how this can best be implemented.
[4] Participating in the local planning / commissioning of children's services.
[5] Reviewing all local child deaths
[6] Ensuring agencies are effective individually and collectively.
[7] Conducting Serious Case Reviews as appropriate.

The LSCB's role is to scrutinise local arrangements and it should therefore have a separate identity and an independent voice. It should not be subordinate to, nor subsumed within, other local structures in a way that might compromise it.

LSCBs are the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do.

Agencies include:

- children's services
- health
- police
- probation
- voluntary organisations
- youth offending team

LSCBs are strategic not operational bodies. They are subject to regulation (Local Safeguarding Children Regulations 2006) and detailed guidance (currently Working Together 2015, Chapter 3). The importance of the role of LSCBs was endorsed by Professor Eileen Munro in her report: 'On the Protection of Children in England' (2011) and the revision of Working Together guidance reflects this.

LSCB Governance Arrangements

The Board meets quarterly. Board membership is listed at Appendix (a) Attendance at the Board is reported in Appendix (b). In order to provide effective scrutiny, the LSCB must be independent. The local partnership and accountability arrangements are specified in the Board's Constitution. The LSCB has approved protocols with the Children's Trust and Health and Wellbeing Boards which specify their respective functions and relationships. The LSCB and the Leicester Safeguarding Adults Board (LSAB) share a joint values statement which underpins the work of the two Boards. Board office arrangements are hosted by Leicester City Council. See Appendix (c).

In order to assist the Board with discharging its wider responsibilities, the following Sub-groups have been created:

- Business Delivery Group (formerly the Executive Group).
- Safeguarding Effectiveness Group.
- Serious Case Review Sub-Group.
- Child Death Overview Panel.
- Communications Programme Group.

[1] Each Sub-group is comprised of a multi-agency membership and is chaired by persons at senior management level within their agency.

[2] Each Sub-group has a working mandate which is set out within their Terms of Reference and a related delivery plan.
[3] All members should ensure there is representation from their agency at all Sub-group meetings.
[4] For a sub group meeting to be quorate there should be at least 50% of members present, with at least 3 different partner agencies represented.
[5] The position of Chair and Vice-Chair will be reviewed annually with new nominations sought.
[6] Other task groups may be established from time to time to undertake specific pieces of work on behalf of the LSCB.

A number of working groups operate on a Leicester, Leicestershire and Rutland (LLR) basis, recognising that children and families do not limit their activities by local government boundaries and also reflecting the organisational structures of the police, health service providers and some other agencies. They include the following

- LLR Development and Procedures Sub Group
- LLR Child Sexual Exploitation, Missing and Trafficking Group
- LLR Training Strategic Safeguarding Learning Group

The LSCB sub-group structure chart 2014 is detailed on page 11.

LSCB Members: Who's who?

The Board is a partnership arrangement which includes representation from strategic leads in each agency. It is not a remote entity, but a co-ordinated multi-agency partnership at the forefront of coordinating services for children. To this end it is useful to think of the agencies in terms of parts of a whole system.

All organisations listed are subject to Section 11 of the Children Act 2004, which includes a duty to co-operate with each other through the board. However there are further responsibilities specific to each delivery sector, as defined by Working Together 2015

Key Roles

Independent Chair

The Board continues to be led by an Independent Chair, ensuring a continued independent voice for the Board. Dr David Jones was appointed in 2010 as the Independent Chair of both the Leicester Children (LSCB) and Adult (LSAB) Safeguarding Boards. He was reappointed for a second 3 year term in 2013. The Independent Chair is directly accountable to the Chief Operating Officer of Leicester City Council, Andy Keeling, who acts on behalf of the partnership, and continues to work closely with the Director of Children's Services, Frances Craven who has statutory operational responsibility for coordination of safeguarding.

Whilst the direct accountability of the Chair is to the Local Authority, the role is independent, with an equal emphasis being given to all partners on the Board, including the voluntary and independent sectors, the lay members of the Board and increasingly, the voices of children and young people in the City.

Leicester City Council is responsible for establishing an LSCB in its area and ensuring that it is run effectively. The Assistant Mayor for Children's Services, Sarah Russell is an elected Councillor, with responsibility for making sure that the Local Authority fulfils its legal responsibilities to safeguard children and young people. The Assistant Mayor contributes to the LSCB as a participating observer and is not part of the decision making process.

Partner Agencies

All partner agencies in Leicester are committed to ensuring the effective operation of the LSCB. This is supported by the LSCB constitution which sets out the governance and accountability arrangements. Members of the Board hold a strategic role within their organisation and are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

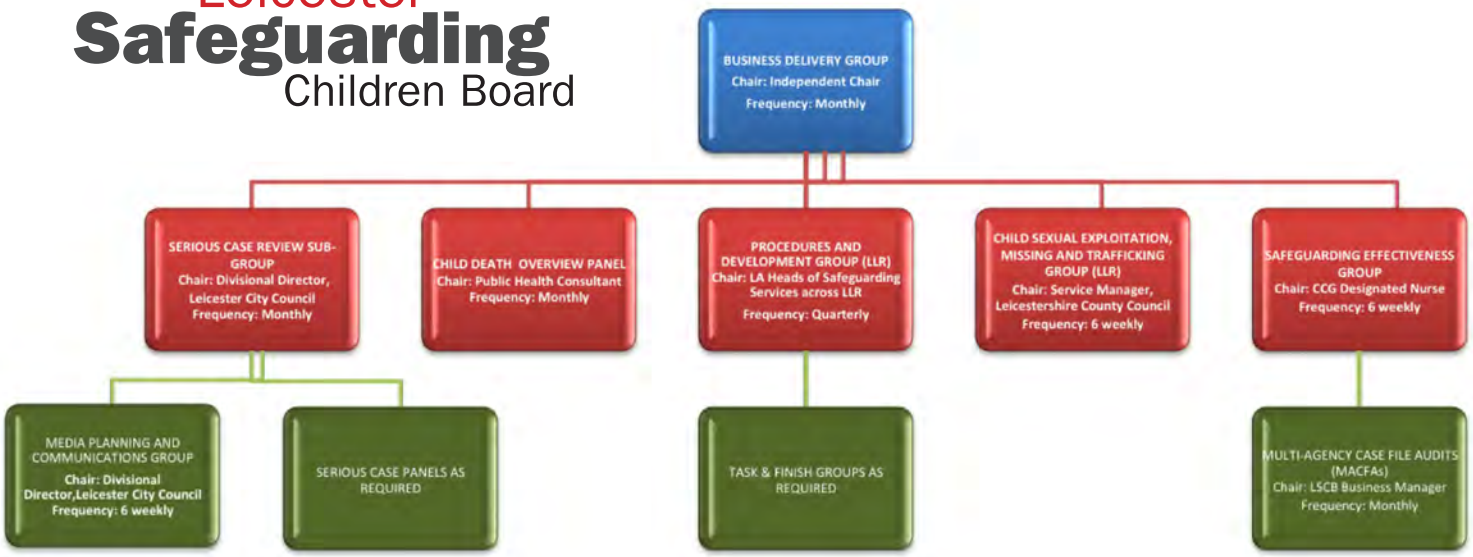
Designated Professionals

Health commissioners are required by statutory guidance to appoint a Designated Doctor and Nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB; these professionals sit on a number of the Sub Groups of the LSCB and inform decision-making.

Lay Member

Lay members operate as full members of the LSCB, participating as appropriate on the Board itself and on relevant sub-groups. Lay members 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.

Leicester
Safeguarding
Children Board



Structure 2014/2015

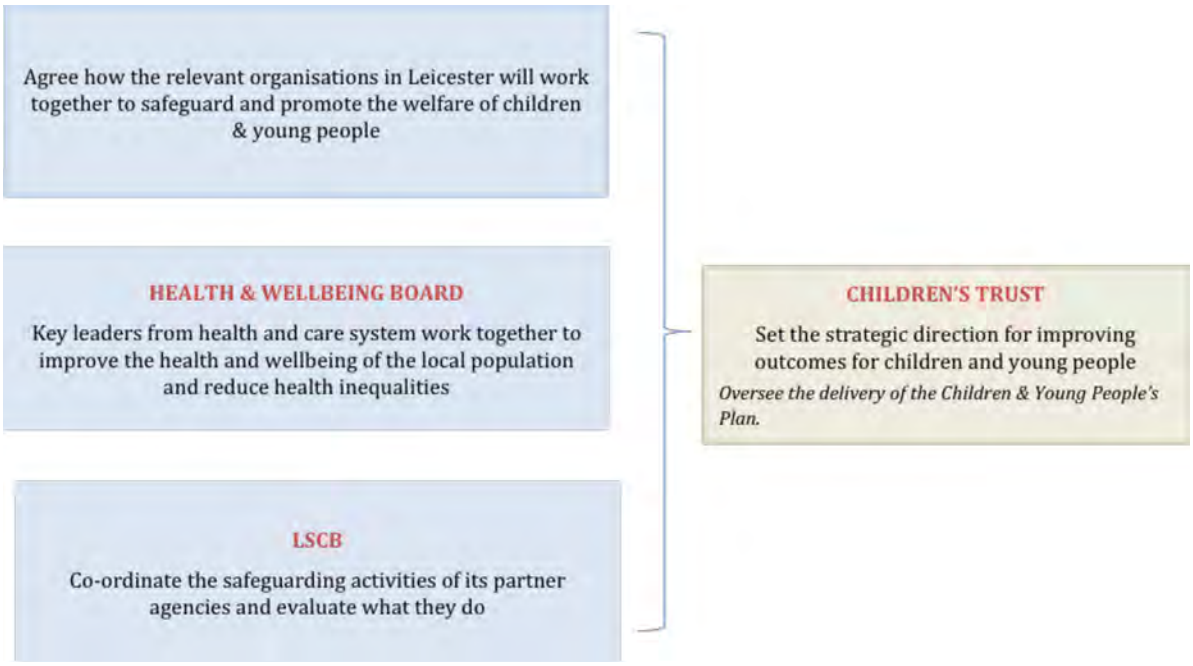
Key Roles and Relationships

The LS Key Roles and Relationships

The LSCB's role with other partnerships is 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 can be jointly addressed.

A protocol is in place between the LSCB, Children's Trust and Health and Well-being Board to set out the accountability and reporting arrangements, including arrangements for scrutiny and challenge. Business planning recognises this and there are shared aims and objectives linked to safeguarding.
These Boards include:



There are a number of Executive fora that relate directly or indirectly to the work of the LSCB in terms of safeguarding children, multi-agency working and / or link to strategic priority within the LSCB Business Plan.

Please see table below:

STRATEGIC BOARD	BOARD/FORUM CHAIR
Leicester Adults Safeguarding Board	David Jones – Independent Chair
Leicestershire and Rutland SCB	Paul Burnett - Independent Chair
LCC Chief Operating Officer	Andy Keeling
The City Mayor and Executives Office	Sir Peter Soulsby
Health & Well Being Board	Rory Palmer
Children's Trust • Stay Safe and Early Help	Frances Craven, DCS (from October 2014)
Leicester Safer Partnership Board	
Police and Crime Commissioner	Sir Clive Loader
Family Justice Board	Neville Hall

Relationship between the LSCB, Children's Trust Board and Health and Well-Being Board

The LSCB and the Children's Trust Board (CTB) link through the Independent Chair of the LSCB, who is a standing member of the CTB. The Director of Children's Services chair's the CTB and is a member of the LSCB and will provide a quarterly update to the LSCB on the work of the Children's Trust Board.

Similarly, the LSCB Independent Chair (representing the LSCB) reports to the CTB on the work of the LSCB. As a standing member of the CTB, the LSCB Independent Chair should both influence and monitor progress against the priorities of the CTB.

The strategic relationship between the two Boards is in line with national guidance issued at the end of March 2010. In November 2010, the statutory requirements for CTBs were removed, permitting local areas to make arrangements to reflect local needs. In Leicester, CTB partners agreed to continue with the current arrangements.

The CTB reports to the Leicester Health and Wellbeing Board (HWB) through the Director of Children's Services (DCS). Although, the LSCB Independent Chair is not a standing member of the HWB, he can attend to present the LSCB Annual Report and can be co-opted to attend the Board as required.

Relationship between the LSCB and the Leicestershire Police & Crime Commissioner

The Police and Crime Commissioner (PCC) has a legal responsibility under section 1(8) (h) of the Police Reform and Social Responsibility Act 2011 to "hold the chief constable to account for the exercise of duties in relation to the safeguarding of children and the promotion of child welfare that are imposed on the chief constable by sections 10 and 11 of the Children Act 2004". The office of the PCC is in contact with the LSCB Chair as necessary.

Relationship between the Leicester Safeguarding Children Board and other specified organisations and individuals.

The LSCB maintains links with the other agencies through membership or communication, including the voluntary and community sector and schools as directed by Working Together (2015).

Chapter three

Sub-groups and Reference Groups

What is the LSCB structure?

In order to assist the Board with discharging its wider responsibilities, the following programme groups have been operating;

- Business Delivery Group
- Safeguarding Effectiveness Group
- Serious Case Review Panel
- Child Death Overview Panel
- LLR Development and Procedures Programme Group
- LLR Child Sexual Exploitation, Missing and Trafficking Programme Group
- Training Strategic Safeguarding Learning Group
- Communications Programme Group

Role of the Chair within the Sub-groups Groups

The Chair of the sub group will be elected from within the programme group and will drive the progression of the work plan in line with the LSCB business plan. The chair of programme groups is expected to attend the Business Delivery Group to report on the groups work and agree the agenda for the Full Board.

Role and Function of the Sub-groups

Business Delivery Group (BDG-Former Executive Group)
This group meets on a monthly basis to drive the work of the Board and to ensure that the Board is delivering against the LSCB Business and Improvement Plan actions.

Serious Case Review Panel

The panel undertakes reviews of cases where a child has died or been seriously harmed as a result of abuse and there is cause for concern as to the way in which agencies have worked together to safeguard the child.

Child Death Review Panel

The panel collects and analyses information about the deaths of all children in Leicester: this became a statutory duty in April 2008.

Safeguarding Effectiveness Group (SEG)

The SEG has responsibility for ensuring that all agencies are safeguarding children effectively by working in partnership. It does this by monitoring performance including carrying out multi-agency audits, interrogating and analysing data from partner agencies.

LLR Development and Procedures Group

The group responds to local need and government directions to develop local policies & procedures that enhance the ability of those working with children and young people in Leicester, Leicestershire and Rutland to work together to promote and safeguard their welfare.

LLR Safeguarding Multiagency Training, learning, Development Commissioning & Delivery Group

The group has responsibility for ensuring that relevant single-agency and inter-agency training on safeguarding and promoting welfare is provided to all those working with children and young people in Leicester, Leicestershire and Rutland. It is estimated that ??? people are working with children and young people in the City on a paid or voluntary basis.

The Communications Programme Group

The group is responsible for communicating and raising awareness of the need to safeguard and promote the welfare of children and how this can best be done by agencies, children and young people, families and the community.

Reference Groups

The LSCB has also created reference groups to enable delivery of key priority areas that are identified within the its Business plan;

- Leicester. Leicestershire and Rutland, Female Genital Mutilation, task and Finish group, chaired by Dr Sethi
- Children and Young People Engagement Group, chair TBC
- Voluntary and Community Sector Group, Chair Peter Davey

Chapter five

Overview of Progress March 2014 – March 2015 (including Progress Reports from Sub Groups and reference Groups)

Safeguarding Effectiveness Group (SEG)

The recent OFSTED inspection found that the framework was not robust enough and concluded that,

"The Board has not been receiving adequate performance management data of safeguarding activity from partners and it is therefore unable to hold agencies effectively to account."

LSCBs have a duty to monitor and challenge the effectiveness of local safeguarding arrangements (Working Together 2013 & 2015). This work is undertaken in Leicester by the Safeguarding Effectiveness Group (SEG), which is responsible for monitoring and challenging the effectiveness of safeguarding arrangements of partners. This activity should enable the LSCB to reach a judgement about the effectiveness of the local safeguarding arrangements.

The performance framework involves the following interlocking domains:

- Performance monitoring – monitoring partner agency quantitive performance using the agreed 13 statistical indicators.
- Co-ordination of multi-agency qualitative audits – conducting multi-agency case file audits and Section 11 audits to provide qualitative information for triangulation with statistical monitoring to obtain a fuller picture of the effectiveness of safeguarding activity by partner agencies in Leicester.
- Embedding learning from case reviews and case file audits – tracking progress on recommendations.
- LSCB Effectiveness – reviewing the work and effectiveness of the Board itself.

SEG's activity through partner agencies and with support from the Board for 2014-2015 included:

- Quarterly monitoring against the agreed 13 indicators and submitting the quarterly summary reports to both the LSCB Executive and the Board. It was recognised that there was a lack of analysis of the data and triangulation of data with qualitative information such as information from Serious Case Reviews, multi-agency & single agency audits and from work relating to the views of children and families. The performance framework has been reviewed and a revised quality assurance and performance framework will in place for 2015-2106.
- Agreeing a case file audit process and schedule. Eight out of twelve scheduled, multi-agency case file audits were conducted during 2014-2015. The case file audit process has been revised for 2015-2016 following the Ofsted recommendation for the LSCB to increase the number of audits conducted (see Page 20 for further information)
- Serious Case Review - actions from previous Serious Case Reviews were tracked to check progress and ensure that these actions have been completed.
- Briefings were conducted for practitioners and managers on the findings & recommendations of the Baby Z SCR and also in relation to the outcomes and learning emerging from the multi-agency case file audits that were conducted.
- Review of the quality assurance and performance framework, including the monitoring process.
- Section 11 audit was conducted. For the 2014-2015 additional services (who were not familiar with the S11 audit) were requested to complete the audit. Agencies were mostly compliant with the agreed standards. A challenge session for statutory partners was held and another will be arranged to take place with partner agencies & services based on the Section 11 audit questionnaire, which has been revised for the 2015-2016 audit.
- The effectiveness and governance of the Board and sub-groups was reviewed, and revised governance arrangements were put in place during 2014. The sub-groups were requested to identify vice chairs to chair the sub-groups in the event that the chair was not available. A report card system has been put in place for chairs of the sub-groups to report critical messages to the LSCB Business Delivery Group and through this group to the Board and, as a result, the chairs of sub-groups are more accountable for the progress of the sub-groups in meeting the LSCB's priorities.

Critical Messages:

- The voice of the child needs to be more clearly identified within performance data reported to the Board.
- Increase of LSCB Case File Auditing required 2015/2016.
- Implementation of Quality Assurance Performance Management Framework (QAPMF) – it will take the first two Quarters of 2015 before the QAPMF is fully embedded. Adrian Spanswick - Chair

Multi-Agency Case File Audits (MACFAs)

Working Together to Safeguard Children (2013) requires Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.

The audits undertaken during 2013 & 2014 on behalf of the Board focused on multi-agency practice. The aim for 2014 was to audit one case a month on a deep dive basis, which focused on a particular aspect of safeguarding.

The process involved:

- Themes identified by national/local SCRs, Ofsted thematic issues, local safeguarding issues
- Schedule established of dates/themes to explore
- Case identified by Safeguarding Unit, Children Social Care
- Reports and key information sent to LSCB
- Case details put together
- Key lines of enquiry established
- List of practitioners compiled
- Lead auditors from different agencies identified and confirmed
- Practitioners and lead auditors invited
- Audit meeting takes place
- Draft report written and consulted on
- Report presented to SEG before finalising and dissemination
- Action plan monitored on behalf of SEG
- Feedback to the Board

8 MACFAs and 1 Serious Incident Review Process (SIRP) took place during 2014. Three MACFAs were postponed (due to a large number of apologies being received; time constraints and/or crucial information to enable identification of practitioners to invite to the MACFA not made available to the LSCB office in time).

The following topics were explored:

- January – "Step down" process from a Child Protection Plan
- February – Exploration of a particular safeguarding incident and the multi-agency support provided (SIRP)
- March – A looked after child placed out of the local authority's area
- May – Adult service user with dependent children for whom there had been a referral to Children's Social Care (Joint Audit between Adults and Children's Safeguarding Board)
- June – A disabled child requiring safeguarding
- July – A child using self-harming behaviour
- August – A child who goes missing from home
- September – A child who engages in sexually abusive behaviours
- October – A privately fostered child

The MACFA reports were submitted to and approved by the Safeguarding Effectiveness Group before dissemination to the key leads and practitioners involved in the audits. The findings from the audits were presented to the LSCB.

Two briefing sessions for managers and practitioners took place in April 2015 to disseminate the key messages and learning emerging from the audits.

The Ofsted Inspection report March 2015 stated that:

"Arrangements to monitor the effectiveness of multi-agency frontline practice are not well developed".

The system of monthly Multi Agency Case File Audits (MACFAs), where practitioners come together with agency leads to discuss one case, does not give sufficient coverage of the range of vulnerable children. Only eight MACFAs were held during 2014. No thematic audits were undertaken. The experiences of young people were not being collected and used to inform service improvement. The Board was not fully sighted on frontline practice and Ofsted therefore concluded that the Board could not hold agencies properly to account.

Ofsted recommended that the LSCB "Increase the number frequency and range of multi-agency audits initiated by the Board".

The LSCB multi-agency audit process has been reconsidered to take into this recommendation into account. The audit process from 2015 includes an increased number of multi-agency audits conducted with involvement of key partner agencies. The audits focus on the effectiveness of multi-agency working in safeguarding children and the LSCB's key priorities: Neglect, CSE, FGM and Early Help. It is envisaged that the priority 'voice of the child' will be a considered in all audits.

Thresholds, Assessment Protocol and Frameworks

Thresholds

The Multi-Agency Thresholds for access to specialist children's services were agreed by the Leicester, Leicestershire and Rutland Local Safeguarding Children Boards in March 2014. They were distributed to partner organisations following the LSCB agreement.

Leicester's Early Help section of the thresholds was revised in January 2015 ready for publication from April 2015.

Leicester City Council introduced the Liquid Logic ICS system in May 2014. It is the recording system for all social care cases and will be expanded to include Early Help from July 2015.

Basic performance information generated from Liquid Logic was available from September 2014.

In 2014-15, using the performance information available from September 2014, there were 24,911 contacts with children's social care concerning children who were thought to

meet the threshold for access to children's social care services. Of the contacts, 4,809 turned into referrals (cases that needed further consideration to see whether further work needed to be done with the child and their family). Of the total number of contacts with social care, 19.3% turned into referrals and 2,980 (12.0%) progressed to assessments.

Assessment Protocol and Framework

Any child who is identified as being at significant risk is assessed in accordance with the Children Act 1989 Section 47(S47). Social workers will carry out the assessment, including consideration of information about the child and their family from other partner organisations.

The single assessment protocol was implemented in 2013. It replaced the previous system of initial and core assessments. A single assessment is carried out where a child or young person meets the threshold for social care services and work needs to be carried out to assess their family circumstances and their needs. Social workers carry out single assessments, drawing on information from the child, their family and professionals involved with them. The assessment is recorded on the Liquid Logic ICS system. It should be completed within a maximum of 45 days, although many assessments can be concluded earlier. Some assessments lead to the provision of services through social care for children and families who meet the threshold for social care. For other children, the agency that referred them may be advised to continue to work with them; or they may be referred for an Early Help Assessment (formerly CAF).

In 2014-15, social workers carried out 1,444 S47 assessments. 527 (36%) children became subject to an initial stage child protection conference and 465 (32%) child protection plans commenced in the year.

In 2014-15, social workers completed 2,795 single assessments. 1,673 of these were completed within the timescale of 45 days, and 1,122 took longer. 781 assessments were delayed by the shortage of social work staff between April 2014 and March 2015.

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

The local authority and partner organisations provide universal health and education services for all children and young people. They also provide specialist education, early help and social care services for children who need additional support, as described in the threshold document. The need for specialist services is identified and monitored through the assessment process.

National reductions in public sector funding led to reviews of the provision and funding of services for children and their families in the city. The focus is on maintaining services to children, young people and families who most need help and support.

How well did we do it?

In children's social care there was a major restructure in the teams covering duty, assessment, children in need, child protection and children in court proceedings. At the same time, a new computer system was introduced. This resulted in a high turnover of staff in Children in Need Teams, a significant level of vacancies, and work to recruit agency and permanent staff to fill these vacancies.

Performance information is not available on children's social care for the full year, due to the change to the Liquid Logic system.

The performance information from May 2014 relating to contact, referral and assessment is presented below.

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

The Ofsted inspection of services for children in need of Help and Protection, Children Looked After and Care Leavers which took place between 14th January- 4th February 2015 rated Leicester as 'inadequate' overall, whilst also recognising strengths in the local safeguarding arrangements, including positive joint working by all the agencies; up-to-date procedures for handling safeguarding cases; a robust policy on access arrangements for social work intervention (thresholds); effective services for the assessment of initial child protection concerns and well managed serious case reviews. The inspection report contains a series of recommendations for improvement. Among these is the development of an effective performance management framework for the local authority and for partners through the LSCB. This will enable the local authority and partner agencies to gather and analyse data during 2015-16 which will provide a stronger basis for evaluating the effectiveness of the safeguarding arrangements.

What are the priorities for the work over the next 12 months from April 2015?

The structural changes and introduction of Liquid Logic during 2014 led to significant disruption in the service to children, young people and families, mainly due to staffing turbulence. Work to address this started in October 2014, but the high level of vacancies affected the quality of services and the service was not fully staffed until the end of January 2015. Improvement Plans were in place from November 2014 to address key areas of performance. The recommendations from the Ofsted inspection alongside local plans inform the Improvement Plan for Children's Services and the LSCB's Progress against the plans is monitored by an independent Improvement Board with an independent chair and government approved membership.

Priorities for 2015-16 are therefore be drawn from the Ofsted inspection and detailed in the Improvement Plans, with reporting arrangements to the LSCB through SEG and to the Improvement Board.

Early Help

The Ofsted inspection contained a series of recommendations for improvement, including the following on Early Help.

"*The Board has not provided effective scrutiny to evaluate the impact of the early help offer. Partners are not clear about their early help responsibilities and referral thresholds are not well understood.*"

"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."

The Thresholds document, which sets out partner responsibility for working with families at various levels of complexity, was re-issued in early 2014. Evidence from the inspection and other sources, indicated that the Early Help strategy was not clearly understood by partner agencies and front-line staff. Some practitioners continued to refer inappropriately to social care and appeared unaware of their responsibility to carry out an early help assessment. The number of Early Help Assessments fell significantly (by 23%) from quarter 1 to quarter 2 during 2014, and this downward trend was reported to the Board by the Safeguarding Effectiveness Group. This persisted into 2015-16.

In 2014, a review of the Common Assessment Framework (CAF) showed that partner agencies working with children and young people across the city were using the CAF as a referral form for local authority services, instead of the intended purpose of collecting information about a child/family which could be used to determine which level and type of service they needed.

The CAF was replaced by the 'Early Help Assessment', launched in March 2015. Assessments are recorded through the Liquid Logic IT system since July 2015. Further training is being provided for Early Help practitioners across all services to enable them to engage with children, young people and families and to gather information from them so as to come to a conclusion about which services will best meet their needs.

Targeted Services	Specialist Services
Childcare Learning	Targeted Youth Support
Family Support	Education Welfare Service
Parent and Community Engagement	Youth Offending Service
Children Centre Teachers	MST
Pre School Settings	Connexions
Early Help Assessment	Young Carers

In 2014-15, 12,215 families were supported by Early Help: Targeted Services across the City (See Appendix (d) Early Help Figures).10,434 children and families accessed Children, Young People and Family Centres

- 1,058 Children, young people and families received targeted early help services (single agency response accessing targeted preventative pathways)
- 491 Common Assessment Framework cases
- 723 Family Support cases (single agency response accessing targeted casework support pre CAF – 2 or less unmet needs and one agency involved)
- 500 contacts through the 'Advice Points' for low level info, advice and signposting which prevented escalation.

Performance information is not available on Early Help: Targeted Services for the full year, due to the review of Children Centres and Family Support concluding in July 2014.

Work undertaken to review reporting systems found the data sources to be unreliable. In particular, a significant number of CAF cases were 'open' when they should have been 'closed' or did not meet threshold. This has been addressed through the development of manual tracking system that will go live from April 2015 and has been cross referenced with the 'One system and Liquid Logic' when became operational from Autumn 2015.

Leicester has one Multi Systemic Therapy Team (MST standard). MST is an intensive family intervention delivered over 3-5 months aimed at young people aged 11-17 who have serious problematic behaviours that could result in them being taken into care or youth custody. MST in Leicester went live in November 2012 and takes approximately 40 cases per year.

Cases are referred when there has been deemed a high risk of placement via direct referral or the Local Access to Resources Panel (LARP). The case is then fully assessed against strict criteria of eligibility and allocated to a therapist.

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

MST measures outcomes bi-annually. Data from the period 30.01.2014 – 31.01.2015 demonstrates the following:

- 40 cases discharged
- 92% of young people remain at home
- 66.5% are in education, training and employment
- 79% have not been re-arrested
- 92% completed treatment successfully

The cohorts of young people are tracked for 18 months post MST treatment. Whilst numbers tracked remain fairly low due to the age of the programme; a comparator audit has shown that an MST group had 90% less placement days than a business as usual group.

THINK Family is Leicester's response to the national Troubled Families programme. The programme identifies and supports families who have children not attending or behaving in school, young people involved in crime and / or adults out of work. Workers conduct a whole family assessment and coordinate an action plan of activity involving other partners as required.

In 2014/15 the programme started work with an additional 257 families, meeting the three year target of working with 1140 families.

Families supported through the Think Family programme in Leicester which includes delivery of support by the Education Welfare and Youth Offending Services have shown:

- 89% no further fixed term exclusions
- 79% improved attendance
- 30% reduction in unauthorised absence
- 336 individuals into work
- 84% no further (youth) offending
- 47% reduction in the number of offences at the end of intervention
- 75% reduction in number of offences at follow-up

The remodelled youth support service is now delivering more targeted support to vulnerable young people including young people identified through the early help assessment process and the Think Family programme. The youth service will commence targeted work with a number of secondary schools in the summer term supporting the raising of aspiration and attainment with pupils at risk of poor outcomes.

The Connexions Service is tracking and maintaining contact with 750 young people in the NEET group aged 16 – 19 in the city and are supporting 150 young people pre 16 who are at risk of NEET.

What is the evidence for that?

The introduction of 'traded' family support services for schools from September 2015 resulted in 21 schools purchasing services. Evaluation reports provide schools with a termly analysis of the impact Family Support is having on their students and families.

What are the priorities for the work over the next 12 months from April 2015?

A review of the current processes within Early Help took place between November and February 2015. Proposals were approved by the Early Help and Stay Safe Board in January 2015 and are reflected within the updated Leicester City Council Early Help and Prevention protocol and the sub regional Leicester, Leicestershire and Rutland Thresholds Document.

The key changes from this review are as follows:

- CAF has been replaced by the Early Help Assessment (EHA) with defined eligibility criteria.
- There is an EHA pathway with all requests for an assessment coming through one route to ensure thresholds are met.
- The development of a partnership management panel (MASP – Multi Agency Support Panel) where open cases at an EHA, CIN, CP and LAC level that meet a defined criteria can be presented for management oversight, robust scrutiny and agreement of resources.
- Operational performance reports.
- Trialling of an outcomes based tool 'Rickter Scale' measuring impact and evaluation within one cluster running from February – August 2015.

Key priorities for the next 12 months will include:

(a) Embedding the Early Help Assessment, Eligibility Criteria and Pathway.
(b) Developing a shared partnership early help performance framework.
(c) Evaluating impact and outcomes.
(d) Closer integration with social care.
(e) Review traded early help services, developing an accessible offer for all.
(f) Developing a one whole family approach offer that embeds the Think Family Phase 2 programme.

LLR Procedures and Development Group

Policies, procedures and guidance for multi-agency arrangements, to protect children and promote their welfare (Business Plan Action 2)

The purposes of the Group are to:

- Agree the content of procedures and guidance across the agencies
- Ensure their easy access and dissemination

How much have we done in the last 12 months up to March 2015?

The Leicester, Leicestershire and Rutland (LLR) LSCB Development and Procedures Group oversees the development of multi-agency safeguarding procedures and ensures that procedures are up-to-date.

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 necessary.

The procedures are compliant with Working Together 2013 and have been revised to be compliant with Working Together 2015. They are available on the Leicester and Leicestershire & Rutland Safeguarding Children Boards website and 'hosted' by Tri-x Child Care Ltd, **http://llrscb.proceduresonline.com/chapters/contents.html**

How well did we do it?

Two planned updates take place per year, in October 2014 and March 2015, affecting procedures that required updating and/or procedures that needed to be developed and produced as identified by the group. 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, and these are consulted upon prior to being signed off by the group. Procedures such as Safeguarding Children and Young People from Child Sexual Exploitation, Female Genital Mutilation and LLR Information Sharing Agreement were finalised and approved in 2015.

The key procedures updated and/or produced include:

- The Thresholds for Access to Services for Children and Families in Leicester, Leicestershire and Rutland.
- Common Assessment Framework and Early Help.
- Referral into Children's Social Care
- Child Sexual Exploitation risk assessment tool and guidance.
- East Midlands Regional Protocol: Notification by Other Local Authorities of Children Placed within local authorities in the East Midlands.
- Children Moving Across Boundaries.
- Safeguarding Children and Young People who Self-harm.
- Safeguarding Children and Young People with Suicidal Behaviour.
- Safeguarding Children Vulnerable to Violent Extremism (PREVENT).

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.

What is the evidence for that?
Google analytical data shows that: in the three months (December 2014 – February 2015) there were 6470 Sessions involving 5211 different users consulting the procedures manual, with 13,627 pages being viewed. About 25% of these users are returning users and 75% are new users. (This information is calculated using the IP address of the user so it double counts if a user logs on from both home and work). These figures compare with the following from December 2013 – February 2014 – 3572 sessions with 2739 users viewing 10,106 pages. There is therefore a significant increase in access of the procedures manuals.

What are the priorities for the work over the next 12 months from April 2015?
Launch key revised and new procedures to practitioners across Leicester, Leicestershire and Rutland.

Explore ways to (and) include the 'voice of the child' in the work of the group in reviewing and developing policies and procedures.

Procedures identified for review or for developing new ones for 2015-2016 include:

- Domestic Violence in intimate relationships between young people.
- Safeguarding children where there is an interface with military welfare.
- Resolving Professional Disagreements.
- Complex (Organised or Multiple) Abuse and Historical Abuse Allegations.
- Allegations of Harm Arising from Under Age Sexual Activity.
- Multi-agency Protocol on Child Sexual Abuse.
- Safeguarding children who are Home Educated or Home Schooled.
- Neglect.
- Safeguarding of Children Travelling to Syria.
- Culturally Appropriate Practice and also Race & Racism.
- Think family/Whole Family Approach.

LLR Safeguarding Learning, Development and Training

The Multi-Agency Safeguarding Learning, Training and Development Commissioning and Delivery Group is responsible to and develops the Interagency Training Programme for both Leicester City and Leicestershire and Rutland LSCBs, drawing its membership from strategic training and welfare 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 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 processes for quality assurance – all of which support the LSCB role and activity around assurance, and the identification of impact of learning and the difference training makes to practitioners and the outcomes to children and families.

The strategy will support the children's workforce in undertaking their safeguarding duties in a confident, competent and committed manner; the Framework seeks to measure at all levels in the children's workforce, including senior managers and trainers.

A wide-ranging set of briefings and engagement work to support the application of the new Strategy and its application was put in place to support organisations, managers and practitioners, and this work will continue during the 3 year implementation period.

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.

The drivers and content of the programme respond also to local and national learning from reviews, LSCB Business Plans and from Serious Case Reviews. A Priority Needs Analysis and course outlines develop and share the content of the programme, which is regularly reviewed by the Group (meeting on average four times a year), which considers also gaps and emerging needs.

For 2014/15, the Programme was extended to include greater focus on Child Sexual Exploitation, Neglect and workshops on 'Assessing Effectiveness and competency'.

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.

After nine months of 2014/15, the evaluation feedback shows:

- Perceived and significant improvements in knowledge, skills and confidence of course attendees, as a result of the courses
- These improvements are sustained into the three-month evaluation
- There are generally high scores for achievement of training and personal learning objectives.
- There are generally high scores for event administration and facilities.

As regards the coverage of the programme in 2014/15:

- 847 practitioners have received training in the past nine months (a 7% increase on that received in 2013/14).

- Attendance for the full year is projected to be 45% higher than 2013/14.
- 'No shows' have reduced to 7% (was 12%).
- A projected delivery of 63 courses/events, covering 17 themes.
- 43% of total attendees work in Leicester alone.
- A further 19% of total attendees work at least part of their time in Leicester and/or Leicestershire.
- 12% of total attendees work in adult social/health care (6% in 2013/14); evidence of the expansion of the programme to include the 'whole family' approach.

For 2015/16, commitments to the programme have been made already, covering much of what was delivered in 2014/15, a wider range and number of practitioners, and incorporating an increased number of themes.

In 2014/15 both Safeguarding Boards have supported essential awareness learning for the Private, voluntary and Independent Sector, and agreement has been made to continue to offer this learning for the next financial year.

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 next year.

During 2015/16, greater emphasis will be given to: Assurance, an increased focus on implementation of the Strategy and Framework, improved/deeper links with other strategic sub-groups (e.g. CSE and 'Missing'); and incorporating the 'voice of the child'.

Finally, recognition should be given to the commitment and enthusiasm of members of the group and, in particular, to the work of the Project Development Officer and Training Coordinator (sourced from Voluntary Action Leicestershire), who have made major contributions to the development, administration and delivery of a continuously improving and flexible programme.

Steve Atkinson
Sub Group Chairman

LLR Child Sexual Exploitation, Trafficking and Missing Children

This work is overseen by the Leicester, Leicestershire and Rutland (LLR) LSCB Child Sexual Exploitation, Trafficking and Missing children programme group. This group also focuses on 'Trafficking' (within the UK and international) and Missing (children missing from their place of residence). During 2014-2015 there has been increased governmental and national focus on Child Sexual Exploitation (CSE) due to the findings of the Jay report into Child Sexual exploitation in Rotherham 1997-2013 and the Ofsted thematic report 'The Sexual Exploitation of Children: It Couldn't Happen Here, Could it?'. A bench-marking exercise against the recommendations from these reports was undertaken with a view to integrate actions within the programme group's CSE action plan which has been reviewed.

To keep pace with national/local changes the programme group continually reviews its membership, and includes the Police Licensing Inspector and representatives from the Voluntary/Third Sector.

What have we done?

- The CSE, Trafficking and Missing Children strategy and action plan was reviewed. The action plan, including the action plan in relation to Leicester City, has been revised to correspond with the 'See Me Hear Me' framework suggested in the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups 'If only someone had listened' (2013)
- The Children and Young People who Run Away or Go Missing from Home or Care joint protocol was reviewed and is available on both the Leicester City and Leicestershire & Rutland LSCB websites
- The CSE Risk Assessment Tool and associated guidance has been revised and is available on both the Leicester City and Leicestershire & Rutland LSCB websites
- Consultation on a revised CSE practice guidance and procedure document took place and a final draft is almost ready for sign off by the programme group and the LLR LSCB Procedure and Development Programme Group.
- Multi-agency safeguarding training on CSE was delivered to practitioners across Leicester, Leicestershire and Rutland. The CSE training delivered through both single agency and the multi-agency safeguarding training was surveyed to establish what CSE training was available to practitioners across Leicester, Leicestershire and Rutland. A further survey to map training and learning also took place.
- An audit relating to CSE is scheduled in the LSCB Safeguarding Effectiveness Group's audit programme for 2015-2016. SEG have agreed to undertake a regular schedule of multi-agency audits in relation to CSE
- A localised CSE Seminar for managers and practitioners across LLR took place on 26th February 2015. This seminar focussed on learning from national projects such CEOPs, Boy & Men, Muslim Women's network, and a parents support group (in which parents talked about the impact of CSE on their and their family's lives).
- The 'Spot the Signs' CSE awareness raising campaign was launched and includes the hospitality trade. The theatre production 'Chelsea's Choice', which has received wide ranging positive reviews, was performed in secondary schools across LLR. A Leicester City CSE Stakeholders forum took place in November 2014 to ensure key partners across Leicester City were briefed on the LLR LSCB CSE, Trafficking and Missing Children Strategy and Action Plan.
- Work with Madrasahs continues in relation to the overall safeguarding children agenda with a focus on developing the CSE agenda across communities.
- A draft 'voice strategy' for young people has been developed and will be finalised for 2015-2016.
- Successful recruitment of the LLR LSCB CSE co-ordinator, who has started in the post and will take forward the priorities identified by the LLR CSE, Trafficking and Missing

Children programme group.

- Successfully securing funding, through a bid submitted to the Police Crime Commissioner (PCC), for a post across LLR focusing on missing children and return interviews linked to CSE.
- Workstreams and Task and Finish Groups have been established for:
  - Refreshing the CSE, Trafficking and Missing Children strategy and action plan – has been reviewed.
  - Discussions on progressing further with a multi-agency CSE team across LLR are continuing at a strategic level through the CSE executives group.
  - Commissioning, to scope the priorities and gaps in services which should inform and link with the JSNA.
  - Training to establish CSE training/learning needs across the corporate and children's workforce for Leicester City.
  - Health Strategic leads have met and have progressed proposals for health campaigns on CSE and contribution to the multi-agency CSE team
- Data collection and monitoring on CSE and Missing on a quarterly basis has been implemented and will evolve as there is variation in the data collection, recording, quality, consistency and analysis, and this should be improved during 2015-2016. The indicators focus on the strategic objectives of prevention, protection, pursue and show:
  - An overall reduction in the numbers of missing children from home and care - less children going missing more than once; the overall percentage of return interviews completed has increased, but remains a priority for further work.
  - A significant increase in CSE concerns and referrals indicating greater and heightened awareness; CSE referrals are improving in quality, there is evidence of this enabling earlier intervention in more cases.
  - An impact of raising awareness e.g. use of NRM re trafficking increasing, referrals from a wider range of sources including GPs and licensing authorities.
  - Increase in prosecutions and orders imposed on adults who present risks to young people including on-line concerns.
- In addition to the quarterly monitoring there also 'Google' analytic data available in relation to the accessing of information on the LSCB websites; the raising awareness campaign has evaluation built in including data and there is data available regarding attendance at multi-agency training. However, there is an issue regarding the unavailability of any PHSE data. Education leads and Heads of Schools have been invited for themed discussions at the LLR LSCB CSE, Trafficking and Missing Children programme group meetings, and during 2015-2016 their involvement will continue to further develop the agenda in school/education settings.
- The aim of the LLR LSCB CSE, Trafficking and Missing Children programme group it to use the data collected/ analysed, learning from audits, information from the development of a multi-agency problem profile, intelligence from operational activity and the voice of children, families and communities to inform the development of the strategy and action plan.

What are the priorities for the work over the next 12 months from April 2015?

- Implement and monitor the reviewed LLR LSCB CSE, Trafficking and Missing Children strategy and action plan (which was initially launched in 2013-2014).
- Implement the PCC LLR post focusing on missing children return interviews linked to CSE.
- Commission task and finish group to report on gaps in services including therapeutic provision.
- The LLR LSCB CSE co-ordinator to further develop the strategic work and priorities (including data collection) of the LLR CSE, Trafficking and Missing Children programme work to enable change to be developed at a greater pace.
- Further develop the CSE data framework and problem profiling for LLR.
- Progress development of the LLR CSE multi-agency team by the CSE executive group to include:
- Establishment of a single LLR approach to tackling the issues relating to CSE, trafficking and missing children.
- Sharing and pooling resources which reflect equitable contribution and distribution of resources and support within the multi-agency CSE team.
- Development of a multi-agency team steering group.
- Implementation of the third stage of the communication Strategy and development of the continuing communication strategy.
- Discussion and agreement in relation to the future role of the LLR LSCB CSE, Trafficking and Missing Children following the development and implement of the LLR CSE multi-agency team and associated governance arrangements.
- Further develop a wider Quality Assurance Framework including report cards (providing critical messages) and audits which take into account the findings of the Ofsted Inspection in January 2015 and the priorities of the Leicester City Children's Improvement Board.

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

- The data shows an improvement in the safeguarding of children e.g. reduction in the numbers of missing children and an increase in prosecutions to bring alleged perpetrators to account.
- A reported increased level of awareness following the raising awareness campaign amongst children and schools has resulted in more referrals and some direct disclosures.
- The development of the training programme and delivery to corporate services teams increases the knowledge and awareness raising that supports increases in referrals being made.
- Use of the LLR LSCB multi-agency safeguarding procedure ' Complex (Organised) Abuse Cases' in an organised abuse case has enabled valuable information to be gathered in relation to the case which contributed to the criminal process.

Victor Cooke | Chairman

Engagement with and Participation of Children

In line with the priority of the 15/16 Business Plan, a more strategic approach is being taken to participation. Whilst there is some effective work with good practice, there needs to be a more systematic approach with more evidence of impact. All of the sub groups have to agree how young people are involved in the work of the groups or their voice is taken into account. Young people are contributing to the drafting of the LSCB Engagement and Participation Strategy which was agreed by the Board during 2015. Once agreed, the LSCB will be able to hold agencies to account for the way that young people take part in decision making on an individual level and influence service design and strategic thinking.

There are robust participation arrangements across the City Council and within schools with Young People's Council, Big Mouth and Little Mouth Fora, Children in Care Council, Youth Council, School Councils and young carers' groups. Young people have attended significant Council meetings including Scrutiny Committees and Corporate Parenting Forum. The Young People's Council has recently negotiated representation on the Police Community Gold Stakeholder group and the impact of this will be evaluated during 2015. The Ofsted inspection described participation as 'strong'. Young people have been consulted about tenders, for example in relation to supervised play and youth service holidays. They are involved with recruitment of officers, for example the appointment of the Director of Children's Services. Their views have been sought by the Prevention, Care Planning and Sufficiency Project Board which is developing strategies to reduce the numbers of looked after children as well as ensuring that there are sufficient appropriate placements available.

The Council Participation groups have continued to collaborate and the Let's Talk Hate Crime event was held in June 2015 and achieved a national award. This gave an opportunity for young people to meet LSCB members and contribute to the LSCB Participation Strategy.

Public Health has continued to involve young people in developing the Joint Strategic Needs Assessment, which means that the information should be more useful and accurately reflect the needs of young people.

The Children in Care Council hosted an event ran by the Youth Commission to seek young people's views about CSE/Missing. Their comments and ideas were reported to the CSE/ Missing sub-group and the idea of having Young People's champions was agreed. The Youth Commission are recommending that they are part of Local Safeguarding Children Boards.

Following the re-launch of the City Council's Young Advisors scheme, they have carried out mystery shopping including across the school nursing service. They are planning a consultation event for Leicester City Clinical Commissioning Group on access to health for young people.

The Young People's Council has continued to carry out neighbourhood patch walks and presented their findings around crime and safety to the Police Community Gold Stakeholder group and Leicester Safety Partnership. A range of actions were agreed in response to these findings. They have consulted more than 6,000 young people about priority issues for the City and encouraged 2,500 young people to register on the electoral register.

Leicestershire NHS Partnership Trust is developing their action plan to improve engagement with Looked After Children

CAMHS has a participation group for young people, which has increased their engagement with young people

The Advocacy Service for children and young people has an allocated social worker. It mainly works with Looked After Children and Care Leavers and has good outcomes, including high levels of conflict resolution, for example in relation to placement moves and contact. It received 76 referrals during the year and continued to work with ten young people referred in the previous year. The Service continued to effect changes in practice, including clearer guidance about the provision of driving lessons and changes to fostering allowances for a particular young person. Its involvement helps to improve relationships between the young person and their social worker. Young people express high levels of satisfaction with the advocacy service. For example they comment on how they felt listened to and that it helped them resolve their difficulties.

Work has been done to promote awareness of the Advocacy Service including for children going through social care processes. Ofsted noted that take up was still too low and that the Service lacked capacity. The Service is considering how capacity can be increased to meet increasing demand. The young people who received advocacy said that they found it helpful and that it helped them understand the child protection process better.

Local Authority Designated Officer (LADO)

How much have we done?

The LADO and Allegations Service is based within the Safeguarding and Quality Assurance Unit, Children, Young People and Families.

This service is responsible for chairing strategy and outcome meetings, maintaining management information and providing advice and guidance for professionals making referrals and enquiries.

Guidance was introduced in 2006 to ensure that all Local Authorities had procedures for responding to and dealing with allegations against an adult who comes into contact with children in a work or care setting. This includes volunteers, foster carers and prospective adopters. (Working Together to Safeguard Children 2006 revised 2010 and 2013 supported by Handling Allegations of Abuse Made Against Adults Who Work With Children and Young People-Practice Guidance DCSF 2009, Guidance for Safer Working Practice….2009 and Keeping Children Safe In Education-2014).

Section 3.9 LSCB procedures sets out the local procedures for managing allegations against persons who work with children.

The guidance provides a framework and procedure for managing allegations where there is cause to believe a child is suffering or likely to suffer harm. It also covers cases of allegations that might indicate a person is unsuitable to continue to work with children.

The procedures should be used if it has been alleged that member of staff, foster carer or volunteer has:-

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child
- Or behaved towards a child or children in a way that indicates she/ he may be a risk to children in the work place.

This applies when the allegation of concerns arises within the adults' own work setting, their own children or other children living outside the family make allegations or there are historical allegations.

The Leicester City LADO is based within the Child Protection and Allegations Service Safeguarding and Quality Assurance Unit. The LADO is managed by the Service Manager for the Child Protection and Allegations service. This is a full time post with additional support from 2 Independent Chairs for 2 days a week and from administrative services. LADO work currently uses a confidential data base that holds information about referrals taken and the outcomes. This database is able to provide information about patterning from adults, establishments or the child. This database is being replaced. (See below).

The LADO service provides advice and guidance to employers and voluntary organisations about the thresholds of harm and unsuitability. Staff liaise with police, social care and partner organisations as necessary to ensure a safe, consistent, fair and thorough process for child and adult.

The 2 Investigative Officers are experienced social workers based within the Duty and Advice, Fieldwork Service. They undertake assessments, investigations and support the allegations process by attending strategy meetings and by assisting in investigations where there is a need for risk assessments in respect of adults about whom allegations have been made.

Within the Child Abuse Investigation Unit there is a police representative whose role it is to coordinate the police involvement in the process of managing allegations. This is a beneficial service as it offers consistency, good communication and the role has developed an area of specialism.

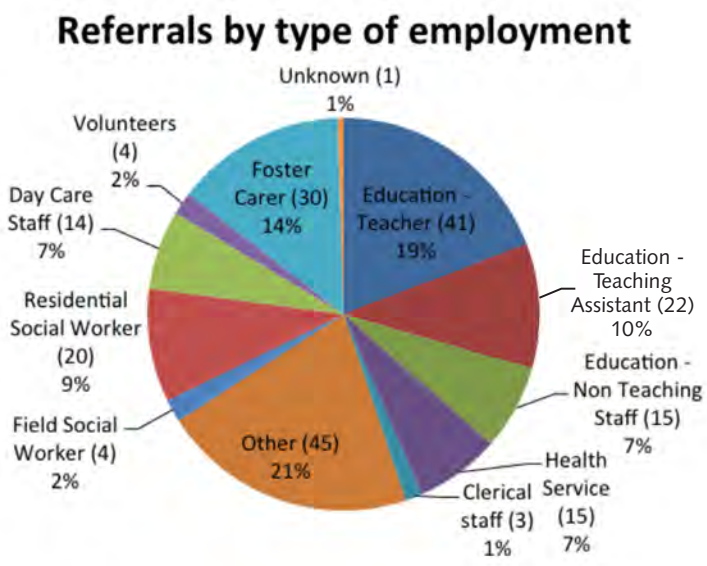
The Safeguarding in Education Development Officers (based within the Safeguarding and Quality Assurance Unit) work closely with the Allegations Service regarding any referrals where education staff or resources are identified as requiring safeguarding input to enhance practice, to increase compliance with procedures and to improve outcomes for children. An example of this is when allegations were made against several teachers in an Independent Faith School of not following Child Protection Procedures. The Safeguarding in Education Officer attended the strategy meeting and made links with the school governor quickly and engaged the school in a series of safeguarding training events that linked with the needs identified in the strategy meeting. The Safeguarding and Education Officers will work with schools who are in need of training needs, which have been identified during the course of the allegation.

The Leicester LADO has a good working relationship with the Leicestershire LADO. Good liaison takes place on cases that cross boundaries. Knowledge and development is shared and arrangements made to work together if there is a conflict of interest in a particular referral.

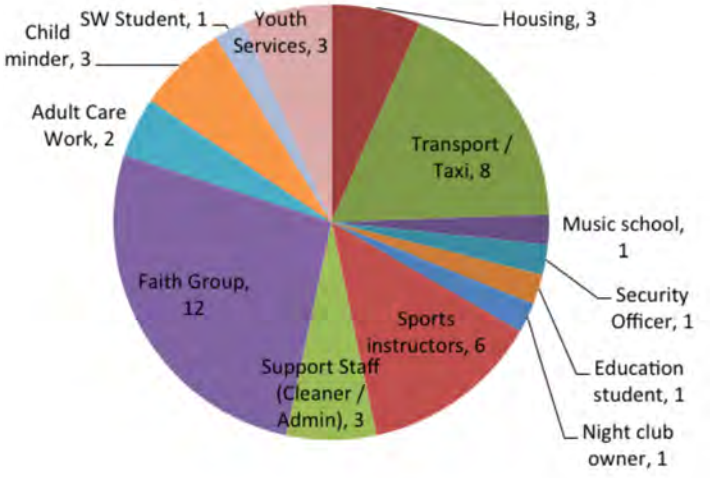
The LADO has 3 monthly meetings with a Detective Inspector from the Police Child Abuse Investigation Unit. This provides an opportunity to share information about cases and agree a way forward on complex or "struck" cases. The meeting also promotes a positive working relationship.

The LADO meets quarterly with Team Managers within the Duty and Advice Service to review cases and consider the joint working procedures. This ensures the procedures and arrangements

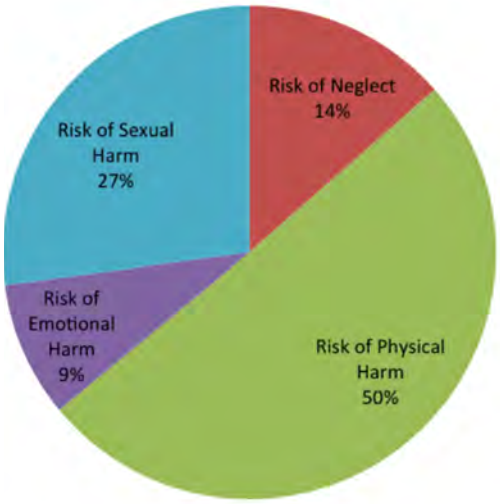
Between April 2014 and February 2015 the Allegations Service worked with 214 referrals.



Referrals that make up 'other' category



Type of harm referrals



Of the above referrals dealt with in Leicester City during this time:

- *7% (12 referrals) involved specifically the misuse of technology/social media.*
- *22% (47 referrals) involved a concern raised about an adult whose primary job is to work with Looked After Children. E.g Foster Carer/Kinship Carer/Residential Worker/Social Worker.*

Number of referrals per month

Training

The service provides training to LA staff and partners via the LSCB training programme. Between March 2013 to February 2015, 5 sessions took place that were aimed at a variety of employers and senior managers, these offered 90 places.

The LADO service has also provided bespoke training to groups of staff within a health setting (school nurses and health visitors) and a group of home start volunteers.

The LADO service has close links with the Operational Lead for Safeguarding in Madrasahs project. This role has focused on developing safeguarding practices for Madrasah teachers and providing training for Madrasah senior teachers. In the last year there have been 2 training events for police in relation to investigating alleged harm in Madrasahs provided by the LADO lead and Safeguarding in Madrasah lead.

There are 3 further sessions of training planned for 2015 to a variety of senior managers from education and social care. These sessions are planned to focus additionally on engaging day care services especially private nurseries, leisure services, voluntary groups and faith groups to attend the training. These organisations were identified from la LADO report as having a high referral rate.

Between April 2014 and December2014, the Safeguarding in Education workers provided 71 training sessions to school staff and governors.

This included training for 121 designated safeguarding leads from 70 schools including private and independent schools. Whole school training was provided for 27 schools and 9 sessions for school governors.

26 E safety sessions for school staff, parents and pupils have been completed.

During the above training the role of the LADO and managing allegations is incorporated alongside safer working practices. The training also includes the whistleblowing policy and signposts to the Allegations service. The training also incorporates reference to the Nigel Leet and Jeremy Forrester serious case reviews, both contain learning for school staff working with children.

A Safeguarding in Education Development Officer is also a lead in E Safety for Children's Services and he has delivered bespoke training to foster carers and supervising social workers.

Policy/Procedures and Guidance.

The LADO has developed and is using information leaflets for children and young people, parents of children who have made an allegation, the adult against whom an allegation is made and a risk assessment tool when suspension should be considered. A flow chart has also been used as guidance to ensure compliance with procedures and the child(ren) is safeguarded.

Outcome forms continue to be used to inform the adult whom the enquiry is in relation to about the outcome of enquiries.

Letters are written to young people where appropriate to inform them of the outcome of their allegation/concern raised.

Data Base

An updated data base is being devised to address the needs of the allegations service. The data base is Liquid Logic as used throughout the children's service. The aim is for the implementation of allegations data base for June 2015. This data base will provide the LADO with additional data and a more systematic recording system.

How well did we do it?

The outcomes of the referrals to the service during the period of reporting were:-

- 53.27% did not meet the threshold for risk of harm (60% 2013-14). This could indicate a similar and consistent threshold for referrals is being managed.

- 10.5% were unfounded - there was sufficient evidence to disprove the allegation (this is sometimes referred to as a false allegation or malicious – where there is evidence of a deliberate act to deceive), (16 % 2013-14).
- 12.8% were substantiated – there was sufficient evidence to prove the allegation (12% 2013-14).
- 7.6% were unsubstantiated - there was insufficient evidence to either prove or disprove the allegation (11% 2013-14). It is beneficial for this to be a lower figure indicating clearer decisions were able to be reached about risk of harm from adults who work with children.
- 13.5% of current referrals are ongoing, an increase of 2% since last year.

Although the number substantiated is relatively low, there will have been actions and recommendations in respect of all of the cases where the outcome was unsubstantiated and unfounded.

Of the referrals substantiated, 16 individuals were referred to the Disclosure and Barring service. This is 73% of referrals that were substantiated.

This cohort includes:

- Evaluation meetings that are held to evaluate a pattern of concern or concerning information that does not meet the Section 47 threshold but requires further examination of the information and information sharing.
- Cases that have been referred to a LADO in another Local Authority after agreement is reached regarding the most appropriate LADO to deal with a referral that crosses boundaries
- Referrals that do not meet the threshold for harm are considered with the referrer or employer to ensure advice and guidance is given regarding any additional needs highlighted from the referral e.g. training needs, disciplinary processes, monitoring and supervision of staff vulnerability of child/ren and adult.
- All referrals involve a strategy discussion and decision between the Allegations Lead, DAS Team Manager and a CAIU Police Sergeant.
- If there are a number of repeat referrals (3) involving the same adult or young person as a victim or the same provider/resource, consideration is given to convening an evaluation meeting or a specific professionals only meeting to consider the history of concerns and relevant chronologies.

Training

The training delivered is evaluated by attendees and the feedback from the Allegations against Adults course attendees was good. The feedback evidenced that the learning experience was positive and enabled participants to gain a good understanding of the key principles and procedures required when managing and dealing with allegations against persons working with children.

Feedback from Professionals

A feedback form was given out at strategy meetings in March, April and May 2014 as part of the quality assurance systems for the management of strategy meetings. 58 feedback forms were received from 37 meetings.

Overall the professional's feedback was positive in relation to the preparation and chairing of the strategy meetings. The meetings on the whole considered and addressed the child's and adults needs and vulnerabilities whilst ensuring that risk was identified and clear plans to address risk were made. This feedback indicates that consistency is required to ensure these factors are clearly understood and considered in every meeting.

The comments that were noted as part of the feedback were positive in relation to the chairing skills of the Independent Chairperson.

Timeliness of activity

We aim to complete the managing allegations process for individuals within recommended timescales. Referrals have been managed in a timely way within this period, although slightly under the recommendation from Working Together which recommends that 80% are completed within 4 weeks and 90% are completed within 3 months.

Of the 214 referrals in this period the following timescales were met:

- Within 4 weeks - 133 referrals were completed (62%)
- Between 1 and 3 months - 40 referrals were completed (19.6%).
- Therefore 81.62% of referrals are completed within 3 months.
- Between 3 and 6 months - 6 referrals were completed (3.4%)
- 1 case remains ongoing since February 2014 - this is a complex historic investigation involving another local authority police service.
- Currently ongoing from this period are 29 referrals, which are 13.55% of the total since April 2014.

Of the above ongoing referrals the timescales are:

- Under 3 months – 15. Between 3 and 4 months – 7. Between 5 and 6 months – 6. Over 12 months -1.

Responding to Learning

Our processes and procedures are subject to review following new information from Serious Case Reviews and new policy and legislation. For example, the agenda for all evaluation, strategy and outcome meetings ensures each meeting covers the vulnerability of the adult of concern and of the child that may be a victim. This is learning from a Local Serious Case Review regarding the vulnerability of a young person who had made allegations against a member of staff working with him.

The LADO Service uses the learning from serious case reviews for example Nursery Z and North Somerset review to ensure that investigations are thorough and the professionals are informed by learning. This involves taking seriously warning

signs of adults behaviour, use of technology is examined and subject of safer working practices and that there is a continued focus on safeguarding for children . The culture and boundaries within organisations should be questioned. Overall the LADO Service is able to help professionals believe the unbelievable so that safe decisions can be reached.

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

The LADO process is embedded within the Local Authority's and partner agencies' safeguarding processes-as illustrated by the breadth of type of employees referred and by the number of own children referrals.

The Investigating Officers, based within the Duty and Advice Service, add value to assessments within evaluation and strategy meetings and their experience and expertise in this area of work informs risk assessments of adults of concern-they also provide advice and guidance to employers.

A three monthly meeting between the LADO and a Detective Inspector within the CAIU tracks open cases to ensure that there is no drift, timely outcomes and proportionate responses to concerns. The police are involved in every strategy discussion regarding threshold and are invited to strategy and outcome meetings. A designated officer attends and the continuity of the involvement of this officer and the development of their expertise in this area of safeguarding, has been very useful. This model has ensured good information sharing to help with informed decision making.

The aim is to capture evidence regarding the difference we have made with the implementation of our new database and with the systematic use of post meeting evaluation/ feedback.

There have been 16 referrals to the Disclosure and Barring service from employees in this period. This represents 59% of substantiated allegations. These actions will help to safeguard children.

The LADO continues to advise and recommend that regulatory bodies are contacted by the employer to share information.

Feedback from professionals indicates that strategy meetings are chaired well and focus on the risk to children.

Work between the Safeguarding in Education Officers and the LADO has resulted in safeguarding training taking place with an Independent School.

What are the priorities for the work over the next 12 months from April 2015?

The workspace will be changing to Liquid Logic - with safety and security of information assured. The system being developed will provide more reliable, sophisticated, management information to inform the quality assurance of the service and provide evidence of outcomes. This is in progress and the aim is for this to be completed by June 2015.

Evaluation feedback surveys have been developed for professionals/partners involved in the delivery of the service and for children and adults, subjects of the service.

Training will continue to be available; the following groups are being targeted:-

- Day care- particularly day nurseries.
- Faith groups - a more detailed analysis is required to address particular Faith groups so as to target training to the most appropriate groups.
- Sessional staff/youth workers
- Transport services.
- Voluntary groups

Timeliness of completing the process remains a priority. This is achieved by weekly reviews of the on-going referral to track the cases and avoid unnecessary drift and delay.

An auditing process/tool is being developed to ensure that thresholds remain consistent and key decision making is completed in a timely and safe manner. This will include the LADO auditing 4 cases a month, which have been managed by the two Independent Chairs, who have been supporting the service.

Written feedback from parents and children will be obtained and this will be used to review and develop the service.

LADO Service admin processes will be reviewed to ensure that an effective and robust system is provided.

An audit will be completed of venues, schools and organisations that have not had recent contact with the LADO service. The organisation will be invited to relevant training events and ensure that relevant support and advice is available from the Safeguarding and Education Officer.

Steve Tee | Interim LADO

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 Investigation.
- Stage 3 Independent Review Panel.

The Regulations specify the time allowed for responding to Stage 1 complaints is 10 working days, or if the case is complex up to 20 working days.

- 52.5% of Stage 1 complaints were responded to within 20 working days, (80.3% 2013-14, 74.6% 12/13 and 61.8% 11/12).

On 31st March 2015 there were 2211 children and young people receiving a (social care) service from the Department, 1141 male, 1015 female and 55 unborn/not known.

- 67 new complaints relating to 90 service users were received in 2013-14, (4.1% of service users). These complaints were made by people who fall within the categories identified under 'Who Can Make a Complaint' (DfES guidelines 2006).

Any complaints from people who fall outside of these categories are dealt with under the City Council's Corporate Complaints Procedure and are not included in this report.

10 complaints were made directly by children and young people, relating to 12 service users. These complainants were offered the support of the Children's Rights and Participation Officers who provide support and advocacy. 7 young people accepted this support (5 complaints), one was supported by his solicitor and the remaining 4 decided they had no need for an advocate. The Children's Rights and Participation Officers provided advocacy to a young parent who made a complaint.

59 commendations were received about children's social care services.

Who Can Make a Complaint?

The Children Act 1989 and the Adoption and Children Act 2002 require the council to consider complaints and representations from:

- Any child or young person who is looked after by the local authority or who is in need;
- His/her parent or someone with parental responsibility;
- Any local authority foster carer;
- Young people leaving care;
- Special Guardians;
- Any child or young person under a Special Guardianship Order;
- Any person who has applied for an assessment;
- Any child placed for adoption and their parents/guardians;
- Persons wishing to adopt a child;
- Any person for whom adoption services may be provided;
- Adopted persons, their parents, natural parents and former guardians;
- Such other person who the local authority considers has sufficient interest in the child or young person's welfare.

Equality and Diversity

The purpose of recording data is to monitor access to the complaints procedure and to ensure services are appropriate for all service user groups.

Gender

Gender of Complainant/ Service User	2011/12	2012/13	2013/14	2014/15
Male	38 (45.2%)	29 (40.8%)	30 (37%)	30 (45%)
Female	32 (38.1%)	28 (39.4%)	22 (27.2%)	29 (43%)
Not declared/Not Known	14 (16.7%)	14 (19.7%)	29 (35.8%)	8 (12%)

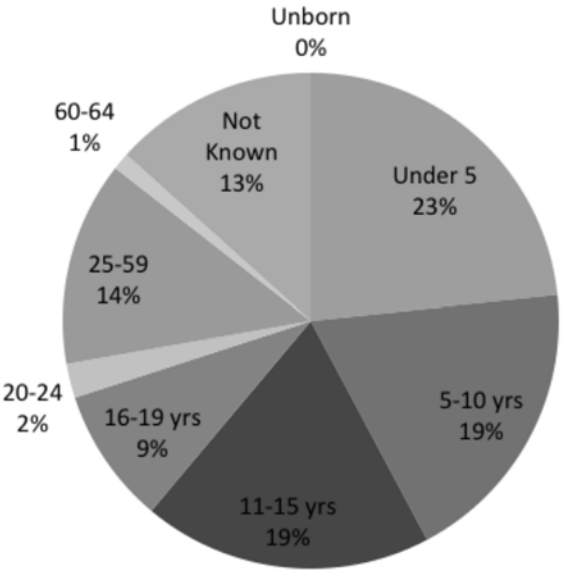
Ethnicity

Ethnicity of Complainant/ Service User	2011/12	2012/13	2013/14	2014/15
Asian or Asian British – Bangladeshi	0	0	0	0
Asian or Asian British – Indian	7 (10%)	3 (4.2%)	1 (1.2%)	1 (1.5%)
Asian or Asian British – Pakistani	0	4 (5.6%)	2 (2.5%)	0
Asian or Asian British – Other	0	1 (1.4%)	0	1 (1.5%)
Black or Black British – African	3 (4.3%)	1 (1.4%)	3 (3.7%)	1 (1.5%)
Black or Black British – Caribbean	2 (2.9%)	1 (1.4%)	0	4 (6%)
Black or Black British – Other	0	0	0	2 (3%)
Chinese or other ethnic groups	0	0	0	0
Not Declared/Not Known	3 (4.3%)	5 (7%)	3 (3.7%)	6 (9%)
White - British	45 (64.3%)	38 (53.5%)	27 (33.3%)	37 (55.2%)
White - Irish	1 (1.4%)	0	0	0
White - Other	2 (2.9%)	0	2 (2.5%)	0
Not declared/Not Known	14 (16.7%)	14 (19.7%)	29 (35.8%)	8 (12%)

The number of complainants who have not declared their ethnicity has reduced this year, following a large increase last year.

Complaints from White British service users remain the highest proportion of those who have declared their ethnicity. Numbers of complaints from service users of other ethnic backgrounds remain reasonably constant.

Age of Service User



Disability

Of the 90 service users involved in these complaints, 6 (6.7%) have a disability compared to 4 (4.9%) last year and 5 (7%) during 12/13.

Looked After Children

Of the 90 service users involved in these complaints, 22 (24.4%) are Looked After Children/Young People or those whom have recently left the care of the Authority. This is a more constant figure following the notable decrease to 27 (33.3%) last year from 39 (55%) in 2012/13 but continues the downward trend.

Stage 1 Complaints Activity

There were 67 new statutory complaints received between 1st April 2014 and 31st March 2015 compared to 66 last year and 61 in 2012/13.

4 of these complaints were withdrawn by the complainant before the Stage 1 response was sent out and one complaint was accepted at stage 2. The remaining 62 complaints were investigated and responded to within Stage 1 of the complaints procedure, although one complaint remains unanswered at 15th July 2015 so outcomes are only available for 61 stage 1 complaints.

Of the 61 complaints responded to within Stage 1, 32 (52.5%) were within 20 days, that is within the statutory timescale, compared to 80.3% last year and 74.7% during 12/13. The average number of days taken to respond to a Stage 1 complaint was 24.2 days compared to 14.9 last year and 17.8 during 12/13. This is disappointing for our service users and their families who want a quick resolution to their complaint and is currently being addressed by senior management.

Although the time taken to respond to complaints has recently increased, the responses from Team and Service Managers added to the invitations to discuss complaints at Alternative Dispute Resolution meetings is still having a positive effect on resolving complaints at Stage 1 without them progressing further. Of the 61 complaints responded to at stage one, 60 were resolved and 1 progressed to stage 2.

Stage 2 Complaints Activity

Only 2 complaints were investigated at Stage 2. One complaint bypassed stage 1 at the request of the complainant, was partially upheld by the independent investigator and resolved by the Authority offering financial redress. The other progressed from stage 1 and is currently being investigated by an independent investigator.

The timescales for a Stage 2 investigation are 25 working days or up to 65 working days if the complaint is complex. The complaint accepted at Stage 2 was completed within timescales, the one currently being investigated is also within timescales.

Stage 3 Complaints Activity

No stage 3 Review Panels were held this year compared to one last year.

Local Government Ombudsman (LGO)

The Local Government Ombudsman received no statutory complaints relating to Children's Social Care for Leicester City Council this year, down from 1 last year and 2 during 2012/13. Therefore the LGO made no recommendations to the Authority for the third year running.

Reason for Complaint

This year complaints spanned 8 categories.

Reasons for complaint are recorded at the very beginning of the process, prior to investigation and as the complainant perceives the problem at the time.

The most common area of complaint at 40.3% was 'Challenging a practice decision'. Last year this was the second most common reason at 22.6%, up from 14.3% in 2012/13. This shows that families are increasingly taking up the opportunity to challenge the departmental decisions made about them and the care of their children.

The second most common area of complaint was 'Lack of Communication' at 22.4%. This was last year's most common at 29% and had increased from 13.4% in 2012/13. This is being addressed within an updated training package for social workers.

'Staff Attitude and Behaviour' continues to reduce and this year is the reason for 11.9% of statutory complaints. This has reduced from 12.9% last year and19.3% during 2012/13. Experience suggests this is often the category used when service users are not satisfied with a decision made within departmental policy or legislation.

Service Area Complained About

Changes to the divisional structure mean that comparisons to last year are difficult.

The 2 services receiving the most complaints last year were the Child Protection and Proceedings Service based at Greyfriars and the Child Protection and Proceedings Service based at Beaumont Way. These are now the Child In Need (CIN) service based at Greyfriars and is the service receiving the highest number of complaints this year at 32 (48% of the total number of complaints).

The second most complained about service is Looked After Children (LAC) with 8 complaints (12%) and the third is Duty and Advice with 7 (10%). Complaints about Residential Care reduced from 7 last year to 2 (3%) this year.

How Complaints Were Resolved

Changes to the divisional structure mean that comparisons to last year are difficult.

The 2 services receiving the most complaints last year were the Child Protection and Proceedings Service based at Greyfriars and the Child Protection and Proceedings Service based at Beaumont Way. These are now the Child In Need (CIN) service based at Greyfriars and is the service receiving the highest number of complaints this year at 32 (48% of the total number of complaints).

The second most complained about service is Looked After Children (LAC) with 8 complaints (12%) and the third is Duty and Advice with 7 (10%). Complaints about Residential Care reduced from 7 last year to 2 (3%) this year.

Outcome of Complaints

Outcomes/findings were made on 62 of the 67 complaints received as 4 were withdrawn before a response was issued and 1 is yet to be responded to.

50% of these complaints were not upheld (71% last year). These were responded to by explaining the legislation, policies and procedures which the department works within and this explanation being accepted by the complainant.

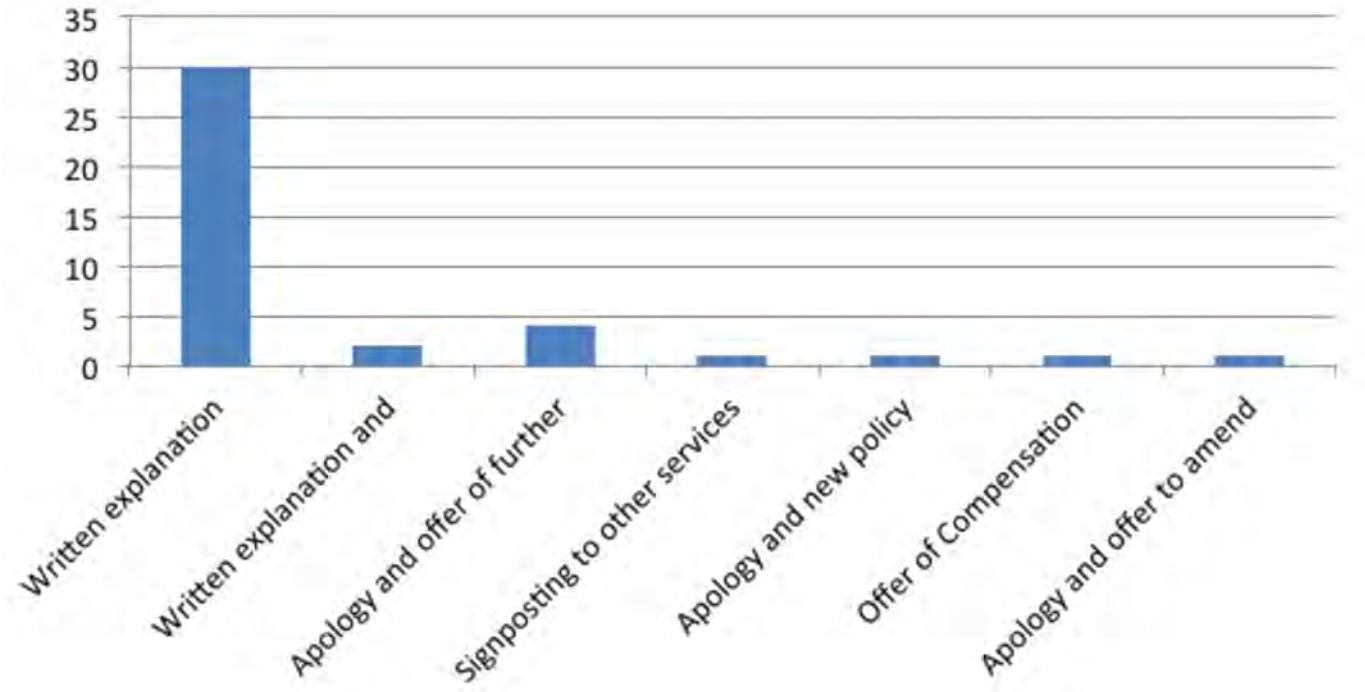
13 complaints (21%) were partially upheld compared to 12 complaints (19%) last year. 18 complaints (29%) were upheld compared to 6 complaints (10%) were last year, which is a 200% increase from last year.

Stage 1 complaints are investigated and responded to by line managers. Stage 2 reports and recommendations are received and responded to by Divisional Directors. Stage 3 panel recommendations are received and responded to by Strategic Directors. This ensures that managers at all levels are aware of and can address the reasons for complaint.

Commendations

There were 59 commendations received this year compared to 83 last year and 39 during 12/13. This is a significant decrease on last year and could be the result of the high turnover of staff over the last 12 months. This is being addressed by the Complaints Manager who is visiting Team Manager meetings to discuss complaints and commendations with new Team Managers to enable them to easily identify issues and good practice that need progressing.

Placement and Commissioning and Family Placement and Support each received 17 commendations this year. The remaining 25 were spread across the services.



The majority of commendations were made by city council employees regarding other members of staff, whilst 1 was made by a Judge who praised the quality of a social work report.

Leicestershire Police have commended 3 social workers and both Leicestershire and Warwickshire Police have commended the Complaints and Access to Records Service for their help in locating and providing files for criminal convictions. Head Teachers have commended 2 social workers and Health Visitors have commended one. 16 commendations were received from service users and their families. These included letters of thanks, thank you cards and poems sent to social workers, contact workers and Children's Rights and Participation Officers.

Lessons Learnt from Complaints

Generally services struggle to identify lessons learnt from complaints. This is being addressed by the complaints manager who sends a 'Learning From Complaints Feedback Form' to the manager who responded to the original complaint. This encourages the manager to recognise why the complaint was made and whether or not processes need to be put in place or changed to prevent the same complaint reoccurring.

Sometimes there is no identified learning from the outcome of the complaint but other times complaints have highlighted gaps in the service provided to children and young people and processes have been put in place to ensure these gaps are filled.

There are a range of ways in which the division has recently learned from complaints, for example:

- Complaints regarding staff have been dealt with through formal supervision processes and have contributed to formal capability processes. Where a pattern has emerged regarding staff ability in response to particular areas of work, this has been fed back to workforce development regarding the future needs for individual or collective staff.
- A complaint last year from a parent regarding not having access to a report prior to a Child Protection Conference led to a development session with staff in DAS regarding ensuring that parents see the Social Work report to conference at least 48 hours prior to the meeting. This has resulted in no complaints of a similar nature this year.
- A complaint from a father regarding incorrect information about him being held on the social care system has led to more robust information sharing processes with our partners being put into place.
- A complaint from a mother about the actions of a contact worker during a contact session led to a 'de-brief' meeting and monitoring of staff to ensure they are working in a professional manner at all times. The incident was also discussed during staff supervision sessions for them to reflect on what they had individually learnt from the outcome of the complaint.
- Complaints last year by Foster Carers regarding the attitude of some Social Workers towards them led to Foster Carers having input on the training for student Social Workers. This has led to no complaints of a similar nature this year.
- A complaint by the mother of a young person in residential care led to refresher training with all team members reiterating good practice in supporting young people to attend medical appointments.
- Following a number of complaints from a mother with mental health issues, processes were put in place to assist her to understand the issues relating to her child. This has resulted in no complaints being received from her this year.
- Two complaints by parents of children in a residential home have led to additional staff training to ensure thorough assessments are carried out and more robust processes have been put into place when matching young people to placements. No further complaints of a similar matter have been received.
- A complaint from a young person who is looked after by the Authority identified problems in the way the department financially supports young people in further education. This led to changes in our financial processes.
- A complaint from adopters has resulted in new guidelines being issued to social workers restricting the information that is released to birth parents.
- A complaint from a young person in foster care identified that the Authority had no clear policy on the Staying Put Scheme and resulted in clearer policies and staff training.

Actions for 2015/16

- Complaints Manager to continue to represent the Authority on the Regional Complaints Managers Group contributing to national policy on complaint handling.
- Complaints Manager to continue to encourage the use of Alternative Dispute Resolution to resolve complaints.
- Complaints and Access to Records Team to continue to make direct contact with service users to collect customer feedback on the service families are receiving.
- Complaints Manager to continue to encourage Team and Service Managers to complete pro-formas that will give a more complete picture of complaints received and will identify actions taken to resolve the issues and any positive examples of learning from complaints.
- Complaints Manager to identify any themes or trends emerging and recommend to the Divisional Director any additional work required.
- The Complaints Manager to ensure that complaints and learning from complaints is embedded into the Performance Management and Quality Assurance Framework for Children's Services.

Therese Ball | Complaints Manager

Partner Agency Inspection Findings LPT

In the 12 months up to March 2015 Leicestershire Partnership NHS Trust (LPT) did not undergo any external inspections in relation to Child Safeguarding, however assurance was provided both internally and externally through completion of the LPT Annual Safeguarding Audit, Measurement against the Markers of Good Practice and completion of the Section 11 Audit. The annual LPT Safeguarding Children Audit was also completed, which assessed health visiting compliance with the recommendations arising from the Baby Z Serious Case Review.

In addition to a making a commitment to work with other agencies to achieve the objectives within both LSCB Business Plans, the LPT Child safeguarding Annual Report outlined several future priorities for 2014/15. Progress against the priorities in the last 12 months has included:

- Developing guidance for staff on responding to Female Genital Mutilation (FGM): LPT have and continue to contribute to a Multi-agency approach to tackling FGM, including development of Multi-agency procedures. A flow chart (FGM decision making flow chart) has been developed for staff across LPT and has been widely circulated throughout the organisation.
- Developing a training programme for staff on how to respond to FGM and raise awareness for staff – FGM is now included in all Child Safeguarding training packages across LPT. The information included in the training packages will be reviewed following publication of the Multi-agency FGM Procedure to ensure a consistent message across agencies.
- Developing guidance to support staff in providing evidence in legal proceedings. This Guidance has been developed and implemented in Family, Young People and Children's Services (FYPC), work is currently underway to consider Trust wide Roll out.
- Developing the role of the Clinical Team Leaders (CTL) in providing locally accessible safeguarding advice and support for front line Health Visitors and School Nursing staff. To support the anticipated increase in newly qualified health visitors in response to The Health Visitor Implementation Plan 2011-2015: A Call to Action (DH 2011). The safeguarding Named Nurses have reduced the advice line opening hours, with safeguarding advice being sought from CTL's. This initiative is still in pilot stage however there has been no significant reduction in referrals since implementation. A review is planned later this year.
- Supporting a simple and acceptable solution to the information sharing difficulties arising from the roll-out of Enhanced Data Sharing Model (EDSM). A solution has been sourced; a system is in place to allow nominated managers and Named Nurses to access records where safeguarding concerns have been identified, in line with information sharing protocols.
- Conducted a review of safeguarding children training and embed Domestic Violence and Abuse (DVA) and DASH risk assessment training into these programmes. DVA is included in all LPT safeguarding children training. Use of the DASH RIC is included in the LPT DVA training package. Staff also access multi-agency DASH RIC training via the LSCB. Additionally a MARAC Standard Operating Procedure has been developed for Health Visitors outlining their duties in relation to cases referred to MARAC.
- Reviewed LPT Training & Education Strategy in light of the publication of Royal College of Paediatricians and Child Health (2014) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Intercollegiate Document, Third Edition: March 2014. The LPT training strategy was updated in Sept 2014 to include the new safeguarding children and young people: roles and competencies for healthcare staff 2014 and also working together to safeguard Children 2013.
- Reviewed the current Peer Supervision process. This was actioned by gathering information from a neighbouring Health Trust, reviewing audit results and ascertaining the views from supervisors and supervisees, using Listening into Action methodology. It is envisaged more Peer Supervisors require training to strengthen the current process. The 'Listening into action' event, took place in November 2014 and work began to review the supervision process taking the views of staff into consideration. The launch of the new Safeguarding Supervision Process takes place in late March 2015.

In addition continuing to take forward work completed in 2013/14, it is a priority for LPT in 2015 to develop robust systems to capture what positive difference we are making to people's lives. We plan to develop a basket of data to help us identify areas where we are seeing positive change, but also to help to identify any gaps in safeguarding provision.

The 2015 LPT Annual Safeguarding Audit is currently underway. The results from this audit, teamed with any learning identified from the March 2015 visit by the CQC to the Trust and learning from the recent Leicester City Ofsted inspection, will inform key priorities in 2015/16. LPT key priorities will also align to the LSCB Business plan and include implementing a 'Think Family' approach to safeguarding and developing an integrated approach to all strands of safeguarding, including Child Sexual Exploitation (CSE) and FGM. The key priorities were outlined in the LPT Child Safeguarding Annual report in May 2015.

Ensuring the Safeguarding Children's agenda is embedded in the practice of all staff, and ensuring that we work effectively to keep children and young people safe continues to be of the highest importance for LPT in 2015/16.

Chapter 5

What happens when a child dies or is seriously harmed in Leicester?

Leicester, Leicestershire and Rutland (LLR) Child Death Overview Panel (CDOP)

The Child Death Overview Panel is a Sub Group of the LSCB. All child deaths expected or unexpected in Leicester, Leicestershire and Rutland are reviewed. CDOP 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.

CDOP is required to review ALL child deaths (from 0 up to 18 years) of any child who is resident within the LLR. Significant work has been undertaken within LLR to ensure all deaths are reported in a timely manner (1 working day). HM Coroners and Registrars provide information to LLR CDOP on a weekly basis to allow for cross referencing to ensure all data has been captured.

The Department for Education (DfE) requests annual data submissions on all cases that have been reviewed. Questions are asked in relation to the demographic details of the child, as well as identification of modifiable factors, which are factors which, if different, might have prevented the death of the child.

There are discrepancies in how CDOPs (nationally) interpret findings – in particular 'modifiable factors'. As there is currently no national database, identifying emerging trends and themes in a timely manner is difficult.

The data submitted to the DfE is analysed and a statistical review is produced. This report has a number of limitations, the 2 main areas being;

- Figures less than 5 are suppressed (not reported)
- Data is presented on a regional basis making local interpretation difficult.

During the time period 1st April 2014 – 31st February 2015 LLR CDOP held 9 panels and reviewed a total of 71 cases;

- 23 neonatal cases
- 23 expected cases
- 25 unexpected cases

From the cases reviewed, modifiable factors were identified in 23 cases covering areas such as;

- Review of current policies within partner agencies
- Consanguinity
- Unsafe sleeping
- Smoking
- Medication compliance
- Poor parental supervision
- Risky behaviour

In all cases where the panel identify modifiable factors, panel members are asked to consider what (if any action 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'. Examples include information from other CDOPs and public health data.

Currently there is no national database that would allow for 'real time' data gathering and also provide a national context.

This has been highlighted to both LSCBs and the Independent Chairs have raised it within their networks. A tender has been awarded by central government to develop a national database. The University of Leicester will be supporting this and the CDOP Chair and CDR Manager are liaising with the key professionals to secure LLR CDOP involvement in how this is developed.

In the absence of such a resource it falls to individual CDOPs to identify themes within their own local area. This can prove extremely difficult due to the small numbers involved.

From 2015 LLR CDOP has in place a 'learning' database (capturing learning on all cases from the previous 5 years). This includes learning identified by partner agencies as part of their

involvement in the CDOP process. This is a standing agenda item at all panel meetings and all panel members are required to provide updates.

As part of the work plan of CDOP, the 'themes' that are captured on the learning database are reviewed quarterly. This information is utilised to help CDOP panel identify areas of work they will be required to prioritise.

2 key areas of work have been undertaken in 2014-15;

[1] Ingestion of disc button batteries

A campaign is planned across LLR to raise awareness of the lethal dangers associated with the ingestion of disc button batteries. A comprehensive work plan has been developed outlining how this will be managed (including working with communication teams and identifying key areas to target). Contact has also been made with the family to make them aware of the work being proposed.

All agencies/organisations on the CDOP panel are committed to supporting the campaign and work is taking place with communication managers to identify the most appropriate strategy for ensuring relevant areas are targeted

[2] 999 calls – language barriers

There have been a small number of cases where parents have identified that they did not feel able to call 999 in an emergency as English was not their first language. Instead they may have chosen to call a relative or neighbour. In NO cases was this felt to have contributed directly to the outcome for the child.

LLR CDOP has undertaken a significant amount of work with the emergency services to establish the current processes in place for dealing with such situations. All services have systems that they are able to utilise. LLR CDOP felt that this matter required additional support from a national level and addressed its concerns to the Department for Education. A response is still awaited.

Challenges

Measuring impact

Due to the nature of the work of CDOP it is extremely difficult to measure the impact of any work undertaken. It is not possible (in the short term) to state that a reduction in the number of deaths reported (in a particular category) is due to the work of CDOP as there will be multi-factorial influences. Alongside this CDOP are not aware of the number of 'near misses' that occur, which would help to formulate a wider picture.

Capturing the voice of the child (and family)

Through meetings with the LSCB Board managers and the Child Death Review Manager (CDR) appropriate forums are to be identified (across LLR) to look at how this can be achieved. It is hoped that CDOP can ensure it captures areas that young people find challenging (for example mental health and well-being)

There is also a need to ensure learning identified within CDOP informs relevant partner agency working. Work is currently being proposed that would allow stronger links between CDOP and the LLR Suicide Audit and Prevention group.

The CDR Manger is currently undertaking a review of the interface CDOP has with families following their bereavement. There are plans to strengthen this (following feedback received by families) and plans to establish a clearer pathway across agencies for identifying bereavement support (for parents/ carers and siblings).

2015-16

The CDR Manager has been approached by an associate professor from Northampton University to participate in research in order to review how CDOPs can measure the impact of the leaning they identify. A formal proposal will be made to the LSCB to agree to LLR CDOPs involvement.

Work is currently being undertaken by the CDR Manager to collate information from the learning database that will outline key areas that have arisen. This will then be included within the CDOP annual report as the identified priorities for 2015/2016

Serious Case Review Group (SCR)

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.

LSCBs must always undertake a review of these cases. These reviews are called Serious Case Reviews (SCRs). The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

The Serious Case Review programme group is responsible for coordinating serious case reviews and learning reviews. The SEG is responsible for monitoring the implementation and effectiveness of all of the reviews action plans on behalf of Board.

The programme group is chaired by the Director for CYPF and the group meets monthly. Progress on the actions arising from Serious Case Reviews (SCRs) and learning reviews are monitored by the LSCB Serious Case Review programme group. Progress and exception reports on the actions are presented to the Business Delivery Group (former Executive Group) and to the LSCB on a quarterly basis or as required.

No SCRs were published during 2014-15

Systems Approaches

Professor Eileen Munro recommended a systems approach for serious case reviews (SCRs) the same approach she had applied in her review of Child Protection in England. The approach moves away from the primary focus on what happened at the frontline, and instead calls for a 'deep dive'

into why things happened. This encourages reviews to explore how a range of organisational factors come together and contribute to the difficulties of doing the work well (of critical importance to partnership working). It equally requires that reviews should focus on what factors help frontline practitioners to operate at a consistently high level of safeguarding performance.

Serious Case Reviews & Alternative Learning Reviews

The SCR programme gave consideration to nine cases over the course of the 2014/15. In January 2015 a new robust assessment tool was agreed to aid decision making on cases presented for consideration for SCR. The LSCB Chair endorsed a serious case review to be commissioned on five of these cases, two are subject to alternative learning review processes and two were deemed not to have met the criterion for further review.

Three of the cases that are subject to SCRs have similarities in terms of the age of the children and the injuries sustained. The Independent Chair of the LSCB sought advice and agreement from the National Panel of Independent Experts on Serious Case Reviews to complete a composite review of findings on these cases in order to conduct a whole system review. This was agreed.

Chapter 6
Issues and Challenges Facing Safeguarding Effectiveness

Ofsted Inspection Outcome March 2015

The LSCB has been operating in a rapidly changing and politically sensitive environment throughout 2014-2015. It has worked hard to deliver on a challenging agenda in regard to its safeguarding arrangements. There remains a very positive commitment to safeguarding children, young people and families from partner agencies.

In September 2014 the LSCB held its annual development day and identified key areas for development and improvement. There was an impetus for change in the following areas:

- Governance
- Strengthening Partnership arrangements
- Scrutiny and Challenge
- Challenge and Effectiveness. The LSCB and its partner agencies had begun work to drive decisions and actions from the development day.
- Voice of the Child

Work had begun to review the LSCB structure which included its governance and a change to the groups that support the delivery of the work.

See Appendix (e): LSCB Structure Chart 2015

Whilst work had begun, it is acknowledged that this was not sufficiently embedded at the point of the Ofsted Inspection which commenced in January 2015.

In March 2015 Ofsted published the inspection report on Local Authority Children's Services and the effectiveness of the LSCB. Ofsted judged children who need help and protection in the city to be 'inadequate'. The LSCB arrangements to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children were also judged as 'inadequate'.

Ofsted made 24 recommendations for improvement by the Local authority and 9 for the LSCB. The Local Authority has been issued with a Notice for Improvement by the Department of Education. Actions within the improvement notice are timetabled for completion within 18 months from issue of the Notice and an improvement Board with an independent chair has been established.

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. This should include reliable quantitative data, qualitative information, service user's views and experiences and practitioner's views.

[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 so that concerns and challenges can be identified more promptly and accurately.

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.

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 Ofsted findings confirmed the LSCB self-evaluation as all of the areas identified at the Board Development Day are featured in the Ofsted Report. The Ofsted Inspection outcome is subsequently viewed as further endorsement of the work that had already begun in order to improve and strengthen the safeguarding arrangements in Leicester and is integral to the LSCB Business and Improvement Plan 2015-2017.

The LSCB Business and Improvement Plan for 2015-2017 has been developed supporting a complex and evolving transformation agenda.

Improvement Board

The Improvement Board monitors the delivery of the Children's Services Improvement and LSCB Plans, including the contribution of agency partners.
It is chaired by Tony Crane.

The importance of the role of the LSCB in initiating effective challenge on a number of safeguarding issues across partnerships is well understood and recognised. In order to ensure the key actions and improvements are achieved, the LSCB Chair is also a member of the Improvement Board, along with the key public sector partners in the City.

The LSCB has a key role in monitoring the delivery of a range of actions from Leicester's Improvement Plan.

National Drivers

The Government's action on implementing sustained austerity measures across the country has led to increasing numbers of families feeling the pressure whilst also reducing resources for childrens services in general. There are growing expectations from a local and national perspective that the children's workforce, across all agencies, will work more efficiently, in a timely, safe and effective manner with limited or lessening resources. There is evidence from across the country that these developments are contributing to an increase in the volatility of the children's workforce, particularly within frontline children's services.

The most frequently cited factors in research studies which challenged the effectiveness of LSCB were:

- the under-resourcing and turnover of staff in partner agencies
- a training offer that was not strong enough and could not be shown to demonstrate impact
- negativity and dissonance arising from conflicting agency cultures
- lack of agreement on and use of performance information
- the extent to which LSCBs had the necessary statutory powers to hold partners to account or sufficient authority in relation to Chief Executives.

LSCB Executive Business and Improvement Delivery Plan

See Appendix (h):

The LSCB has published a two-year Business Plan to ensure the programme of work benefit from a longer-term planning process. A two year plan will also allow for the 2018 LSCB business plan to be aligned with the LCC Children's Trust, Children and Young Peoples Plan and both thereafter would be subject to a three year business planning cycle.

The implementation of the plan will be reviewed by the Board quarterly which will allow progress to be monitored and any delays or risks to implementation to be quickly identified. A review of the full plan will take place annually to ensure the plan remains dynamic and current.

The LSCB has already made significant progress against the improvement and business plan.

Priority Areas

The business priorities for 2015-17 for the LSCB have been agreed in response to the Ofsted Inspection findings and from the review of the Local Safeguarding Children Board. They have also taken account of the outcomes from the LSCB development day in September 2014.

An improvement plan has been devised and agreed by Board members which will be monitored by the Improvement Board as part of the Improvement Notice issues by Department for Education on March 2015.

The key priority areas for 2015–17 are:

[1] Post Ofsted Improvement Plan
[2] Core Business and Governance (Strengthening partnership arrangements including representation of Schools on the LSCB)
[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
[4] Participations and Engagement
  [a] Voice of the Child
  [b] Engagement with Frontline Practice
[5] Effectiveness of Multi-agency Practice (performance monitoring)
[6] Children's Workforce Development

Chapter 7
Key Messages

The LSCB will drive and demand through its leadership and governance, evidence of the effectiveness of its members to assure quality of professional practice, delivery of the best services locally and assure better outcomes for children and young people and their families following any intervention.

Messages for the Children's Workforce

Ensure you are booked onto and attend all safeguarding courses and learning events required for your role, to enable you to demonstrate you have the competencies identified as essential for effective safeguarding;

Ensure your learning is discussed with your line manager in supervision and used in your practice;

Be familiar with, and use when necessary, the LSCB Procedures and the Thresholds framework to ensure the most appropriate response to identified concerns about children and young people and where appropriate engage with Early Help services;

Ensure that you do your best to ensure that the voice and perspectives of children influence your practice, decision-making and partnership working and communicate with your agency representative on the LSCB to ensure that the voice of children informs policy and practice;

Communicate with your agency representative on the LSCB front line practitioners group to ensure that the perspectives of staff involved in service delivery are heard and shape development of practice and policy.

Messages to the Community

The LSCB know that You, the people of Leicester, are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them.

We all share responsibility for protecting children.
If you are worried about a child,
call Leicester's Children's Services: **0116 4541004**
Police: **0116 222 2222**
In an emergency always call 999

Messages to Local Media

Communicating the message that Safeguarding is everyone's responsibility is crucial to the safety of children and young people and to the LSCB.

People are rightly concerned about the safety and welfare of children. It is important to communicate examples of effective work as well as areas where there are service shortcomings.

Your continued interest in the work of the LSCB is welcomed.

Children and Young People

Children and young people are at the heart of the child protection system. Your voices are the most important of all and we want to hear from you.

The LSCB plans to develop better ways of hearing the voices of children and young people and acting on their concerns and recommendations. There are opportunities available to you to make your views count through:

- your direct involvement with particular agencies and services,
- child protection and looked after processes, and
- LSCB, school and community led events.

Chapter 8

What next for safeguarding and child protection in Leicester?

The Independent Chair of the LSCB, City Mayor, Lead Member, Chief Executives and LSCB Members are fully committed to and engaged in the work of the LSCB. There is an added momentum and appetite to drive forward change and be assured that a positive difference is being made to the lived experience of children and young people of Leicester.

Successful partnership working requires commitment, contribution and congruency at the highest level to ensure effective safeguarding arrangements are in place.

The Safeguarding Pledge

All partner agencies continue to commit their support to the work of the Improvement Board and the Children's Services & LSCB Improvement Programme, in order to raise the standard of inter-agency safeguarding practice from inadequate to good.

All partner agencies will ensure that the safety and protection of children is given the highest priority within their organisation.

All partner agencies will ensure the LSCB is informed of any organisational restructures. The restructure must include risk management and give a clear understanding of the agency's capacity and the impact on safeguarding children and young people in Leicester.

All partner agencies will ensure that their individual agency plans take account of the Strategic Priorities stated in the LSCB Improvement and Business Plan 2015/2017.

All partner agencies will ensure effective delivery of single agency safeguarding training and ensure compliance with LSCB competency framework to monitor learning and impact on children and their families.

All partner agencies will ensure contribution to the shared delivery of the LSCB's work programme. This includes complying with the duties under Section 11 of the Children Act 2004.

All partner agencies will contribute to the LSCB's work programme by committing appropriate resources and officer support at the right level to implement the action plan and deliver the change needed across the LSCB sub-structure.;

All partner agencies will ensure that, to discharge their safeguarding duties effectively, services are commissioned for the most vulnerable children and young people.

All partner agencies will contribute to the multi-agency 'Early Help' arrangements and do their utmost to ensure children, young people and families are provided with the right support at the right time.

All partner agencies will ensure that the 'Voices of Children' and 'Engagement with Frontline Practitioners' remain central to service improvements and delivery.

APPENDICES

Appendix (a): List of LSCB Members 2014/2015

Statutory Members		
Member	Role	Agency
Dr David Jones	Independent Chair	N/A
Carole Ribbins	Director of Nursing/Deputy DIPaC	University Hospitals Leicester
Caroline Roberts	Lay Member	Lay Advisor
Carolyn MacLean	Head	National Probation Service, LLR
TBC	TBC	City Primary Heads
Cllr Sarah Russell	Lead Member	Children's Services, Leicester City Council
David Thrussell	Head of Service	Early Help – Specialist Services
Dawn Leese	Director of Nursing & Quality	Leicester City Clinical Commissioning Group
Adrian Spanswick	Designated Nurse	Leicester City Clinical Commissioning Group
Diane Postle	Head of Professional Practice and Education	Leicestershire Partnership Trust
Dr Sudhir Sethi	Designated Doctor	Leicester City Clinical Commissioning Group
Frances Craven	Strategic Director	Children's Services, Leicester City Council
Jason Dent	Service Manager	CAFCASS
Jon Brown	Detective Superintendent	Leicestershire Police
Manjit Darby	Director of Nursing and Quality	NHS England
Ruth Lake	Director	Adult Social Care & Safeguarding, LCC
TBC	Director	Education Improvement Partnership
Lee Brentnall	Locality Quality Manager	
HCPC Paramedic	EMAS	
Nikki Thompson	Children's Service Manager	Barnardo's CareFree Young Carers Service
Pretty Patel	Principle Lawyer	Legal Services, Leicester City Council
Rama Ramakrishnan	Service Manager	NSPCC
Shabir Ismail	Deputy Principal	Leicester College
Sue Ashwin	Vice Principal	Wyggeston QE College

Programme Group Chairs		
Member	**Programme Group**	**Agency**
Adrian Spanswick	Safeguarding Effectiveness Group	Leicester City Clinical Commissioning Group
Barney Thorne	Communications Group	Leicestershire Police
Clair Pyper	Serious Case Review Group	Children's Services, LCC
Elizabeth Best	MACFA	Children's Safeguarding Unit, LCC
Jasmine Murphy	CDOP	Public Health
Chris Nerini	LLR Procedures and Development Group	Head of Strategy,
Leicestershire County Council		
Victor Cook	LLR Child Sexual Exploitation	Service Manager- Safeguarding, Leicestershire County Council
Steve Davey	LLR Safeguarding Multi-agency training, Learning and Development, Commissioning and Delivery Group	

Appendix (b): LSCB Members Record of Attendance

Organisation/Agency/ Role	Record of attendance				
	June 2014	September 2014	December 2014	March 2015	%
Independent Chair	✓	✓	✓	✓	100
Director of Children's Services	✓	✓	✓	✓	100
Leicester City Council	✓	✓	✓	x	75
Leicester Partnership Trust	✓	✓	✓	✓	100
Clinical Commissioning Group	✓	✓	✓	✓	100
University Hospitals Leicester	✓	✓	✓	✓	100
Leicestershire Police	✓	✓	✓	✓	100
Lay Member	✓	✓	✓	✓	75
Lead Member for Children's Services	✓	✓	✓	✓	100
Leicestershire & Rutland Probation Trust	✓	✓	✓	✓	100
CAFCASS	✓	✓	✓	x	75
Further Education Colleges	✓	✓	✓	✓	100
Schools representation	x	x	✓	x	25
Youth Offending Service	✓	x	✓	✓	75
Average total attendance	87.5%				

Sub-Group	Record of attendance %
	April 2014 to March 2015
CDOP	100
FGM	100
MACFA	100
Media/Communications	0
	100
SEG	100
Average total attendance	**83.3%**

Appendix (c): Values Statement

JOINT LSAB/LSCB VALUES STATEMENT
The values that the Leicester Safeguarding Boards are committed to are as follows:

[1] All people of Leicester have the right to:

- dignity, choice and respect
- protection from abuse and/or neglect
- effective and co-ordinated work by all agencies to ensure a holistic child/person centred response
- the best possible outcomes, regardless of their age, gender, ability, race, ethnicity, religion, sexual orientation and circumstances
- high quality service provision

[2] Safeguarding the wellbeing of children, young people and adults is a responsibility we all share.

[3] Openness, transparency and sustainability will underpin the work of the Boards.

[4] Participation by children, young people and adults is essential to inform services, policies, procedures and practices.

[5] Services to meet the individual needs of children, young people and adults aspire to reach the highest standards.

[6] Constructive shared learning to protect children, young people and adults will be integral to the Boards' business.

[7] Celebration of strengths and positive achievements is important to the Boards, as is the commitment to a process of continuous development and improvement.

Appendix (d): Early Help Figures

Indicator	Actual May 2014	Actual Jun 2014	Actual Jul 2014	Actual Aug 2014	Actual Sep 2014	Actual Oct 2014	Actual Nov 2014	Actual Dec 2014	Actual Jan 2015
Number of initial contacts to Duty and Advice	2150	1933	1662	1675	1800	2142	2071	1571	1862
Number of referrals to social care	496	419	323	226	381	402	367	348	398
% contacts progressing to referrals	23.1%	21.7%	19.4%	13.5%	21.2%	19.4%	17.7%	22.2%	21.4%
Number of children in need during the reporting period						2268	2606	2587	2587
Cases allocated to CIN Team Managers								105	11
CIN child seen within last 15 working days (report)									39.5%
CIN child seen within last 20 working days (4 weeks)									48.0%
CIN child seen within last 30 working days (6 weeks)									59.3%
CIN child seen within last 60 working days (12 weeks)									76.2%

Indicator	Actual May 2014	Actual Jun 2014	Actual Jul 2014	Actual Aug 2014	Actual Sep 2014	Actual Oct 2014	Actual Nov 2014	Actual Dec 2014	Actual Jan 2015
% cases with case notes recorded within 28 days							80.5%	81.9%	92.0%
% cases with supervision recorded within 36 days							58.9%	62.5%	70.7%
% referrals progressing to single assessment	52.4%	57.5%	58.2%	65.9%	65.4%	61.7%	60.5%	62.6%	57.5%
Number of single assess-ments open at month end	546	635	494	458	458	561	564	607	315
Number of single assess-ments opened within the month	274	262	189	166	269	276	236	230	239
Assessments open at month end that have gone beyond 45 days from the start of the assessment	97	138	204	195	97	122	160	187	30
% of assessments open at month end that have gone beyond 45 days from the start of the assessment	17.8%	21.7%	41.3%	42.6%	21.2%	21.8%	28.4%	30.8%	9.5%
S47 enquiries within the period	96	126	124	88	93	134	149	89	146
CIN child seen within last 60 working days (12 weeks)									76.2%

Indicator	Actual May 2014	Actual Jun 2014	Actual Jul 2014	Actual Aug 2014	Actual Sep 2014	Actual Oct 2014	Actual Nov 2014	Actual Dec 2014	Actual Jan 2015
S47 completed within 15 days	56.3%	54.8%	69.4%	84.1%	86.0%	68.7%	75.2%	78.7%	90.4%
% Initial child protection conferences held within 15 days of the strategy discussion	75.0%	50.0%	50.0%	63.0%	71.0%	47.0%	76.0%	62.0%	88.0%
Number Initial child protection conferences				24	14	32	25	21	17
Number of children subject to a child protection plan at the end of the reporting period	312	309	309	324	299	299	322	349	363
% Review child protection conferences held within 3 months of the initial conference and six monthly thereafter	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix (e)


Strategic Partnerships
Health and Wellbeing Board
Children's Trust
Stay Safe Early Help
Leicester Safeguarding Children Board
Business Delivery Group
Strategic Partnerships
Leicester Safeguarding Adults Board
Safer Leicester Partnership
Domestic Violence
Programme Groups
Safeguarding Effectiveness Group
Serious Case Reviews
Child Death Overview Panel
LLR Safeguarding Multi-Agency training, Learning and Development, Commissioning and Delivery Group
Programme Groups
Communication
Leicester, Leicestershire and Rutland Procedures and Development
Child Sexual Exploitation, Missing and Trafficking
Reference Groups
Children and Young People Engagement
Frontline Practitioners Engagement
Leicester, Leicestershire and Rutland Neglect
Reference Groups
Female Genital Mutilation Task and Finish Group
Voluntary and Community Sector

Appendix (f): LSCB Team's supporting role

The LSCB has an administrative and officer level support team to provide support, advice and guidance to the LSCB as well as facilitating multi-agency actions alongside individual agency representatives. The team consists of;

- LSCB Board Manager
- LSCB Policy Officer
- Training Officer
- Child Death Overview Panel Officer
- Full time administrator
- Part time administrator

It is important to note, this team is not the LSCB: it is there to support the agencies that make up the LSCB and does not hold responsibility for the work of the LSCB.

The team's contact details are included as follows:

LSCB Officers		
Name	**Role**	**Contact Details**
Janet Russell	Interim Manager	0116 454 6525 Janet.russell@leicester.gov.uk
Pratima Patel	Policy Officer	0116 454 6524 Pratima.patel@leicester.gov.uk
Emma Ranger	LLR Project Development Officer	0116 454 6523 Emma.ranger@leicester.gov.uk
Sanjiv Pattani	Interim Project Officer	0116 454 4263 Sanjiv.pattani@leicester.gov.uk
TBC	LSCB Administrator	
TBC	LSCB Administrator	
Board Office	0116 454 6520 lcitylscb@leicester.gov.uk	

Leicester
Safeguarding
Children Board

Executive Summary Improvement and Business Plan 2015 – 2017

Introduction

In March 2015 Ofsted published their inspection report on Local Authority Children's Services and the effectiveness of the LSCB. Ofsted judged children who need help and protection in the city to be 'inadequate'. The LSCB arrangements to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children were also judged as 'inadequate'.

Ofsted have made 24 recommendations for improvement for the Local authority and 9 for the LSCB. The Local Authority have been issued with Notice for Improvement from the Department of Education. Actions within the improvement notice are timetabled for completion within 18 months from issue of the Notice and an improvement Board has been established.

An improvement plan has been devised and agreed by Board members which will be monitored by the Improvement Board as part of the Improvement Notice issues by Department for Education on March 2015.

The Ofsted findings offered some confirmation of the credibility of the LSCB self-evaluation, as much of the areas identified at the Board Development Day for areas for development are featured in the Ofsted Report. The Ofsted Inspection outcome is subsequently viewed as further endorsement of the work that had indeed already begun to improve and strengthen the safeguarding arrangements in Leicester and is integral to the LSCB Business and Improvement Plan 2015-2017.

The business priorities for 2015-17 for the LSCB have been agreed in response to the Ofsted Inspection findings and from the review of the Local Safeguarding Children Board. They have also taken account of the outcomes from the LSCB development day in September 2014.

The LSCB Business and Improvement Delivery Plan for 2015-2017 has been developed and has a complex and evolving transformation agenda.

This executive summary, is underpinned by a detailed LSCB Delivery Plan. Together these plans will shape and monitor the activity the work of the Business Delivery Group and the LSCB Programme Groups and the contribution of partner agencies. This plan and the work of the LSCB is further complimented by the LSCBs Quality Assurance and Performance Management Framework (QAPMF).

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 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 key 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 key 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

LSCB Priority Areas Diagram

STRATEGIC PRIORITY AREA	Objective	Key Activity	Responsible Lead	Desired Outcome	Timescale/ Progress Review Points
1 **POST OFSTED IMPROVEMENT PLAN**	The identified priorities and areas for improvement within the OFSTED findings (March 2015) are embedded within the LSCB business plan as well as being subject to a separate improvement plan.	a. LSCB to review its current work programme to respond to the findings of the inspection.	LSCB Chair LSCB Members	The LSCB to work to improve safeguarding arrangement and achieve a 'Good' OFSTED grade at re-inspection. Children and Young people are safer and perceive their circumstances as having improved/have better outcomes as a result of the intervention they receive from agencies.	March 2015 – Ongoing quarterly Review periods
2 **CORE BUSINESS** **ProS4 Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013)**	The LSCB has improved governance arrangements and is compliant in its delivery of core Board functions.	a. LSCB to conduct its own self evaluation programme to further refine governance arrangements, priorities and planning and work methods. b. Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013) c. Develop strategic plan for 2015-2017 d. Section 11 audits are to be completed with SMART action plans for identified areas of improvement. e. Enhance operational arrangements of the LSCB and its partners f. Board office to coordinate and analyse S11 audits findings to be reported back and inform business planning.	LSCB Chair LSCB Members LSCB Business Manager	There is an effective Safeguarding Children Board in Leicester that meets it statutory obligations fully and ensures that safeguarding arrangements in the region are robust and protect children.	From April 2015 and Ongoing September 2015 April 2015 From April 2015 and Ongoing October 2015

STRATEGIC PRIORITY AREA	Objective	Key Activity	Responsible Lead	Desired Outcome	Timescale/ Progress Review Points
3 **LSCB IDENTIFIED PRIORITIES FOR 2015 - 2017** **S5 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** **S6 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 LSCB needs to be assured that the multi-agency response is robust in supporting children and young people in specific circumstances. • Evaluation of early help • Strengthen CSE • Female Genital Mutilation • Neglect • Voice of the Child • Domestic Violence	[a] The LSCB to know about a child's journey starting with all children in the local area through levels of need to those who are care leavers. [b] Evaluate the current operation of the contribution of the multi-agency early help offer, including partners understanding and implementation of their early help responsibilities and the understanding and application of service thresholds [c] 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 [d] To ensure children at risk of FGM are identified and responded to effectively in communities where the practice is known. [e] Establish a neglect reference group responsible for producing and driving the neglect strategy.	Chair of SEG LSCB Members LSCB Policy Support Officer Chair of Early Help Group Head of Service Early help Chair of SEG LSCB Members LSCB Policy Support Officer Chair of Early Help Group Head of Service Early help Chair LLR CSE Group LCC Lead for CSE LSCB CSE Co-ordinator Chair of LLR FGM Group LSCB Policy Support Officer Chair of LLR Neglect Group LSCB Policy Support Officer Chair LLR Domestic Violence Steering Group Head of Service Community Safety Domestic Violence Co-ordinator Chairs of Strategic Partnership LSCB Policy Support Officers Chairs of Strategic Partnership LSCB Policy Support Officers Chairs of Strategic Partnership LSCB Policy Support Officers	There is an effective multi-agency response to safeguarding concerns and thresholds are well understood and applied. There is improved access for families to early help and prevention services. Children and young people have the right intervention at the right time during their journey through safeguarding systems. Ensure children and young people are effectively safeguarded from Child sexual exploitation. Increased identification of children and young people at risk of FGM. Awareness raising campaign plan in place for communities. The Board has an overview of neglect in the region that provides an indication of what areas require further analysis and development of practice, training and services Practitioners have a greater awareness of the signs of domestic violence and mental health/substance misuse and the impact on children and young people. Referrals are consistently made and families receive a timely response and the right services.	All Programme Groups From April 2015 and Ongoing LSCB Business Delivery Group is to receive reports, exception or otherwise, from all programme and reference groups. Quality assurance and Performance Management on progression and the impact of the themed areas, including thematic areas of audit activity on a quarterly basis. Children and young people views and frontline practitioner views will be known and inform development of work in all areas. LSCB to receive reports on themed priority areas as scheduled and/or by exception.

STRATEGIC PRIORITY AREA	Objective	Key Activity	Responsible Lead	Desired Outcome	Timescale/ Progress Review Points
3 **LSCB IDENTIFIED PRIORITIES FOR 2015 - 2017**		[f] Establish links with Safer Leicester Partnership (SLP) regarding the shared priority relating to domestic violence. Coordinate the information, data and evaluate the effectiveness of the domestic violence strategy.		Strengthen the interface between the Strategic Partnerships to ensure a consensus view in terms of identify the most vulnerable children, young people and their parents/carers in the Local Authority area. Ensure there is a targeted and coordinated approach across Strategic Partnerships to reduce risks. Assure a strategic interface between adults and children's safeguarding agenda's to improve service delivery creating stronger families through the Think Family approach to safeguarding.	
4 **PARTICIPATION & ENGAGEMENT** **L3 Establish a clear line of sight and reporting from front line practice to the Board so that concerns and challenges can be identified more promptly and accurately.**	Establish a clear line of sight and reporting from front line practice to the Board so that concerns and challenges can be identified more promptly and accuratelyThe LSCB needs to assured the 'voice of the child', participation & engagement from parents/ carers and frontline practitioners informs the planning, commissioning and delivery of services.	[a] Develop and implement a plan to engage with children and young people in order to hear and act upon their voice [b] The LSCB will establish an Engagement and Participation group to assure the voice of the child in the LSCBs work. [c] The group will produce and implement an Engagement and Participation Strategy.	LSCB Member Agencies Chairs of LSCB Programme Groups Chair of Practitioners Forum LSCB Policy Support Officer Chair of Communications Programme Group LSCB Member Agencies LSCB Policy Support Officer	The communities that children and their families are a part of, understand and are engaged proactively in the safeguarding agenda and raise their awareness of what to do if they are concerned about themselves or others Board members are able to hear from front line practitioners. Practitioners on the frontline will report good knowledge of safeguarding and demonstrate that it is implemented in practice	From April 2015 and Ongoing LSCB Business Delivery Group is to receive reports, exception or otherwise, from Chairs of all programme and reference groups on the work undertaken to ensure the progression of work regarding the Voice of the Child and frontline practice is considered.

STRATEGIC PRIORITY AREA	Objective	Key Activity	Responsible Lead	Desired Outcome	Timescale/ Progress Review Points
5 **EFFECTIVENESS OF MULTI-AGENCY PRACTICE** **L3 Establish a clear line of sight and reporting from front line practice to the Board so that concerns and challenges can be identified more promptly and accurately.**	To be assured the multi-agency delivery of child protection services to children and young people and their families is consistent in approach, whereby needs and risks are assessed and they have opportunity to access the right services at the right time and intervention is timely and keeps children and young people safe. The LSCB to be assured that the workforce is fit for purpose and is able to understand and apply safeguarding knowledge and have the skill to respond according to safeguarding concerns, in a way that is proportionate to their roles and responsibility.	[d] The LSCB will establish a Practitioners Forum and will support practitioners to discuss key issues in relation to practice and areas of learning and development. [e] The LSCB will develop a Communication Strategy that supports dialogue with the community.	[a] Develop an improved quality assurance and performance management framework. To include data analysis of [1] Core data sets [2] Single agency audits/S11 audits [3] MACFAs [4] SCR [5] CDOP [6] Engagement and participation, 'Voice of the child', parents or carers [7] Engagement and participation with practitioners. [8] LA/LSCB quality assurance programme purposeful data extraction [b] SEG to develop an understanding of data to inform Leicester's JSNA and use it effectively to strengthen service planning across agencies. [c] 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. [d] Review and develop upon the multi-agency case file audit process to "increase the number frequency and range of multi-agency audits initiated by the Board".	Communicate to persons working with CYP and families how best to keep children safe and encourage early response to concerns amongst agencies and communities, of the need to safeguard children.	April 2015 and Ongoing LSCB Business Delivery Group is to receive reports, exception or otherwise, from the Safeguarding Effectiveness Group (SEG) on a quarterly basis. From Sept 2015 and Ongoing From Sept 2015 and Ongoing From June 2015 and Ongoing

STRATEGIC PRIORITY AREA	Objective	Key Activity	Responsible Lead	Desired Outcome	Timescale/ Progress Review Points
6 **CHILDREN'S WORKFORCE DEVELOPMENT**	C, YP&F are safeguarded and supported by practitioners who are trained to a high standard.	[a] Elicit the views of frontline practitioners to inform training and practice developments [b] Seek assurance that practitioners have appropriate caseloads and are provided with effective supervision. [c] Targeted work to promote the consistent use of multi-agency thresholds and child protection procedures. [d] Ensure access to relevant training and development opportunities [e] Develop and embed the competence framework to evaluate the effectiveness of learning from multi-agency training and its impact on frontline practice and CYP.	Chair of LLR Procedures Development Group LLR Training and Development Co-ordinator	Feedback from service users is sought, evaluated, analysed and utilised to develop practice. This includes the analysis of data from complaints and LADO. Staff are receiving relevant training and learning opportunities that enable them to undertake their safeguarding duties. The outcome of learning is evidenced in consistently good practice and improved outcomes for children, young people and families.	March 2016/2017