Suffolk Safeguarding Children Board
www.suffolkscb.org.uk

Suffolk Local Safeguarding Children Board

Annual Report 2014-15

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1.0 Introduction and Chair's Summary

1.1 Introduction

I am delighted to introduce the Suffolk Local Safeguarding Children Board (LSCB) Annual Report 2014-15 which sets out how we have met our statutory duties and addressed the priorities we set in our Forward Delivery Plan for 2014/5 and gives a summary of safeguarding work in Suffolk.

I took over as Independent Chair of Suffolk LSCB in December 2014. It is my intention to build on the dedicated work undertaken by Peter Worobec in his role as Independent Chair in Suffolk for over eight years and I would like to personally thank Peter for his support and advice throughout my induction to the work of Suffolk Local LSCB.

In my first months as Chair, I have been able to consider and evaluate the work of Suffolk LSCB. I see strengths in a good Board Structure, good commitment from partners, a focus on priorities and clear strategic support at a senior level across the agencies.

The Learning and Improvement Group is well resourced and effective There is a clear and well implemented Learning and Improvement Strategy with considerable practice auditing and action resulting. The Section 11 audit process is robust with good peer challenge and support. A stronger approach to include commissioned services needs to be developed over the next year.

Service risks are being clearly identified and a new risk register approach is ensuring these are monitored and mitigated. The culture of challenge between the partners is strengthening but the strategic focus of this challenge needs to be refined.

A revised performance data set is helping the Board to concentrate scrutiny on the most important things. The data set is improving but the quality of analysis need to be developed. The Board needs a clearer focus on impact and outcomes and to increase its emphasis on hearing and acting on the views of children and young people and front line practitioners

The MASH has been embedded in practice and is well resourced with effective systems. However all partners need to develop their understanding of role of the MASH and the thresholds for social care in order to reduce unnecessary contacts into the MASH for children who could be supported in early help service. The Early Help Offer needs to more clearly demonstrate its effectiveness in in ensuring children and young people's needs are met at the earliest stage;

The introduction of the Signs of Safety model is beginning to have an impact on safeguarding work. Training has been well taken up and practitioners are demonstrating a clear understanding of the model. A recent research review on working with avoidant families, undertaken as a result of a recent serious case review, emphasised the value of

the Signs of Safely approach in engaging them. During the coming year the Board will receive an external evaluation of the impact of the use of the model.

There is a concern about the consistent attendance of all relevant agencies at child protection conferences and partners need to ensure that this is addressed urgently.

There has been a focus on improving work with Missing Children and the numbers have slightly reduced over the last year. The Exploited Children action plan is now more focussed and additional capacity secured by the chair from partners is assisting in driving it forward. There needs to be continued urgency in the implementation of the Exploited Children action plan.

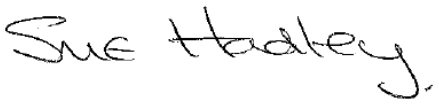
A strong case review panel is ensuring that lessons from the last Serious Case Review and other multi-agency reviews are being learned and clear improvement plans are successfully implemented. The panel also reviews and learns from examples of good practice.

Whilst a number of policies, procedures and practice guidance have been successfully developed of reviewed over the last year the Planning, Policy and Engagement Group has not been as effective as it might due to inconsistent attendance and the lack of a Board Partner chair. The group now has a new Chair and work plan which is aimed at moving this work forward over the next year. All partners need to ensure that they allocate appropriate staff resources to progress this work.

The Board has not yet had an in depth look at the safeguarding of disabled children and this is scheduled for the coming year.

I would like to thank all our partners in contributing to the LSCB meetings and sub groups and supporting and participating in our multi-agency audit work, serious case reviews and associated groups.

It is my intention that we continue to strive for excellence in the work we do and capture the evidence to demonstrate the difference we have made in safeguarding children, young people and their families. I outline below the priorities and recommendations for the LSCB for 2015/16.



Sue Hadley, Independent Chair
August 2015

Priorities for 2015/16

The LSCB Executive Group received a report in March 2015 on the impact of the Forward Delivery Plan and outstanding actions. Those outstanding actions, along with information received from audits, discussion at the Board, national and legislative drivers and the Chair's analysis have informed a set of outcome focussed priorities for 2015/16. They are:

- ✓ Deliver on the Exploited Children Action Plan and monitor the impact on CSE awareness and safeguarding practice across the county;
- ✓ Ensure that the implementation of the Early Help Strategy is achieving successful outcomes for children and their families;
- ✓ Ensure the development of a co-ordinated approach to Domestic Abuse across the partnership with clear strategic ownership in order that the true picture and impact on children of Domestic Abuse can be understood by the LSCB;
- ✓ Evaluate the impact of the Multi Agency Safeguarding Hub
- ✓ Ensure safeguarding risks across the LSCB partnership, particularly those as a result of increasing demand for services and on-going re-shaping of services are identified and acted upon;
- ✓ Ensure that as much learning as possible is gleaned, shared and embedded from Practice and Serious Case Reviews; and
- ✓ Ensure that the implementation of actions arising from Case Reviews improves the quality of professional practice
- ✓ Ensuring the work of the Board is focussed on assessing the impact of services on improving outcomes for children, young people and families

Recommendations for Partner Agencies

i. Partners are asked to consider and take appropriate action on the following recommendations:

ii. Ensure the voice of the child is heard within all aspects of the safeguarding arena, including the commissioning and shaping of services and particularly where children disclose abuse or exploitation, and for those children who have a disability;

iii. Multi-agency contribution to the LSCB should remain a high priority. Every agency must take account of the priorities within the LSCB Forward Delivery Plan and to their own contribution to the shared delivery of the work of Suffolk LSCB including the chairing and attending of sub-groups and appropriate and regular representation at Child Protection Conferences.

iv. Ensuring the role of the MASH and the thresholds for social care are understood in each agency.

v. Working across partners to improve data sharing and analysis in order to improve the evaluation of the impact of services on improving the outcomes for children, young people and families

vi. Ensure that Suffolk LSCB is aware and understands the impact of any organisational restructures and financial constraints on your capacity to safeguard children and young people in Suffolk.

1.2 Executive Summary

Suffolk LSCB recognises that the effectiveness of safeguarding across the county is dependent on the quality and co-ordination of the work of those people in direct contact with children, young people and their families. This report seeks to outline some of the achievements of the LSCB in continuing to develop a strong, cohesive partnership with the key focus on safeguarding. Alongside this is the ongoing monitoring, challenge and support function to ensure there is clear progression and impact in safeguarding practice across the partnership in Suffolk.

Local Context: This section (2) paints a picture of Suffolk utilising information from the 2015 State of Suffolk (Joint Strategic Needs Assessment JSNA) published by Suffolk Health and Wellbeing Board as part of the joint Health and Wellbeing Strategy.

Purpose, governance and accountability: Sections 3 and 4 detail the governance arrangements for this report and the statutory and legislative context for the LSCB. It also gives some commentary and statistics on the engagement and participation of partners and an insight into sub group functions and structures.

Section 5 provides a focus for the progress of the LSCB in achieving the objectives of the Forward Delivery Plan; that being to fulfil and exceed our statutory responsibilities in accordance with the Children Act 2004, the LSCB Regulations 2006, and current guidance and best practice.

Section 6 looks at the work undertaken to ensure that LSCB Multi Agency Policies and Procedures are useful, relevant and up to date. Policy work includes the Exploited Children Strategy and Action Plan and the Neglect Strategy and Guidance.

Sections 7, 8 and 9 provide an overview of how the LSCB determines its own effectiveness as well as the effectiveness of collective effort to safeguard and promote the welfare of children. It details some of the monitoring reports the LSCB receives, including Section 11 (Children's Act 2004) Reports; S175/157 Education Safeguarding Reports (Education Act 2002) and a report on the work of the Local Authority Designated Officers (LADOs) who are responsible for managing allegations against professionals. It also

details the work the LSCB has undertaken in its multi- agency audit programme, key partner agency data oversight and via the Learning and improvement framework; including the impact on practice from Serious Case and associated reviews.

Section 10 gives a summary of multi-agency training activity across the partnership, and the annual multi-agency safeguarding conference hosted by University Campus Suffolk in conjunction with the LSCB.

Section 11 focuses on the work of the Child Death Overview Panel and provides details on the work of the panel in reviewing child deaths in order to identify learning and any modifiable factors that can be addressed locally or recommendations made for national change.

Section 12 provides information on Serious Case Reviews in Suffolk

Section 13 Essential Information

Appendices

2.0 Local Context – Suffolk Statistics

Suffolk is a large county covering approximately 1,466 square miles. It remains a rural county with a total population of approximately 750,000*. 2011 Census figures note that 8.2% of Suffolk residents were born outside of the UK and that 4.7% of Suffolk residents were from an ethnic group other than white.

There were 7,792 live births in Suffolk in 2013. The estimated number of children aged 0-4 years old is 42,700 with a percentage of 12.4% of the total population being between the ages of 5-15.

Suffolk comprises of Suffolk County Council, Ipswich Borough Council and 6 District Councils, Babergh, St Edmundsbury, Mid Suffolk, Suffolk Coastal, Forest Heath and Waveney. Ipswich is the most multicultural local authority with 11% of its residents from an ethnic group other than white. 14.1% of students in Suffolk state funded primary schools come from a Minority Ethnic Group.

There are three Clinical Commissioning Groups (CCGs) one of which covers outside the Suffolk Boundary into Norfolk. A number of key agencies work across Suffolk and Norfolk

The Suffolk economy is characterised by stable employment and growth rates, but lower than average productivity and wages. It is reasonably affluent overall, but has significant pockets of rural and urban deprivation.

It is estimated that approximately 1 in 7 children live in relative poverty (15%) in Suffolk. 7.4% of Suffolk's population live in the 20% most deprived areas in England.

64.4% of children age 0-5 eligible to register are registered at a Children's Centre in Suffolk. The percentage of eligible 2 and 3 year olds accessing funded childcare places in Spring 2015 was 67% and 90% respectively.**

The first phase of the Suffolk Family Focus programme ran for 3 years from **April 2012 - April 2015**. Suffolk claimed for **1150 families** which was the maximum possible and all targets were achieved. The Suffolk Approach for Phase 2 is that it is part of the re-structuring under the transformation Programme Making Every Intervention Count (MEIC). The expanded national Troubled Families Programme starting in January 2015 in Suffolk allows all cases that come to the notice of CYPS to potentially be an identified Suffolk Family Focus Family. Suffolk has been set the challenge of working with and achieving Sustainable Progress for 3950 families over 5 years.

Suffolk County Council Children and Young People's Specialist Service were working with 3,654 cases and there were 732 looked after children in March 2015 and 453 who were the subject of a Child Protection Plan.

Regional Collaboration Suffolk LSCB

The LSCB has good links with other LSCBs in the Eastern Region through network meetings for LSCB Independent Chairs and Business Managers. Good practice guidance, lessons from Serious Case Reviews etc. is shared and collaborative work undertaken. A recent example of a collaborative piece of work is the development of a regional LSCB self-assessment toolkit.

The Independent Chair is also a Member of the Association of Independent LSCB Chairs which is also a source of good practice advice and support.

* Figures for 2012 from Department for Communities and Local Government (2014a) Council Taxbase 2013 in England

** Data Source: System One Health Data (Baseline), eStart Data (children registered), EYC funding data

3.0 Purpose of the Annual Report

Working Together 2015 states that 'the Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area *(this is a statutory requirement under section 14A of the Children Act 2004).* The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing Board'.

It is the intention of the LSCB to share this report with all partner agencies and with those that have influence over the services provided to children and families in Suffolk.

The purpose of this report is:

- To provide an outline of the main activities of Suffolk LSCB and the achievements of the Board during 2014-15;
- To provide a rigorous and transparent assessment of the performance and effectiveness of local services;
- To provide the public and partner agencies with an overview of LSCB safeguarding activity, including lessons from reviews undertaken;
- To identify weaknesses and challenges in service development for action in the year ahead.

In preparing this report, contributions were sought from Board partners and the Chairs of LSCB sub-groups, along with reports that came to the full Board meetings or through statutory reporting. These reports will not be repeated in full in this report, but have been utilised to inform the assessment of effectiveness of the LSCB.

The business of the LSCB in the period under review in this report (April 2014 - March 2015) was directed by the Business Plan 2013/15 and Forward Delivery Plan 2014/16.

Our strategic objectives during the currency of the Forward Delivery Plan were identified to assist us to fulfil and exceed our statutory responsibilities in accordance with the Children Act 2004, the Local Safeguarding Children Board Regulations 2006, the latest guidance and best practice issued by Ofsted in November 2013 and both locally and nationally published Serious Case Reviews.

4.0 Governance and Accountability

The work of the LSCB in 2014/15 was guided by the statutory guidance **Working Together to Safeguard Children 2013.** The revised **Working Together 2015** was published on the 26th March 2015.

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

The HM Government publication **Working Together to Safeguard Children 2013** sets out the statutory objectives and functions of LSCBs that include developing local safeguarding policy and procedures and scrutinising local arrangements.

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

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.
- Regulation 5 of the Local Safeguarding Boards Regulations 2006 sets out that the functions of the LCSB in relation to the objectives under Section 14 of the Children Act 2004 are as follows:

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

(i) the actions to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) co-operation with neighbouring children's services authorities and their Board partners

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can be best done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them of ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned

Regulation 5(2) relates to the Serious Case Review function;

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

Regulation 6 relates to the LSCB child death functions.

Suffolk LSCB, through an established Learning and Improvement Framework provide challenge and support to ensure that partner agencies continuously strive to improve their safeguarding practice and are supported to do so.

<u>Changes to Governance Arrangements:</u>

In 2014/15 the following changes to governance arrangements were made:

- The Recruitment of a new LSCB Chair
- The Police and Crime Commissioner invited to become an Associate member of the LSCB
- Revisions to the Learning and Improvement Framework to ensure that the LSCB is better able to capture and demonstrate impact.
- Revisions to Terms of Reference and meeting structure for the Area Safeguarding Groups
- Development of Training Sufficiency Group
- Re-configuration of work streams for Missing Children, Gangs and Groups and Child Sexual Exploitation
- Update of Protocol between Health and Wellbeing Board, Corporate Parenting Board, Adult Safeguarding Board and LSCB.
- Active recruitment of representatives from all levels of the Education sector.

In addition to the above changes, the LSCB also has existing governance documents:

- LSCB Constitution
- LSCB Compact (outlines responsibilities of Board partners)
- Protocol between Health and Wellbeing Board, Corporate Parenting Board, Adult Safeguarding Board and LSCB.
- A Structure diagram (please see Appendix 2 for the structure diagram)
- Terms of Reference for the sub-groups

These documents are reviewed as part of the annual reporting/business planning cycle and are available on the LSCB website at www.suffolkscb.org.uk. In the forthcoming year, work will continue on developing the governance arrangements with key strategic partnerships, particularly those with an influence on Community Safety.

Suffolk LSCB has a large and active membership that fulfils the statutory criteria and has been independently chaired since 2006. It meets on a quarterly basis and despite another year of significant change in personnel within partner agencies, attendance and commitment to resource the work of the Board continues to be strong. The Board has two Lay members who play an active and full role. There is a clear protocol between the LSCB, Safeguarding Adults Board, Corporate Parenting Board and Health and Wellbeing Board.

There is a four part structure to the Board. The main Board providing a clear strategic lead and an Executive Group that meets 8 times a year [pre and post Board meetings] and drives forward the business and operation of the LSCB. The Executive Group develops and agrees the agenda for LSCB meetings, commissions work required for meetings and ensures that before items are taken to the Board clear solutions and/or proposals have been formulated.

A series of sub groups, chaired by members of the LSCB sits under the Executive Group with related or specific task and finish groups formed to undertake focussed time limited pieces of work when required.

There are 4 levels of membership for Suffolk LSCB.

Full and Standing Members of the LSCB are required to sign up to the LSCB Compact [a contract with members], which sets out their responsibilities and commitment. Standing members of the LSCB are key partners on the Multi-Agency Safeguarding Hub [MASH] Strategic Group and signatories to a multi-agency Information Sharing Protocol.

Full Members: Partners with a statutory duty to co-operate or where the Board considers membership to be essential:

- Independent Chair
- Director of Children's Services, Suffolk County Council [SCC, CYPS]
- NHS England and Clinical Commissioning Groups [CCG's]
- Suffolk Constabulary
- NHS Trusts and Foundation Trusts [including Ambulance Service]
- Suffolk Youth Offending Service [YOS]

- The Norfolk and Suffolk Community Rehabilitation Company Limited
- National Probation Service
- Children and Family Court Advisory and Support Service [CAFCASS]
- District and Borough Councils [1 representative]
- Senior Officer, Adult Social Care, Suffolk County Council [SCC]

The Lead Member for Children's Services is a participating observer of the LSCB and routinely attends meetings as an observer, receiving all written reports.

Standing Members: Representatives of agencies, which do not have an obligation under statute, but are full members and expected to attend all meetings

They will include:

- Representatives from schools, colleges and Suffolk County Council [SCC] Children and Young People's Services [CYPS -Education Services]
- Representative from NSPCC
- Representative from the voluntary sector
- Suffolk Fire and Rescue Service
- Designated Doctor/Nurse
- Community Lay members

Associate Members: are not full Board Members with 'voting rights', but would receive all papers and can request items to be included on the agenda or attendance at a particular Board meeting, by arrangement, through the LSCB Manager. Members include:

- Head of Children and Young People's Services [CYPS] Health Improvement and Sexual Health, Public Health
- Director of Nursing, Quality and Patient Experience, James Paget University Hospital
- Director of Quality and Assurance, East Coast Community Healthcare
- Police and Crime Commissioner

Associate members can be a member of any sub-group other than Executive Group and will be invited to attend 1 LSCB meeting per year to update the Board on their agency/organisation using an agreed format.

Professional Advisors Representatives providing a range of professional or technical advice on a fixed or periodic basis**.** The LSCB should be able to draw on appropriate expertise and advice from the relevant sectors. Professional advisors will be invited to County Network events and receive a copy of the LSCB e-bulletin. Professional Advisors can be a member of any sub group other than Executive Group.

LSCB sub group structures are included as Appendix 2.

Chairing of the LSCB

This year brought a change of Independent Chair to Suffolk LSCB. Peter Worobec stepped down in 2014, having been Chair of the LSCB from 2006.

A new Independent Chair, Sue Hadley, was recruited in September 2014 and worked alongside Peter until a formal handover at the December 2014 LSCB meeting.

Sue brings extensive networking and partnership experience that comes from 37 years of experience in Children's Services, the last 15 years as a Senior Manager.

Working Together 2013 assigned the responsibility to appoint and hold to account on the effectiveness of the LSCB to the Chief Executive of the Local Authority. This responsibility was devolved to the Director of Children and Young People's Services in Suffolk and should be noted that Peter Worobec did not meet with the Chief Executive during his time in office. Changes to governance arrangements have ensured that in future years the LSCB Chair will meet with the Chief Executive at least once a year and the first meeting has already taken place.

In addition, the LSCB Chair meets regularly with the Director for Children and Young People's Services.

The Independent Chair of the LSCB is also commissioned to Chair the Executive Group and the Learning and Improvement Group bringing continuity to the audit and scrutiny function of the LSCB and independence and challenge to decision making at a strategic level. This, alongside attendance at the national LSCB Chair's conference and membership of the Eastern Region LSCB Chairs group ensures significant national and local messages of good practice are shared and disseminated.

On the retirement of Peter Worobec, the role of Chair of the Serious Case Review Panel was adopted by the Director of Children and Young People's Services. However, this has not, and will not, impact on the final decision making as to whether to conduct a Serious Case Review which will remain with the Independent Chair.

NOTE: Partner attendance at Board and Executive Meetings are illustrated in graph form in appendix 3.

The Board has had regular representation from a strategic manager for Learning and Improvement in Suffolk County Council. However representation from Schools has been a significant challenge for the LSCB this year, as is how they define and represent a whole sector. Regular attendance by a Secondary Head Teacher at the Board stopped due to a change in employment and the loss of that individual also meant a temporary break in communication between the LSCB and Schools Forum.

Fortunately there has been consistent attendance at LSCB Area Network Meetings and the LSCB has now secured representation at Primary, Secondary, Special, Higher and Governor Levels. The LSCB has also undertaken work throughout the year in supporting and advising schools in the Independent Sector in Suffolk and has plans to develop closer links, including Board representation, over the next twelve months or so.

In January 2015 NHS England wrote to the Chair to inform that while they recognised their statutory responsibility, and wanted to retain a seat on the Board, they were unable to send a representative on a regular basis and would only attend if there was a specific issue requiring their involvement. The Board has had to accept this although it is disappointing. It appears to be a national picture and the Association of Independent LSCB Chairs is raising this with the Department for Health.

From a Clinical Commissioning Group (CCG) perspective, a clash in executive meetings has meant that the named representative has been unable to attend on a regular basis, albeit Designated Professionals have been in attendance in a deputising role. It is hoped that meetings in 2016 can be some re-scheduling to avoid this.

Area Safeguarding Groups have continued to meet on a regular basis and are working to a revised Terms of Reference. The work of these groups is developing to incorporate more local scrutiny and challenge and to provide a supportive arena for local issues to be discussed and solutions found.

It is anticipated that a more formal information reporting system will be developed between the Area Groups and the LSCB in order for the Board to receive practitioner input on local safeguarding issues and for the practitioners on the ground to receive support and guidance from the LSCB. Further areas for development include the regular sharing of Multi Agency Safeguarding Hub (MASH) data within the area groups to provide an overview to the multi-agency partnership of the levels and themes of safeguarding activity in Suffolk, and more specifically, in their locality.

Participation of partner agencies in the LSCB

In order to encourage support and challenge across the LSCB partnership it is crucial that partner agencies contribute to the LSCB agenda to provide an overview of services, results of specific audit activity or items for information or discussion.

Contributions LSCB partners have made to the LSCB agenda include:

- Multi-agency update against Serious Case Review Action Plan at every meeting
- Multi-agency LSCB sub-group reporting at every meeting
- CYPS Updates on Statutory Assessment Framework – progress
- CYPS Progress against areas for improvement following Ofsted Inspection of Local Authority Arrangements for the Protection of Children
- CYPS/CCG/Police Update on the implementation of the MASH
- CCGs – Child Protection Information Sharing Programme
- LSCB Child Exploitation Lead (Police) - Self-assessment as to LSCB effectiveness in relation to Child Sexual Exploitation (CSE)
- Police – CCG – Update on the work of the Sexual Assault Referral Centre (SARC)

- Multi-agency contributions of audit activity and data from all partners to twice yearly performance reporting against the LSCB data set.
- Chairing of LSCB sub-groups is undertaken by representatives from Health, Police, and Suffolk County Council CYPS.

Unfortunately two of the LSCB sub-groups, Planning, Policy and Engagement (PPE) and Training Sufficiency have struggled to keep a quorate membership and partners have been encouraged to ensure there is sufficient representation across the LSCB sub groups.

The Voices of Children and Young People

As part of the Making Every Intervention Count initiative within Children and Young People's Services, the development of an Engagement Hub is encouraging meaningful discussions with Children and Young People as to how they can have an active voice in shaping the future of services.

Throughout a range of consultations young people have been very clear about what they want in a worker – they have said they want workers who are trustworthy, honest and who listen to them. They want to be involved in the decisions that affect them.

They would like more input, information and action on bullying from Schools, they would like a trusted adult to speak to who will listen and not jump to conclusions, and they would like to be able to have more confidential conversations without their parents/carers being informed immediately.

Young people welcome the better use of technology and social media to provide 24/7 access to information and advice. They want a safe shared online space where they can talk about their personal concerns and receive help and support from trained adults or peers.

There are now 15 trained e-Safety Peer Ambassadors in high schools and one young person from the Youth Offending Service, alongside 35 trained e-Safety Champions in primary schools all spreading the message and acting as leaders for internet safety in their own environments.

Feedback from the evaluations of those young people who have taken part in the Peer Ambassador programme evidences the engagement of young people of all ages in talking about their experiences of the internet and promoting the work of e-safety:

District and Borough Councils consult children and young people using a variety of methods. These include:

- Consultations on development of leisure activities and play areas in local communities
- Consultation via a Youth Council and through excellent relationships with schools

- Crucial Crew is an annual event where children to learn about personal safety. This service is reviewed after each event and the views of the young people shape the event for next year
- Customer Forums
- **e-safety in primary schools**
  - 'I am going to spread the word of e-safety'; e-Safety Champion aged 10,
  - 'I need to tell my friends you have to be 13 to have Instagram', e-Safety Champion aged 9,
  - 'I am only allowed to spend 2 hours online but if I could I would be on there all night, I love my tablet', Age 9,
  - 'I've seen things on YouTube that have made me too scared to sleep' Aged 10,
  - It was very useful to learn what was illegal and who the e-safety teacher is;'
  - 'The helpful answers given to us that I didn't know, and I got told how to deal with somebody who has been asking who I am on social media';
  - 'I found hearing about the consequences (the law) of peoples actions was useful,
  - 'My sister was playing my little pony and all of a sudden the ponies started doing rude things, we didn't know what to do, she is only 3 and now I know what had happened so can tell mum'
  - 'The internet can really ruin lives'

Effective Partnership Working

Partner agency representatives and Lay persons were offered the opportunity to give their perspective on the work of the LSCB. Positive examples of effectiveness include:

- Development of the LSCB Health Executive – bringing together Health representatives from across Suffolk;
- Improved understanding of practice, process and effectiveness by participation of Board partners in quality standard observations of child protection conferences;
- Working across the multi-agency safeguarding system to embed the Signs of safety approach;
- Improved engagement with LSCB Board particularly since the core membership includes the Designated Health Professionals;

- Further development of the Section 11 Children Act audit process and improved multi-agency challenge;

- Embedding the learning – recommendations from the evaluation of the methodology of the Serious Case Review feeding into informing the Case Review Panel;

- Ongoing development of Risk Register;

- The streamlining of formats for reports to LSCB ensuring links to delivery plan and demonstrating impact;

- The development of the new Forward Delivery Plan, getting collaborative buy-in from partners to take the work forward and getting a commitment that all members of the Board are partners in a shared endeavour, not just recipients of information;

- Strengthened scrutiny/ oversight of key safeguarding metrics;

- Raised awareness of Child Sexual Exploitation and the work of the Child Death Overview Panel (CDOP).

What has been the impact/effectiveness of the work of the LSCB on partners?

Partner agencies offered the following perspective:

- The Health Executive Group stated that the improvements to the LSCB website, the timely overview of the work of the Board sent out to partners and refreshed functioning of LSCB sub-groups had all been of positive assistance to practitioners and Designated Professionals

- The District and Borough Councils felt that having a raised awareness of safeguarding issues from across the country and moving forward on them (i.e. CSE, Serious Case Reviews) was a positive development.

- SCC Children and Young People's Services stated that they had experienced more holding to account by Board partners and that the impact for the LSCB was that agencies have a better understanding of safeguarding and have ownership in what they have to do.

- Ipswich Hospital Trust commented that they felt there was a more open sharing of risks and issues at Board meetings and that there was demonstrable evidence of holding all partners to account.

- Change of Independent Chair has gone well.

- Suffolk Constabulary reported that as an organisation, they have further developed cross -agency working and looked to enhance this where possible. Undertaking peer

review work has been a basis for additional working and understanding and they are becoming more efficient in respect of action plan management.

Challenges:

Partner agencies were also honest in their assessment of the Challenges to their effectiveness, individually and collectively:

- Connecting data to inform future planning of services to manage demand
- Capacity to deliver and to measure the impact of any service delivery is an ongoing challenge for all partner agencies.
- Funding pressures
- Domestic Abuse – the number of referrals to the Multi Agency Risk Assessment Conference (MARAC), ensuring information sharing between partners and strategic governance are all challenges for the partnership, particularly, Police, Health and Education.
- Increasing workload in the Multi Agency Safeguarding Hub

Opportunities:

- Using the Signs of Safety Mapping at the LSCB to understand where we are and introduce a working Signs of Safety model as a tool in the LSCB work.
- More opportunities to join up with adult safeguarding so that we meaningfully bridge the artificial divide that can sometimes arise when a person turns the age of 18.
- More sophisticated sharing of information, intelligence and data, building on the Multi Agency Safeguarding Hub (MASH) work and discussing how the MASH can assist with this.

Lay Persons:

The LSCB is fortunate to have two committed Lay Persons sitting on the Board. They provided the following commentary on their experiences of the LSCB over the last twelve months.

We both welcome your invitation to comment on the work of the Board over the last 12 months. We thought that a 'joint' response may be appropriate since as non-executive, non -operational but full members of the Board we do not have a direct output to deliver but are generally cross cutting throughout the Partners activities.

We have both been able to attend all this year's Board meetings, and various sub-groups as invited, and have found the experience both rewarding and meaningful. It is sometimes

difficult as a Lay Person to gain any sense of real contribution but we both feel that in our own individual ways and playing to our respective strengths and experiences, we have added value to the proceedings. This can, in our view, be demonstrated by sometimes asking the 'stupid' or 'awkward' questions which many other of the Partners would like to ask, but for whatever professional reasons feel they may be constrained in asking! We have been able to sit back, without any day to day responsibility for delivery, and seek explanations for actions, performance or indeed sometimes lack of performance, where those at the 'coalface' feel that they perhaps cannot ask at the risk of being 'unpartnerly'!

Our role has been that of objective 'critical friends' keen to recognise success but not inhibited in seeking answers to sometimes embarrassing performance shortcomings or at least seeking an understanding of the reasons why such may have occurred and so identifying any learning which can be taken away for future incorporation.

The last year has been a difficult one for many Partners with new organisational structures being introduced, changes in leadership and perhaps most apparently, budgetary constraints which Partners have valiantly tried to resist impacting on front line services. There has been challenge as demonstrated by the Family A case in Lowestoft and the lessons learnt therefrom and some success with the MASH/Safeguarding Hub and Signs of Safety moving from concept to operation with multiple Partners dedicating time and assets thereto.

We feel that the Board has provided a positive and helpful platform for identifying and resolving any issues arising between Partners and that it is very supportive of them wanting to work collaboratively rather than counterproductively. Partners appear to have developed a confidence to share what may otherwise be perceived as negative or unfavorable reports in order to increase understanding and identify ways in which collective solutions and improvements may be achieved

From our perception local Partners have also overcome some degree of national organisational torpor to achieve local effectiveness and success.

We feel that the year has been productive worthwhile and indeed a successful one for 'partnership working'.

LSCB Budget

Contributors to the LSCB Budget 14-15 were:

Babergh and Mid Suffolk District Councils
Forest Heath and St Edmundsbury District Councils
Suffolk Coastal and Waveney District Councils
Ipswich Borough Council
CAFCASS
NHS Suffolk
Norfolk and Suffolk Probation Trust
Suffolk County Council
Suffolk Constabulary

Details as to the breakdown of spending for the year 2014/15 can be found in appendix 4.

5.0 Challenge and Support

Working Together to Safeguard Children 2013 emphasises the importance of agencies working together and the pivotal role of the LSCB in promoting effective practice and monitoring the local arrangements. This is echoed in Working Together to Safeguard Children 2015.

Suffolk LSCB is made up of a wide range of agencies and professionals all of whom are committed to ensure the continued safeguarding and protection of children and young people in Suffolk. The work of LSCB partners to drive forward the work of the Board, to challenge and share data and learning experiences and actively work together to overcome hurdles to multi-agency working, demonstrates willingness and a desire to provide united services to vulnerable young people, children and their families.

Furthermore analysis of Serious Case Reviews, including our own, consistently highlight the importance of multi-agency working and the importance of the early sharing of information across agencies whenever a child is deemed to be at risk of serious harm.

In the last twelve months highlights of the added value and impact that Suffolk LSCB has had on safeguarding children are illustrated by the following examples.

Chairs challenges include:

- Review the effectiveness of the implementation of out of Authority placements of Looked after children as outlined in Department of Education Guidance issued in July 2014.
- Ongoing challenge of a lack of a MARAC steering group since the LSCB MARAC audit in 2014 and again as part of Police Section 11 update and the ongoing challenge of the lack of Governance and ownership of the Domestic Abuse strategy, including the MARAC function. This has been addressed by agreement being reached at the Health and Wellbeing Board to set up a Safer and Stronger Communities Group for Suffolk to provide oversight of the many partnerships tackling problems such as sexual exploitation, youth and gang violence and Domestic Abuse
- Lack of clarity around the commissioning intentions of NHS England with regard to forensic out of hours service provision for children under 13 years and the services to all children and young people over 13 years who present and need assessment and treatment. Development on resolving this is ongoing and the Chair continues to receive updates and assurances with regard to this issue.

- Robustness and delivery of Child Sexual Exploitation action plan and resources required to deliver. This challenge led to agreement for resources/capacity from LSCB Executive Group partners, allowing a small multi-agency team to dedicate several days a month to moving forward the delivery of CSE actions.

Key challenges from minutes of meeting include:

- **High level of re-referrals** to MASH (25% reported in half year performance report Dec 2014). Audit reviewed by Learning and Improvement group. Referred to Board in July to raise concerns re high % of re-referral and an audit commissioned.
- Sub Group reporting on audit work undertaken led to the development of a revised **Housing protocol for 16-17yr olds**
- **Education Representation on the Board** – repeated challenges and requests to Education led to named representatives for Primary, Secondary and Governor Services
- The challenge of the **Risk Register** – recording risks to service delivery. The Risk Register is a standing item at every Board meeting and provides support and challenge
- The challenge of Health Colleagues not receiving **Domestic Abuse/Domestic Violence notifications** from Police. This increases the risk to the family as at present holistic health assessments do not include this information. Ongoing discussions have identified a solution for this issue.
- The challenge on **attendance and participation in child protection conferences** following audit activity has resulted in regular reporting to the Board and LSCB partners undertaking a quality assurance role in conference activity.
- Challenges and policy revisions arising from Case Reviews are documented later in the report.

Progress on priority areas for 2014/15

The 2013/14 published Annual Report laid out the work of Suffolk LSCB for the 2014/15 year.

In March 2015, the LSCB Executive Group received a report on the impact of the Forward Delivery Plan over the previous twelve months and any outstanding actions. Those outstanding actions, along with information received from audits, priorities agreed by the LSCB and National Legislative drivers have informed a set of outcome focussed priorities for 2015/16 and have been agreed by the Executive Group and endorsed by the LSCB.

The report evidenced the progress made by the Local Safeguarding Children Board over the last twelve months and any outstanding/new challenges.

In revising the data set, identifying collective safeguarding risks and setting clear evidence based priorities; the LSCB's objectives aim to ensure that statutory responsibilities in accordance with the Children Act 2004, LSCB Regulations 2006, and latest guidance and good practice are fulfilled individually and collectively by partners.

Going forward, the updated Forward Delivery Plan aims to encapsulate all elements of any outstanding challenges and new priorities formulated as above. It aims to provide a clear framework for the LSCB and its sub-groups and work streams over the next twelve months.

Delivery of the Family 'A' Serious Case Review Action Plan

The SCR Action Plan has been a substantive agenda item for update on development/progress at each LSCB meeting and will continue to do so until all actions are completed and signed off to the satisfaction of LSCB Partners. The LSCB has published two response documents outlining the significant work undertaken following the findings of the Serious Case Review and these are available on the LSCB website. More on the impact of Serious Case Reviews can be found under Section 13 of the report.

Clarifying governance arrangements

IMPACT

- All LSCB partners signed up to the LSCB Compact.
- Terms of Reference for the LSCB Executive Group were revised and agreed.
- The minutes of LSCB meetings clearly reflect challenge
- A revised protocol between the Health and Wellbeing Board, Corporate Parenting Board, Safeguarding Adults Board and LSCB was developed and is on the website. The first meeting of the respective Chairs and their Business Managers took place in Spring 2015.
- The LSCB Escalation Policy was revised and available on the website.
- Minutes of LSCB meetings reflect challenge and the LSCB Meeting attendance list has been revised to reflect role, membership and who they represent.
- LSCB members are also members of the Corporate Parenting Board and Safeguarding Adults Board
- Section 11 Cycle on target with very good engagement in the process
- Membership of the LSCB has been reviewed to reflect Suffolk postcode clients
- Role and function of Case Review Panel has been revised and agreed.
- Role and function of Area Network meetings and ToR have been revised.
- Funding commitment to support activity is stable for the next year

Reviewing policies and procedures

IMPACT

Extensive work has taken place on policies, procedures and the website including:

- Single Assessment Framework
- Thresholds
- Child Sexual Exploitation and Pre-Birth Toolkit
- Safe Sleep Guidance
- Guidance on Public Law Outline (PLO)
- Escalation Policy and Working with Evasive Families
- Work on policy revision is monitored via a spreadsheet and discussed at the LSCB Policy, Practice and Engagement (PPE) sub-group.
- CYPS Safeguarding Representative member of PPE sub-group and LSCB Manager sits on Child Protection Improvement Group to ensure consistency of work.
- LSCB Manager and Professional Advisor have attended Signs of Safety and Wellbeing (SoSW) Training to ensure that promotion and scrutiny of SoSW approach by the LSCB is informed. LSCB website now hosting Signs of Safety and Wellbeing web page.
- Section 11 audits provide evidence of LSCB partners having awareness of policies
- Thresholds document has been revised and signed off.
- Auditing of Multi Agency Safeguarding Hub cases has commenced
- Annual report evidences audit and reporting to the LSCB
- Signs of Safety rolled out and used in practice, including Child Protection Conferencing
- Website statistics used to monitor the use of policies and procedures.
- Training sufficiency and quality assurance group re-convened
- Training incorporates website content

Ensuring that the Board has maximum influence and impact

IMPACT:

- Evidence from the Section 11 process of challenges and recommendations from Learning and Improvement taken up. 100% compliance with Section 11 requirements by partners.
- LSCB professional advisor actively involved in practice audits
- Format for the LSCB Annual Report was created by utilising good practice recommendations from several sources
- Website moved to new platform to allow for growth
- LSCB website now portal for Signs of Safety and Wellbeing information site
- Response from last year's LSCB recommendations to the Health and Wellbeing Board developed for the Annual Report

- Regular attendance by authorised and empowered deputies at the LSCB Board and Sub Group Meetings.
- LSCB Manager attends the Safeguarding Adults Board(SAB) on behalf of the LSCB and meetings taking place between SAB/LSCB Chairs and Managers
- Shared protocol between Boards developed
- Most partner organisations evidence engagement with children and families via Section 11. Feedback from children and families was considered in detail in the development of the Statutory Assessment
- Youth Panel run as an integral part of interview process for a new LSCB Chair.
- LSCB Learning and Improvement framework reviewed.
- Annual Report and SCR Response provides evidence of numbers trained across the partnership, as a result of the SCR, dissemination events and via online training.

Quality assurance, performance and effectiveness

- Learning and Improvement strategy revised
- Evidence on how learning is shared and what learning processes take place has been provided by all partners and collated into a report for the LSCB.
- Annual Report provides considerable multi-agency audit information
- Training strategy developed and implementation of Training Quality and Sufficiency sub group agreed
- Revised ToR for Area Safeguarding Groups
- Learning and Improvement Strategy updated. Website updated regularly and now upgraded.
- Area network meetings have been reviewed at least one under the new format held in each area
- MASH information sharing protocol agreed and signed
- LSCB guidance on referrals enhanced/revised and added to Thresholds document
- Successful Safe Sleep Campaign and publication and distribution of Bereavement Directory
- Bulletins sent via LSCB communications mailbox and via website. Website updated with section on Serious Case Reviews.
- Information on learning from SCRs shared across the Eastern Region via Managers meetings and briefing sheets to LSCB partner agencies and Area Network meetings.
- Case Review Panel function and ToR revised.
- Partners have provided information on learning procedures and how they have implemented any areas identified as a result of producing an Independent Agency Review.
- LSCB Report gives an overview of effectiveness and makes recommendations
- Signs of Safety and Wellbeing is generating evidence of changes in front line practice with a formal evaluation underway by University College Suffolk.

Response from the Police and Crime Commissioner

It was agreed last year that not all of the published recommendations for the PCC were appropriate and some lay outside of the PCC remit. The PCC has worked with partner agencies to consider how to bring about better governance of the areas mentioned in last year's Annual Report and the Safer and Stronger Suffolk Group will provide a countywide governance group.

Following the conversation in 2014 about Section 11 of the Children's Act 2004 the PCC has ensured that the Conditions of Award for PCC grant recipients reflects that they must be able to evidence appropriate safeguarding procedures for those using their services and have due regard for the Local Children Safeguarding Board policies and guidance.

The PCC has significantly invested in work to support vulnerable people through enhancing the Constabulary's capacity and capability to tackle 'hidden harm' and granting awards to support children and young people who are victims of crime. Additional resource has been deployed into child and adult abuse, domestic abuse, honour based violence, human trafficking and sexual exploitation. These additional staff will significantly enhance the Constabulary's ability to investigate crimes and bring the perpetrators to justice. The UCS research commissioned by the PCC has helped us to understand experiences of victims of domestic abuse and the Chief Constable is leading on the Constabulary's work to address the findings, inviting all partners to join that work.

6.0 Policies and Procedures

The LSCB Planning, Policy and Engagement Group had a busy year in 2014/15. Some of the Policies developed or updated include:

Escalation Policy

As a result of a serious case review the LSCB reviewed and re-issued its Escalation Policy. Suffolk LSCB recognises that in most circumstances, people working with children and young people in Suffolk refer cases appropriately and there is mutual agreement on the status and disposal of the referral.

However, the LSCB also recognises that there are situations where disputes over thresholds emerge. The Policy is intended to assist in circumstances where a threshold is contested and gives general advice on resolving problems in a range of other situations.

The Policy emphasises some key messages on seeking guidance from safeguarding leads in their own organisations, and supports practitioners to challenge poor practice in the context of multi-agency safeguarding. A 'Quick Guide' to accompany the Policy was also developed.

Policy and guidance on working with Hard to Engage Families within the context of safeguarding children

In a number of documented Serious Case Review reports, including in Suffolk in 2013, the impact of the behaviour of such families has led to tragic consequences for children.

The child's welfare should remain paramount at all times and where professionals are too scared to confront the family, they must consider what life is like for a child in the family.

The aim of this document is to provide some useful guidance when working with hard to engage families to help professionals and their managers to make an authoritative response to a resistant family, making it clear that non-co-operation is not acceptable.

Statutory Assessment

The Suffolk Statutory Assessment was introduced in compliance with Working Together 2013, which, on recommendation of the Munro Review 2011, allowed for local authorities to devise local protocols for assessment, with flexibility in respect of focus and duration, whilst retaining a "systemic" approach and the 3 domains (child/parenting capacity/environment) of the former statutory assessment framework. The former "Initial" and Core" assessments, were re-placed by a single assessment for completion generally within a 45 day timeframe. The new framework was launched with very few associated difficulties and the few anomalies arising from initial use were resolved very easily.

The framework has been well received by the workforce who reported positively upon;

- ease of use;
- fewer sections and tick boxes and more logical sequence;
- readability (especially for families) and presenting child`s circumstances;
- compatibility with the county "Signs of Safety and Wellbeing" practice approach;
- used as report for Initial Child Protection Conferences; and
- flexibility of timescale and professional judgement/proportionality approach.

In December 2014 the LSCB received a further report on the review and revision to the Framework considering changes in accordance with;

- Developing Signs Of Safety & Wellbeing (SOSWB) practice and understanding;
- Any opportunities arising from inclusion within the national government Innovations Programme; and
- Challenges and opportunities within "Early adopter" Multi-Agency teams.

Customer feedback questionnaires are given to all families who were the subject of assessments and the responses collated for analysis. The April`14 to Sept `14 responses totalled 156. The results included:

84% felt listened to – 85% young people

89% felt treated with respect – 94% of young people

70% had confidence in the Social Worker – 61% young people

74% felt involved in planning

82% felt the Social Worker explained things well – 68% young people

76% experienced the Social Worker as reliable – 65% young people

43% felt things had improved – 29% young people (note this is at the beginning of contact and any interventions).

The feedback questionnaire will be revised, to endeavour to better capture the customer experience of the SOSWB approach, its impact upon engagement, levels of satisfaction and customer understanding and participation in the process.

Neglect – strategy and guidance

The strategic aim in Suffolk is to ensure there is early recognition of neglect. From early support to statutory intervention there should be appropriate, consistent and timely responses across all agencies working together. Work with children and families should be positive and empowering and keep a clear focus on the impact of neglect on the child.

It is well documented that awareness of child neglect and its consequences on the future well-being and development of children has increased during the last two decades and is the most common reason for child protection plans in the United Kingdom. Neglect causes significant distress to children and leads to poor outcomes in the short and long term. Research and findings from Serious Case Reviews inform us that in extreme cases, neglect can be fatal.

The guidance in this document aims to provide useful sources of information, support good practice and improve the outcomes for those children and young people who are neglected by their families. It was produced as a response to the Serious Case Review.

Safeguarding Children who run away or go missing from home or care

This document provides guidance to professionals and volunteers from all agencies in Suffolk working to ensure a collaborative response when:

A child is at risk of running away.
A child runs away and goes missing from home or care.
It aims to provide guidance for assessing both the risk to the child or young person and the support needs on return.

The framework for the procedures is based on:

- Statutory Guidance on children who run away and go missing from home or care January 2014
- ACPO Guidance on the Management, Recording and Investigation of Missing Persons 2010
- ACPO Interim Guidance on the Management, Recording and Investigation of Missing Persons 2013
- Children Act 1989
- Working Together to Safeguard Children 2013 & 15

Female Genital Mutilation (FGM) Guidance for Health Professionals

Comprehensive guidance on FGM has been developed by the LSCB Designated Health Professionals and distributed throughout the CCGs.

Training Endorsement and Quality Assurance Protocol

Suffolk Local Safeguarding Children Board (LSCB) has a statutory responsibility to 'monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children' - *(Working Together to safeguard children 2013 & 15)*

The LSCB has a process for quality assuring and endorsing safeguarding training which has been agreed through Suffolk's Children's Trust arrangements. This process has been used by LSCB partners such as Suffolk Constabulary, Ipswich Hospital and Suffolk County Council Children's Services. It provides:-

- endorsement through the application of an agreed set of regional standards and competencies;
- assistance and advice regarding Section11 Audit (Children Act 2004) responsibilities related to training; and
- advice on avoiding duplication in provision by linking organisations providing the same courses and thus potentially reducing costs.

A very successful Trainers Forum run by SCC CYPS Workforce Development and the LSCB provides support and continuity to partner agency safeguarding trainers who provide quality assured Level Two Safeguarding training within their agencies.

Quick guides on: Self harm in Children and Young People and self-harm and self-poisoning

Rates of self-harm have increased in the UK over the past decade and are among the highest in Europe. Moreover rates of self-harm are much higher among groups with high levels of poverty and in adolescents and younger adults. Of the 31,096 children attending the Emergency Departments of West Suffolk and Ipswich Hospitals in 2014/15, 381

children were recorded as self-harming (includes deliberate self-harm, intentional overdose and suicidal thoughts).

A multi-agency task and finish group which included LSCB, Health, Schools and Mental Health trust colleagues designed a practitioner's guide aimed primarily at schools. The aim being to provide pathways of support and to reduce the numbers of attendances at A+E locally which have been increasing over the past 12 months.

Thresholds

Meeting the Needs of Children in Suffolk - Local Protocol for Assessment including Multi Agency Thresholds Guidance

This protocol was updated and a Thresholds Matrix developed for practitioners to use as a 'desktop aid'. The Thresholds Document brings together information which assists practitioners to work with other agencies to meet the needs of all children in Suffolk. It offers a framework for:

- Consultation, co-ordination and co-operation to promote children and young people's welfare;
- identifying when a child has additional needs;
- identification of children at risk of poor outcomes;
- guidance and process on assessing risk and balancing risk and vulnerability; and
- deciding what action to take following identification to deliver integrated support and enable all children to meet their potential.

Safeguarding Children and Young People from Sexual Exploitation Policy, Guidance and Risk Assessment

This policy was updated and includes a risk assessment tool for practitioners, reflecting the dynamic work taking place across the partnership on identifying children and young people at risk of CSE.

The LSCB Strategy and Action Plan for Children and Young People at risk of exploitation is the subject of implementation, monitoring and scrutiny by the LSCB Strategic Exploited Children Group.

Work on implementing the Action Plan includes:

- A successful awareness raising event was held to mark CSE day on 18th March 2015.
- LSCB training on CSE for the Family Justice Board
- The creation of a dedicated 'page' on the LSCB website to ensure information is readily and quickly available to practitioners and the public.

- Distribution to all front line Police Officers of an information leaflet and similar 'Quick Guide' leaflets distributed to all partner agencies.
- The commissioning by the LSCB of a hard-hitting, 40 minute long Applied Theatre Production entitled 'Chelsea's Choice' that has proven highly successful in raising awareness amongst young people of the issues surrounding Child Sexual Exploitation. The play is followed by a 20 - 30 minute (depending on available time) plenary session exploring the issues raised in the play. The LSCB is offering this production free to all schools in Suffolk for Year 9 Pupils commencing November 2015 and has just run a successful 'taster' day for professionals across Suffolk with over 150 attendees.
- Work with all District and Borough Councils in Suffolk to roll out information packs for taxi drivers, operators and the night time economy.
- Planned training for all county councillors.

The Prevent Strategy. Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015

Prevent is a part of the government's counter-terrorism strategy that **aims to stop people becoming terrorists or supporting terrorism.** It is considered to be "the only long term solution" to the threat from terrorism.

Prevent is about **supporting and protecting** those people that might be susceptible to radicalisation, ensuring that individuals are diverted away before any crime is committed.

The Counter Terrorism and Security Act 2015 places a duty on specified authorities including local authorities, schools, HE and FE colleges, health, probation and the police to have **"due regard to the need to prevent people from being drawn into terrorism**".

'Radicalisation' refers to the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups.

'Extremism' is the "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces".

Access to the Vulnerable to Radicalisation (VTR form) can be found on the LSCB website under the 'Prevent' heading.

Appropriate cases are then considered by the **Channel Panel** which is an early intervention multi-agency panel designed to safeguard vulnerable individuals from being drawn into extremist or terrorist behaviour.

Channel is aimed at early interventions before people become involved in criminal activity. For instance, a successful intervention might dissuade someone from travelling to Syria or Iraq. Intervention providers from the Home Office approved list may be accessed if appropriate, for example to mentor an individual.

The LSCB policy has been updated to ensure it meets the requirements of the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent children and young people from being drawn into terrorism.

Frontline staff who work with vulnerable people are encouraged to attend the Workshop to Raise Awareness of Prevent (WRAP) training.

7.0 Monitoring and Evaluation – LSCB Statutory Function

The LSCB has oversight of a series of monitoring reports regarding specific areas of safeguarding activity. These reports are read in detail by the Learning and Improvement Group who meet monthly and form part of the LSCB twice yearly performance reporting. They are outlined in brief below:

Local Authority Designated Officer (LADO) for Managing Allegations against Professionals

The Government published new guidance in April 2014 for Keeping Children Safe in Education which contains new information on managing allegations. A report came to the LSCB Executive Group in December 2014 setting out changes in procedures and process.

The LSCB guidance Arrangements for Managing Allegations of Abuse against People who Work with Children or Those who are in a Position of Trust was updated 2014. The LSCB receives an annual report on the work of the County LADOs. The focus of the LADO role is the management of allegations against adults who work or volunteer with children in the public, voluntary or independent sectors.

The report highlights data and key themes from the service, currently provided by the 3 County Safeguarding Managers based in Ipswich, Bury St Edmunds and Lowestoft. An additional 2 Independent Reviewing Officers posts (IROs) have been approved to provide additional support to the Safeguarding Managers apart from where the case is complex.

During the year 2014/15 the Multi Agency Safeguarding Hub (MASH) has become established as has the centralised system for logging and responding to referrals in respect of children. Quarterly meetings between the MASH and the LADO service are held to ensure that procedures and processes work well.

Referrals from April – March 2015 + Trends since 2010-2011. For simplicity, referrals are set out as totals and not by month.

Total of allegations made, by area

	North	South	West	TOTAL
2010-11	53	79	138	**270**
2011-12	70	77	114	**261**
2012-13	54	44	79	**177**
2013-14	50	115	58	**223**
2014-15 (including those NFA)	**52 (126)**	**121 (229)**	**98 (168)**	**271 (523)**

NB. Figures for 2014/15 are set out as total referrals in brackets, preceded by number of meetings.

- Of the **523** referrals made in 2014-15 **27** have had previous referrals
- **252** referrals resulted in no further action after initial consideration
- Overall **51.81%** of all referrals resulted in a LADO meeting

This data confirms that an additional 48 LADO meetings were held over the previous year, an increase of 21%.

Employment Sectors from which allegations/concerns arise

As per previous years, by far the largest number of concerns, 49% of the total, arise within the education sector. The majority of these involve teaching assistants and lunchtime supervisors.

Allegations by Employment Sector and Category of Abuse

	Physical	Emotional	Neglect	Sexual	Behaviour (Suitability)
SOCIAL CARE	**0**	**0**	**0**	**2**	**9**
▪ Independent Foster Carers	**3**	**0**	**0**	**2**	**4**
▪ SCC Foster Carers	**6**	**1**	**1**	**2**	**7**
HEALTH	**5**	**3**	**1**	**3**	**6**
EDUCATION	**72**	**4**	**0**	**10**	**48**
EARLY YEARS	**7**	**0**	**0**	**0**	**5**
POLICE	**1**	**0**	**0**	**1**	**1**
OTHER	**12**	**0**	**0**	**27**	**28**
OVERALL TOTALS	**106**	**8**	**2**	**47**	**108**

Of the above total figure of 271, **113** people were suspended pending the outcome.

The following trends can be identified within the data for the 2014/2015 period.

- Physical concerns predominate within Education (51%) with Behaviour (36%)
- Physical and behavioural concerns are the main categories within fostering
- The largest proportion of Sexual Concerns is within the 'Other' sector which includes areas such as:-

    - Scouting, sea cadets and Beavers
    - Private music teachers
    - Sports coaches
    - Owners/organisers, staff and volunteers of dance and drama groups
    - Drivers for transport companies
    - Staff and volunteers within not for profit organisations
    - Adults within cafes or other locations where young people meet

Outcomes of Allegations

The LADO meeting is used to both to gather information that ensures an informed outcome and to plan actions necessary to gather such information. It would not be expected that every meeting will result in a substantiated outcome.

For Education, it was agreed part way through the past year, to amend the classification to ensure that that where an outcome is logged as 'Unfounded' or 'Malicious', it could be recorded as 'False'. This amendment to the data collection documentation will be fully incorporated from April 2015. For this report, it means that 12 referrals (just under 10% of the total for Education) could be classed as a 'False' outcome.

Allegation Outcome

	Unsubstantiated	Substantiated	Unfounded	Malicious	Unconfirmed/ Ongoing
SOCIAL CARE	**2**	**7** (78%)	**0**	**0**	**0**
FOSTER CARERS					
▪ Independent Foster Carers	**3**	**5**	**1**	**0**	**0**
▪ SCC Foster Carers	**7**	**7**	**3**	**0**	**0**
HEALTH	**2**	**11** (69%)	**3**	**0**	**1**
EDUCATION:	**35**	**69** (57%)	**10**	**2**	**12**
EARLY YEARS	**1**	**9** (89%)	**0**	**1**	**1**
POLICE	**0**	**2**	**0**	**1**	**0**
SECURE ESTATE (Prison, YOI)	**0**	**0**	**0**	**0**	**0**
OTHER	**17**	**36** (60%)	**7**	**0**	**7**
Total	**67**	**146**	**24**	**4**	**21**

(NB: % figures exclude 'unconfirmed/ongoing')

Employment Outcome

	Number of cases
Continued to work	173
Dismissal	24
Resign	19
De-registered/Cessation of Use	14
On-going	41

These figures do not tell the detailed story behind individuals who remain in work with improvement plans or are subject to disciplinary or capability proceedings. However they do show that 57 individuals, slightly less than 20% of all adults discussed who were the subject of concerns/allegations that resulted in a meeting, are now no longer working in the setting where the concern arose. This is a significant number and highlights the benefit of the LADO process in managing out individuals who pose significant safeguarding risks.

Role of the Police

Police input to LADO meetings is significant as the decision about whether or not a criminal offence may have been committed, is often central. The details set out below show that in 24% of the cases discussed, criminal investigations were undertaken.

Of the total allegations made during 2014-15 there were **66** that proceeded to criminal investigation under the following categories

- 1 x Acquittal
- 3 x Caution
- 2 x Community Resolution Order
- 1 x pleaded guilty (awaiting sentence)
- 3 x Convictions
- 5 x Ongoing Police investigation
- 2 x Summons to Court (awaiting outcome)
- 49 x No further Police action taken

The LADO service is one that continues to be of benefit in safeguarding children by advising and guiding employers on how best to manage allegations and concerns about their staff and it is positive that there is a growing awareness in all sectors that any concerns need to be managed within the LADO processes. However this increased awareness inevitably has an impact on resources and the provision of additional LADO capability by the Local Authority is to be applauded.

At the time of increasing concerns about the potential for adults to exploit positions of trust, the data shows increasing demand on LADOs to both support and manage processes that reduce this likelihood of harm being caused.

Private Fostering

Private fostering is legally defined as an arrangement that occurs when a child who is under 16 (or 18 for a child with disabilities) is cared for by someone other than their parent

or a close relative 1 for 28 consecutive days or more, or 14 days at a boarding school during the holiday period. A private foster carer is anyone who looks after someone else's child usually by agreement with the parent, excluding children looked after by close relatives. They may be a friend of the family, the child's friend's parents or sometimes someone who is not previously known to the family, but who is willing to foster the child privately. The law requires parents and private foster carers to tell the local authority about a private fostering arrangement.

Following the death of Victoria Climbié local authorities were given a duty to promote public awareness of the requirement to notify them of private fostering arrangements and, when possible, before they commenced.

The new regulations and the national minimum standards on private foster care, published in 2005, provided the basis of inspections which were carried out by the Commission for Social Care Inspectorate from 2006–2007 and from 2007 by Ofsted.

1. A close relative is a grandparent, brother, sister, uncle or aunt (whether of full blood or half blood or by marriage) or a step parent.

2. The Children Act 1989

3. The Children Act 2004 Section 44.

Local authorities are not directly responsible for providing care to privately fostered children and young people. They focus on whether children and young people's welfare is safeguarded.

The LSCB receives a report annually that provides information on how the welfare of privately fostered children in its area is satisfactorily safeguarded and promoted, including how it co-operates with other agencies in this connection. It includes an evaluation of the outcomes of the local authority's work in relation to privately fostered children during 2014-2015, and continued developments and actions.

In January 2014 Ofsted released the publication: '*Private fostering: better information*, *better understanding inspections'*. This report made national recommendations that the Private Fostering system increases assurances, as well as its capacity for self-improvement by:

- Improving data collection and use.

- Improving arrangements for self-evaluation of private fostering services – for example, by re-branding Local Authority annual reports on Private Fostering as self-evaluation and publish them in full on LSCB websites

Better targeting of 'raising awareness' by local authorities by:

- Placing the emphasis on key contact points such as school enrolment and GPs, verifying that children, are in fact living with parents

- Making regular contact with all language colleges in the area to check whether they have relevant young people on their roll and where they are living
- Local authorities proactively reviewing such arrangements at regular intervals, in partnership with service providers, in order to evaluate the level of assurance.

The report noted excellent practice in Suffolk, who worked with their school admissions team to incorporate a question as to whether the child is privately fostered. In addition specific training has been provided to designated teachers, school nurses and health visitors.

Private Fostering Arrangements (PFAs)

	2013	2014	2015	Increase or decrease on previous year
P F As that began April 2014- March 2015	68	80	62	-18
P F As that were still open April 2014 from previous year	40	38	40	0
Total P F A s 2013-214	**108**	**118**	**102**	**-16**
Arrangements that on initial assessment, and closer inspection did not become PFAs	24	32	12	-20
Total number of cases worked by CAPFT during 2013-2014	**132**	**150**	**124**	**-26**

The number of notifications received has ranged from 60-80 over the last four years. The service continues to evaluate publicity raising activities, within existing resources, to strive towards increased notifications.

Suffolk County Council has not been successful in increasing the number of early notifications that are made to ensure the Local Authority is aware of arrangements before the child or young person moves in. However, audit findings indicated appropriate arrangements for all cases sampled.

It is however noted that that Fostering Changes for Children Team have continued to have effective working relationships with Educational Guardianship companies operating in Suffolk and they are, in most cases, informed of students coming to the UK before they arrive.

Notifications received by:	Existing pre 1/4/14	New post 1/4/14	Total No. of cases
Educational Guardianship Companies. inc. Samuel Ward & School Admissions (foreign students)	22	31	53
Allocated social workers	11	15	26
School Social Worker		1	1
Family Support Worker		1	1
MASH identified	1		1
Health Visitor		1	1
School	2	2	4
Other relation e.g. Aunt/G-parent	1	2	3
Neighbour		1	1
CAMHS	1		1
Iceni / Family Focus		3	3
Step-parent or other Carer	2	5	7
Total Notifications	**40**	**62**	**102**

This year there has been an increase in referrals coming from families themselves, and one referral has come from a neighbour.

There was a drop in referrals from social work teams from 23 in (2013-2014) to 15 (2-14-2015

The table above shows that 50% of Private Fostering arrangements are currently non-foreign students.

It can be seen from the table above that there continues to be good referral activity from schools and the raising awareness activity in this area continues to bring positive outcomes.

Whilst there have been some changes to the demographics of the children privately fostered, the small variations from year to year does not suggest significant patterns of change in age demographics. There continues to be more children aged 10-16 referred to the service and this reflects the changes in the proportion of older children coming into care. The service continues to work closely with health and education in trying to capture all private fostering arrangements for young children.

Ethnicity of PF Children	Existing pre 1/4/14	New post 1/4/14	Total No. of cases
White British	14	24	38
Black African	0	1	1
Black Caribbean	1	0	1
Mixed Other	1	0	1
White/Asian	1	0	1
Chinese	6	8	14
Other European	1	0	1
White European	16	29	45
Total Ethnicities	**40**	**62**	**102**

There continues to be an increase in the numbers of foreign students from European countries, and a continued decrease in those with Chinese ethnicity, which were trends that began last year.

Disqualification and prohibition

The Private Fostering Panel rarely has cause to recommend such measures as most cases are managed to a satisfactory alternative. However the panel does consider such measures where needed.

There were no prohibitions or disqualifications made during 20-14-2015.

Learning from Multi Agency Audits – Multi agency audit work undertaken includes:

Audit on school exclusions

An issue was raised at a Safeguarding Network meeting by Learning and Improvement Service (LIS) colleagues, regarding the numbers of permanent and fixed term exclusions in certain schools over a 3 month period. Following data confirmation, in January 2014 a thematic audit was conducted by the LSCB.

Five schools were interviewed as part of the audit:-

This sample gave a split across all three Suffolk regional areas, Primary and Upper phases, Academies and Community schools.

It included two schools with high levels of exclusion, two with low levels and one with medium levels.

The Head teachers/Principal/Deputy were interviewed in two schools, and in the other two schools the interviews were with members of the Pastoral team with responsibility for exclusions.

Questions regarding current Social Care practice and policy were posed to a Service Manager for Specialist Services plus a Specialist Services Team Manager and the Quality Assurance Team Manager for Children and Young People's Services (CYPS).

This has led to:

- Guidance for schools being prepared by LIS on their statutory responsibilities, particularly multi- agency discussions before exclusion.
- Exclusion reports by locality team - to share with Specialist and Integrated team managers to encourage a multi-agency responses
- Guidance for specialist teams to encourage information sharing with schools when YPs become a Child in Need or involved in the Child Protection system.
- Links with the Safeguarding and Quality Assurance Team team to update training and include questions in s175/157 Education Act (2002) school safeguarding audits

Clear recommendations were made and the action plan is held by the Learning and Improvement Service with updates to the LSCB.

Child Sexual Exploitation Audit

In June 2014 the Office of the Children's Commissioner (OCC) asked all LSCBs to complete a self-assessment as to their effectiveness in relation to Child Sexual Exploitation (CSE). As part of this self-assessment, the LSCB undertook a piece of audit work, the results of which contributed to a report to the LSCB in December 2014.

The audit findings confirmed that CSE was 'on the radar' of practitioners with both boys and girls identified as at risk and there was evidence of child centred practice taking place. However further work was required in ensuring there was consistent and comprehensive assessment of risk by application of the LSCB screening tool and further work was required to ensure clarity of roles and multi-agency protective actions and processes were in place.

The report to the LSCB gave an honest 'position statement' and offered the Board a revised report and action plan to endorse. The Board require regular updates at each meeting as to the work of the Strategic Exploited Children group and the Action Plan and work continues as an LSCB priority into 2015/16, including a significant piece of multi-agency audit work led by the Police and supported by Police and CYPS analysts and professional advisors respectively.

Child Sexual Exploitation remains a priority for the LSCB in 2015/16, and all recommendations for action have been included in the Exploited Children strategy and action plan.

MARAC self-assessment and LSCB audit

As part of the HMIC Inspection of Suffolk Constabulary's approach to tackling domestic abuse in late 2013, it was reported that:-

'*There has not yet been any evaluation of the success of the MARAC process, but the force is now commissioning this, through Co-ordinated Action Against Domestic Abuse (CAADA). This will help the force understand how the process is working and where it can be improved'*

CAADA then conducted an audit and self-assessment of the three Suffolk MARACs in April 2014.

The LSCB Quality and Performance Advisor was invited to the presentation of the findings from CAADA on 2 July 2014.

The LSCB had previously completed a thematic audit on MARACs in September 2012 at the request of the Constabulary and presented a number of findings and recommendations. It was notable and concerning to the LSCB that there were a number of similarities between the LSCB Thematic Audit findings in 2012 and the CAADA audit findings.

Summary of the findings from CAADA

In summarising the findings from the CAADA, generally the findings were positive, and included:-

- Increased volume of cases to all MARACs, although still below national level.
- Wide representation of agencies.
- Lower than average repeat referrals.
- Evidence of effective information sharing.
- Good focus on victim support needs and action plans.
- Efficient and effective administration under resourced for the number of cases.
- Agencies showed commitment to MARAC.

There were a number of areas for improvement and recommendations made, these included:-

- The formation of a MARAC Steering Group
- MARAC Operating and Information sharing protocols were not in place for each MARAC
- Lack of IDVA (Independent Domestic Abuse Advisors)
- Lack of attendance of some partners, primarily Social Care and Education
- Some Areas didn't have Children Services representative who covered whole age range.

The LSCB continues to seek assurance from Suffolk Constabulary that all recommendations are addressed and considerable progress has been made. However the lack of the formation of a MARAC steering group and the high numbers of MARAC referrals has remained a significant concern and been an ongoing point of challenge by the LSCB Chair.

The LSCB is aware that the Health and Wellbeing Board has agreed a strategic resolution to sharing and providing co-ordination of Community Safety work across Suffolk. Early Help Teams are delivering the Freedom Program in all areas of Suffolk.

Single agency audits also form part of the Learning and Improvement Group activity and provide a wealth of information that informs the twice yearly performance report received by the LSCB. The Learning and Improvement Group, chaired by the LSCB Chair, discusses in detail all the audits brought to the group and makes recommendations to the Board as to actions, risk and impact.

Audits received at the LSCB Learning and Improvement Group over 2014/15 include:

- CYP: Health Evaluations of Level 3 SCR training: A report on the evaluations of training following the Anderson Serious Case Review and the impact of the training on front line practice.
- YOS: HMIP Report of Short Quality Screening (SQS) of youth offending work in Suffolk
- Police: HMIC Inspection Report and Case Audit
- Probation: HMIP Inspection of Adult Offending Work in Norfolk and Suffolk
- Suffolk MARACs Self-Assessment

Looked After Children

The LSCB hold services for Looked After Children to account by including data in the LSCB full Annual Report and on receiving a report from the Corporate Parenting Board. The Independent Chair has attended the Corporate Parenting Group and will do so on at least an annual basis and she also participated in the Corporate Parenting Strategy workshop in November 2015.

	31 March 2014	31 March 2015
Total number of LAC (as at 31st March)	**723**	**732**
No. of children who became looked after in past 12 months (rolling year).	**307**	**333**
Number who ceased to become LAC and outcomes.	**329**	**322**
Permanency.	**145**	**118**
Home to live.	**69**	**89**
Independent living.	**44**	**28**
Other	**71**	**87**
% of LAC reviews completed on time (rolling year)	**99.3%**	**97.6%**
% LAC who had an annual health check within timescales.	**76.8%**	**84.3%**
% LAC with three or more placements in the previous year.	**9.4%**	**9.9%**
% Suffolk LAC placed out of county (as at 31st March)	**18.0%**	**20.7%**

% LAC eligible 2, 3 & 4 yr olds accessing funded childcare.

Age	Spring Term 15	Q4 2013/14
2 year olds accessing funded childcare	**73%**	**73%**
3 year olds accessing funded childcare	**88%**	**67%**
4 year olds accessing funded childcare	**91%**	**70%**

Note: Data started to report by term in 2014/15 so included is Q4 (Jan-Mar 2014) as this will be comparative with Spring 2015. This explains the varying time scales – as this data is not a direct comparison

% of LAC who are currently NEET

16-18 LAC as defined by DfE (using academic age for NCCIS purposes). The situation at the end of March 2015 was:

- NEET: **28.74%**
- As at 1 April 2014 = **23.3%**
-

The number and % of LACs who achieved a permanency plan by their 2nd review

Month	Total LAC	Total 2nd	Permanence by 2nd Review	% by 2nd review
Apr-14	713	13	9	**69%**
May-14	727	15	11	**73%**
Jun-14	733	15	9	**60%**
Jul-14	728	31	20	**65%**
Aug-14	722	11	7	**64%**
Sep-14	720	20	16	**80%**
Oct-14	733	22	14	**64%**
Nov-14	721	15	11	**73%**
Dec-14	703	19	12	**63%**
Jan-15	709	27	16	**59%**
Feb-15	724	23	14	**61%**
Mar-15	733	23	12	**52%**
Total		**234**	**151**	**65%**

In the last quarter of 2014/15 there was a noticeable rise in children coming into care having fallen to 709 in December 2014. The increase rising to 732 which is 9 above the March 2014 figure can be attributed to a number of large sibling groups coming into care from Lowestoft and a rise in young unaccompanied asylum seekers coming into the country. The age profile of children and young people entering and remaining looked after care has also changed significantly with a higher proportion of older children. There has been a rise in children placed out of county due to placement demand, but the majority of them are placed in neighbouring authorities and in the case of some children from Lowestoft, are actually closer to their family home than if they were placed within county.

A much smaller cohort 4% are placed at a distance i.e. beyond neighbouring authorities due to specialist needs of the young person such as a special school placement due to their disability. The figures at 31st March 2015 are as follows:

Neighbouring Authorities: 94

Suffolk Approved Foster Carers 52 (of which 11 are relatives or connected carers and 41 are Suffolk Carers)

Agency Foster Carers 33

Specialist Therapeutic Children's Home 3

Specialist Residential School 6

Children placed at a distance: 29

Suffolk Approved Carers 2

Agency Carers 5

Therapeutic Children's Home 7

Specialist Residential School 10

Tier 4 Inpatient Unit 2

Youth Offending Institution 2

Evidence from research tells us that children placed at a distance can be at risk of abuse and therefore require regular oversight. Where children need to be placed out of county the social work teams ensure that they are regularly visited in accordance with statutory requirements.

Suffolk has a LAC Sufficiency Strategy, agreed by Cabinet and the Corporate Parenting Board to develop a range of local services to ensure the numbers of children placed out of county are at a minimum level. Multi-agency development work is taking place to cater for young people who present with specialist needs, such as Tier 4 prevention and step down from Tier 4 for young people with mental health needs.

We are working with colleagues in Education and special school heads to develop specialist education resources to avoid children on the ASD spectrum with a very high level of need from having to go to schools at a distance.

There has been a significant growth in the use of supported accommodation for young people post 16 to avoid the use of Bed and Breakfast and to offer them ongoing support so that they are in a fit state to take on a tenancy when they reach 18.

The LSCB needs to be reassured that there is effective liaison between local authorities when children are placed in another local authority area.

Children with Disabilities

Research tells us that deaf and disabled children are at significantly greater risk of abuse and neglect than their peers (Jones et al, 2012).

Jones, L. et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet 380(9845): 899-907.

The Children and Families Act 2014 defines a child or young person as having special educational needs, if they have a learning difficulty or disability, which requires special educational provision to be made for them.

From September 2014, new arrangements came into effect for children and young people with special educational needs or disability (SEND). The Children and Families Act 2014 introduces a new statutory framework for local authorities and clinical commissioning groups to work together to secure services for children and young people – up to the age of 25 – who have SEN or disability, including a new statutory code of practice which captures key actions and behaviours (*Special educational needs and disability code of practice: 0 to 25 years* https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Work has been undertaken to develop an integrated care pathway for autistic spectrum disorders 0-25 years, this will be further developed and web enabled to provide a signposting service. The group has identified the profile of need in Suffolk and worked with a number of agencies to develop the local offer.

An action plan to develop an integrated pathway for children and young people with sensory and communication needs was agreed by SCC and health colleagues. This model will ensure children and young people with communication and sensory needs receive a timely response to need from a local service. The local offer will reduce the demand for costly interventions and prevent the need for children to be placed in settings some distance away from Suffolk to have their needs met.

The successful implementation of the SEND reforms has provided a more integrated response to children and young people with special education needs. The development of this included parent / carer representation to ensure the service redesign is coproduced

and responds to the aspirations and wishes of disabled children and young people and their families.

Children and young people and their parents and carers can access a Short Breaks service via a refreshed website giving more choice, control and empowerment to parent carers and more opportunities for disabled children and young people.

The LSCB will receive a report in October 2015 on current arrangements within Suffolk for safeguarding disabled children.

Review and development of the Child Death Overview Process has ensured there is now direct communication with the relevant case workers when reviewing the death of a child with disabilities to ensure that there is a comprehensive picture of the child and family circumstances and services received.

LSCB data set

The LSCB data set was revised in January 2015 and now comprises of eight outcomes. Each outcome has 8-10 performance indicators and commentary and analysis compiled by the appropriate designated lead. The full year performance report from April 2014 – April 2015 went to the LSCB in July 2015. There will be a review of the effectiveness of this new framework and methodology after this reporting cycle. It was agreed that the Signs of Safety model will be used for the commentary in future versions

The eight outcomes are as follows:

Outcome 1 **There is an effective Early Help Offer for Children and families in Suffolk**

Outcome 2 **Risk is appropriately identified and responded to.**

Outcome 3 **Thresholds are effective and ensure the correct level of support**

Outcome 4 **Child protection plans are as effective as they can be and ensure the best outcomes for children.**

Outcome 5 **Looked after children thrive in stable placements.**

Outcome 6 **Young people's emotional health and wellbeing is catered for**

Outcome 7 **Children feel safe in their environment**

Outcome 8 **There is a sufficiently staffed, trained workforce which ensures our children are safe.**

The data set was able to show the following:

- The integration of Children Centre and Health visiting teams should improve Children Centre registration rates and the joint working will promote the future take up of funded 2yr child care. This will be monitored in future reports
- The Number of contacts processed by the MASH reached its highest ever peak with 4814 received in March 2015 with the highest % by far being received from Police and Education.
- The number of cases open to specialist services has dropped by 10% due mainly to the implementation of the Making Every Intervention Count (MEIC) programme which has seen an increase in the number of cases carried by Early Help rather than Specialist Teams.
- There has been an increase to 89% of statutory assessments completed within timescales (45 days) (rolling year) as this is a significant improvement from last year when the figure stood at 65%.
- The number of cases being presented to MARAC (involving children aged 0-18) over the past 12 months has doubled and MARAC are being asked to review 30+ cases at each meeting. The lack of a MARAC strategic group is the subject of an ongoing LSCB risk.
- The number of statutory assessments completed has dropped by 25% over the past 12 months. It was reported that this was due to more cases being referred to Early Help teams following the implementation of the MEIC.
- The percentage of statutory assessments resulting in no further action has risen from 33% twelve months ago to 44% at the end of March. The LSCB will require further information as to the definition.
- The average waiting time for therapy following a CAMHS assessment at 35 days is a figure that the LSCB will explore further to ascertain who this compared regionally and nationally.
- The levels of children recorded as self-harming at West Suffolk Hospital continues to rise and has risen by 25% at West Suffolk Hospital in the past 12 months. The named safeguarding nurse at the hospital has reported that this increase has continued since April. In 2014 work was completed by a task/finish group on guidance for practitioners and the Learning and Improvement group are monitoring its impact but this remains an area of concern.
- This number of episodes children go missing has risen over the past 12 months (1278 from 1298) but the number of children going missing has decreased from 731 to 588. This indicates that fewer children are going missing more frequently.

- The number of violent and sexual offences against children up to the age of 18 has risen for the second year by 30%. The commentary provided by Suffolk Police indicated that the rise was due to the Crime Data Integrity Inspections and adherence to National Crime Reporting Standards. In reality, this means that more incidents are being recorded as crimes that previously and it is expected that this is leading to an additional 2500 plus violent crimes being recorded each year in Suffolk.

- The vacancy rate in Specialist (Social Work) teams is the lowest for 2 years. There are still some recruitment issues in Early Help Teams in the north of the County.

- The breadth of Safeguarding courses being delivered by teams in Workforce Development and Schools Choice has increased following recommendations in the 'A' Family SCR with more attendees than previously.

8.0 Key data about the Child Protection System

Number of Contacts processed by MASH (by Month and Source) April 2014 – March 2015

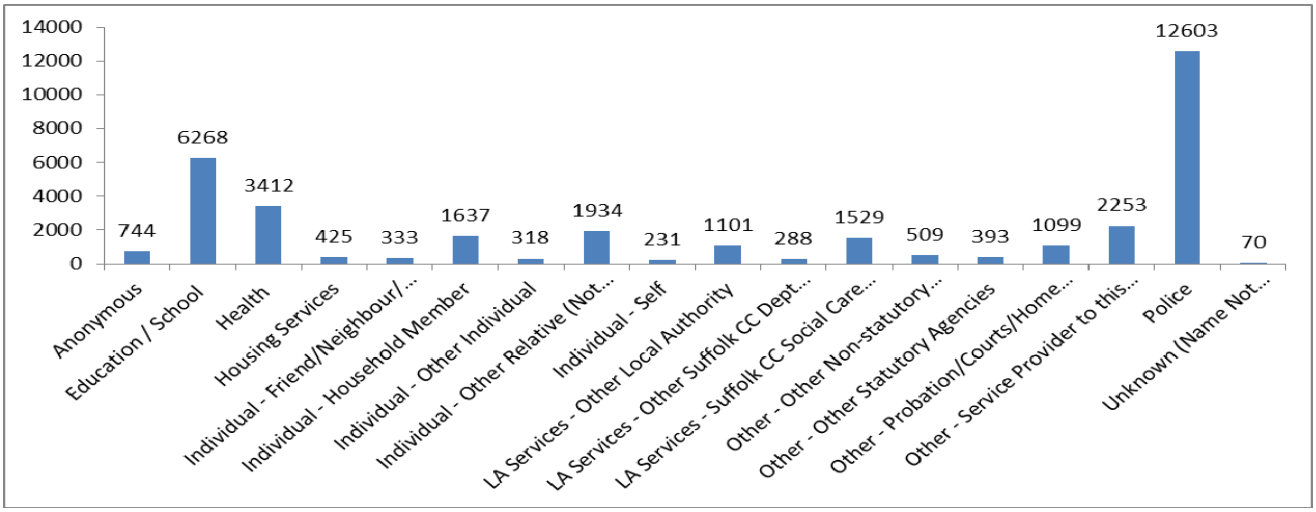
Contacts by month

April	May	June	July	*Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1164	1904	2102	2185	709	3190	3793	4069	4009	3699	3519	4814

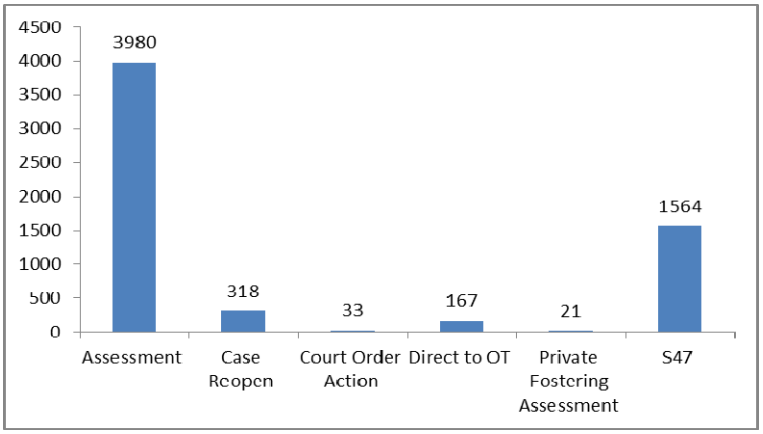
* MASH implemented from August onwards

The number or **contacts received by the MASH** reached its highest level of 4814 in March 2015 with Police being by far the highest referrer.

Breakdown by referring agency



Total number of contacts received in the MASH in past 12 months resulting in outcome of referral to Specialist services



	31 March 2014	31 March 2015
Number of cases open to Specialist Services (as at 31st March)	**4,004**	**3,654**
% statutory assessments within timescale (45 days) (rolling year)	**65.5%**	**89.1%**
Number of S47 enquiries started in past 12 months	**2,577**	**2,363**

The number of **cases open to Specialist Services** has decreased by 10% in the past twelve months

Number of MARACs involving children aged 0-18, in past 12 months

Number of MARAC cases involving children aged 0-18, in past 12 months, broken down by area.

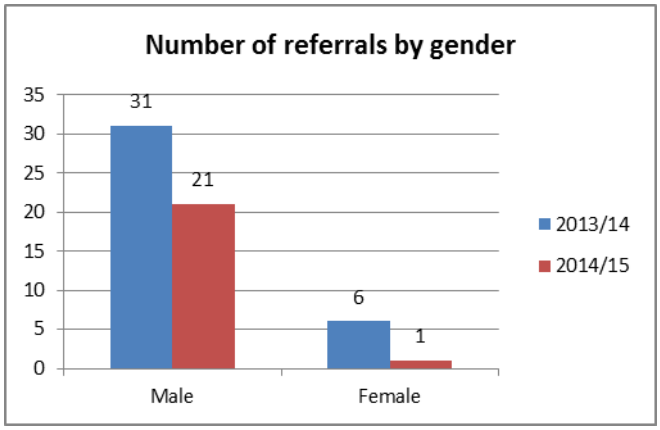
Area	April 2013 to March 2014	April 2014 to March 2015
Southern	136	268
Western	172	239
Northern	120	174
TOTAL	**428**	**681**

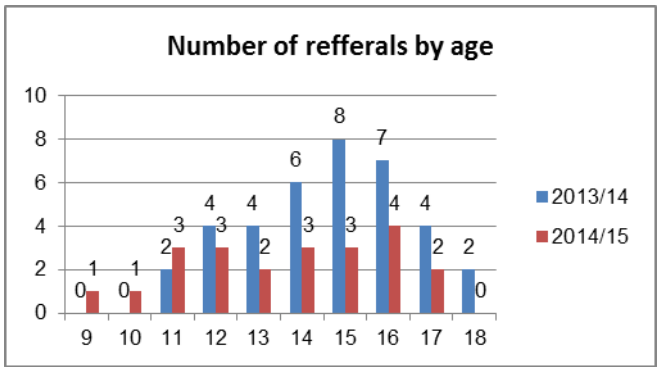
Referrals to the police, recorded as CSE or potential CSE cases, in past 12 months

Since the constabulary had the function to flag crimes as CSE **since October 2014**. Since then we have had **57 crimes** flagged as CSE or potential CSE.

The number of children receiving intervention through the Suffolk Sexually Appropriate Behaviour Service (SSABS)

The following is based on **37 referrals** in the period April 2013 to March 2014 and **22 referrals** in the period April 2014 to March 2015.

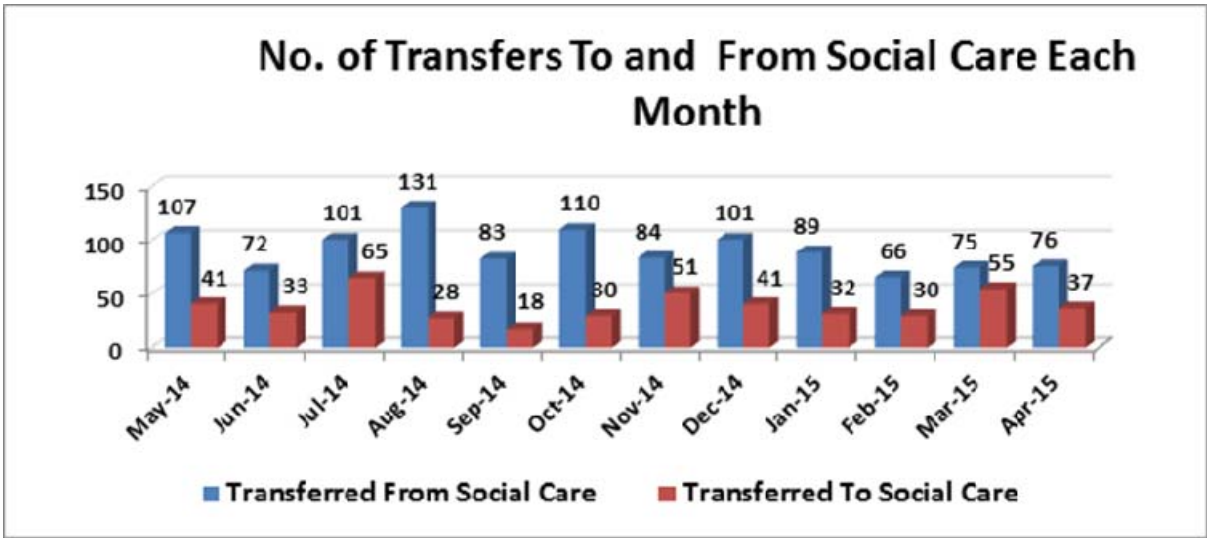




- The **% of statutory assessments** completed within timescale was a concern twelve months ago but this has increased significantly to 89.1%

Children 'stepped up' and 'stepped down' over past 12 months.

- Trends over past 12 months



From CYP Early Help report - Case Transfer between Specialist & Early Help

27% of cases opened in April were transferred from social care. This is an 11% increase from the previous month.
10% of all CAF closures in April were transferred to social care, a 2% decrease from the previous month.
Each month shows more cases have been transferred to Early Help from Social Care than transferred from Early Help to Social Care. **The trend continues that on average across the county, nearly 75% more cases have been transferred to Early Help.**

% of Referrals that are repeat referrals to Specialist Services in the past twelve months	
Year Ending	**%**
31 March 2015	**15.0**
31 March 2014	**20.9**

Repeat referrals, which were a concern last year, have dropped from a figure of 20% twelve months ago to 15%.

	March 2014	March 2015
No of statutory assessments completed in past 12 months	**7,827**	**5,885**
Rate per 10,000 of population	**517.3**	**389.4**
% of statutory assessments completed within the 45 day timescale	**65.5%**	**89.1%**
% of statutory assessments resulting in no further action.	**33.4%**	**44.8%**
% that subsequently resulted in a TAC	**17.9%**	**18.2%**
% of Section 47 Enquiries resulting in no further action.	**62.8%**	**70.8%**
Monthly % of S47s going to ICPC.	**37.2%**	**29.2%**
No of CIN including CPP and LAC (as at 31st March)	**3,506**	**3,302**
No of CIN excluding CPP and LAC (as at 31st March)	**2,190**	**2,138**
Children ceasing CIN (including CPP and LAC).	**9,222**	**7,587**

The number of **statutory assessments completed** in the twelve months to 1 April dropped by 25% to 5885 compared to 7827 the previous year**.**

The % of **statutory assessments resulting in NFA** rose by 30% to 44.8% the previous year

	31 March 2014	31 March 2015
Number of children currently subject to a CP Plan (as at 31st March)	**603**	**453**
Rate per 10,000 of Suffolk population.	**39.9**	**30**
% of children becoming CPP for a second or subsequent time.	**8.0%**	**13.3%**
% of CPP ceased within the year which had lasted two years or more.	**5.6%**	**2.2%**
Children ceasing to be subject to a CPP in past 12 months.	**711**	**804**
% reviews CP cases completed within timescales.	**99.5%**	**99.7%**
No of children on CPP who are also LAC (as at 31st March)	**12**	**13**
% of open CPP cases lasting two years or more.	**2.1%**	**2.4%**

The % of children who have been excluded from school in the past 12 months

Exclusions are monitored in school term dates. The figures below represent **1 September 2014 to 1 April 2015.** % – (Previous year's figures for equivalent period in brackets).

Fixed term exclusions from Secondary - (Figures from EMS)
There were **1531** (1129) pupils and **4.17%** (3.24%) fixed term exclusions from Secondary Schools to 1 April.
Permanent exclusions from Secondary - (Figures from Exclusions Team)
There were **79** (68) permanent **0.22%** exclusions from Secondary schools to 1 April.

Fixed term exclusions from Primary - (Figures from EMS)
There were **654** (624) pupils and **1.38%** (1.27%) fixed term exclusions from Primary Schools to 1 April

Permanent exclusions from Primary - (Figures from Exclusions Team)

There were **20** (28) permanent **0.05%** exclusions from Primary schools to 1 April.

CIN and CP Absence from Secondary and Primary Schools
There is currently no accurate recording of Fixed and Permanent exclusions in terms of CP/CIN children. Suffolk records the CIN/CP cases who are EOTAS (Educated Other Than At School) following exclusion.

At 1 April 2015 **49 out of 221 (21.5%)** EOTAS cases **were CIN or CP children**. This compares with 17% the previous year, although the method of recording changed in 2014 so cannot be deemed 100% accurate.

The system for **reporting of exclusions** to the Local Authority is currently on the LSCB risk register and will be regularly monitored especially for children who are subject to CP or CIN.

9.0 Learning and Improvement

The LSCB Learning and Improvement Framework was updated in 2014. This can be found in appendix 5. The framework outlines the approach developed by the LSCB in fulfilling its role of audit and scrutiny, alongside embedding the learning from audit and review activity and feedback including Serious Case Reviews.

During 2015 the LSCB initiated a Serious Case Review under Working Together 2015 and continued to monitor and sign off the actions outlined in the Family A Serious Case Review published in early 2014. Full findings on the latest Serious Case Review will be reported in the 2015/16 report

Forward Delivery Plan
Following the revised Ofsted Framework for LSCB in November, the LSCB business plan was reviewed and revised. A self-assessment was sent to all LSCB partners and the results analysed and a Forward Delivery plan based on the Ofsted framework was issued. The five main outcomes are linked to the LSCB sub groups and each of these is monitored by a lead LSCB Board partner.

Private and Independent schools
6 visits in the past 12 months to share information, discuss operational safeguarding issues and update on current policies and procedures. Work ongoing to make contact with more in next 12 months

LSCB Risks to Service Delivery Register

The LSCB has revised and developed its Risk Register. It monitors risk at each LSCB meeting including the severity of the risk and mitigating action.

Working with Year 12 and 13 Health and Social Care Students in Ipswich
Information sharing sessions providing information on the role of the LSCB and the Serious case review. One group of students had role played the SCR as part of their course work and invited the LSCB to a morning session where the findings and recommendations were discussed at length with a focus on how these would improve practice.

Section 11 Audit
The Section 11 Audit form has been revised in the past twelve months to include two new questions on Commissioning arrangements and awareness of the LSCB escalation procedures. The latter was in response to recommendations in the Serious Case Review.

Full Section 11 Audits 2014
Suffolk's statutory partner agencies complete the full section 11 audit questionnaire comprising of nine sections with supporting evidence very three years. The audits are presented to the LSCB Learning and Improvement (L+I) sub-group by a representative of the partner agency for robust peer challenge. After presenting the audit, an action plan is drafted with an agreement that the agency will update L+I in twelve months. There are occasions when intermediate updates are requested, usually following the identification of a risk or issue deemed of sufficient importance to warrant an interim review. Support is offered with completion of the full audit from the LSCB Professional Advisor.

Non-statutory partners can use the Section 11 audit as a safeguarding self-review tool. During 2014 the Diocese of Ipswich and St Edmundsbury, East of England Ambulance Service, Ipswich Hospital* and CYP Community Health* all completed S11 self-assessments.

** It should be noted that Ipswich Hospital and CYP Community Health used their audits findings to contribute to the subsequent wider Health and SCC full three year audits.*

Engagement of Suffolk partners in the Section 11 process.

There was 100% engagement to the section 11 process in 2014. Each of the ten partners who completed audits did so willingly and reported that they could see the mutual benefits of the process.

Only one partner, SCC did not complete the Section 11 within the twelve month timescale but it was agreed to defer for two months to allow the CYP Director for Children Services to discuss and agree the audit with all departments in the County Council.

Interim Annual reviews

After a full three year audit there is a process of two interim annual reviews conducted by the LSCB Professional Advisor. They will usually present the interim review findings with a summary report to L+I on behalf of the partner agency.

The interim annual reviews cover a range of items:-

- Update on last year's action plan.

- Identification of new risks.
- Update on previously identified risks.
- Details of any consultations with young people.
- Capture of good practice examples.
- Identification of any training needs or support required from the LSCB.

Risks are added to the LSCB risk register and inform the business planning process.

Findings from the Section 11 Audits in 2014.

Single Agency risks

Single agency risks (that relate to only that partner) are dealt with by reviewing the agreed action plan and risk at the subsequent twelve month review with the Professional Advisor.

Most of the single agency risks and issues during 2014 related to strategic re-organisations within partner agencies. Two examples below:-

- **Norfolk and Suffolk Community Rehabilitation Company –** A new private sector partner taking over responsibility for the organisation from mid December 2014. Still to fully establish ongoing business processes with Probation service.
- **NHS England –** A restructure of regional teams led to uncertainty where the strategic safeguarding responsibilities would lie. Also waiting for national guidance regarding strategic safeguarding policies.

In two of the above examples (CRC and NHS England) the partners were asked to provide a report to L+I within 6 months as the level of strategic risk following the reorganisation was deemed to warrant further reassurances to the LSCB. These have been scheduled.

Multi agency risks

Any risks that are deemed to be **multi-agency** have been added to the main risk register in **Appendix three**.

Multi-agency risks, with a robust focus on commissioning, are reviewed by the LSCB Professional Advisor and can result in further Thematic Audit work where agreed by L+I e.g. a risk was identified by Forest Heath/St Edmundsbury during their annual review in February 2014. They highlighted an issue regarding Housing provision for 16-17 year olds and the protocol with CYP colleagues which can result in safeguarding risks. The LSCB conducted a Thematic Audit with recommendations and an action plan in August 2014.

Joint reviews during 2014

This was the first year that the four joint District and Borough councils completed S11 reviews. In previous years some had presented individual audits. This made the process quicker and more joined-up but it also highlighted that some Districts were still implementing strategic organisations changes and revised overall responsibilities for Safeguarding.

It also meant that Babergh and Mid Suffolk had to delay delivery of their Safeguarding training due to staff changes affecting some training officers. This was highlighted in the June 2014 LSCB full year Performance report and subsequent assurances were given to the L+I group in September to mitigate the risk.

This was also the first year that a joint audit was completed by Health, this incorporated the following statutory partners:-

- NHS England (Suffolk)
- Great Yarmouth and Waveney CCG
- Ipswich and West Suffolk CCGs

All three audits were presented jointly to L+I in June 2014 to allow the group to observe the joined up approach across the County and to provide an appropriate level of scrutiny.

The ‘old’ Norfolk and Suffolk Probation service was split into two separate organisations in May 2014 following the Government’s Transforming Rehabilitation programme.

Norfolk and Suffolk CRC presented a full three year review in November 2014. It was agreed with the L+I group that a further review would be completed in June 2015, following the appointment of Sodexo as the private company acquiring ownership of CRC in December 2014.

The Norfolk and Suffolk Probation Service have been given support with completion of their full S11 review in Autumn 2014. It was felt that due to impending major structural changes they would be given extra time to complete their review until early 2015. L+I have requested that they present a joint audit with the CRC in June 2015 to allow the LSCB to review their cross-organisation approach to safeguarding.

In January 2014 a S11 interim annual review was completed with the Safeguarding Lead Officer at Warren Hill YOI. The focus of the review was the impending closure of the facility in February and the transfer of the Suffolk Young Offenders to other YOIs in the following month. This was completed successfully with sufficient assurances given.

Changes to Section 11 Audit report during 2014

The following changes were made to the Section 11 audit questionnaire for 2014.

- **Commissioned Services** – An additional section was added on Commissioned Services following feedback from partners in 2013. This section covers asks questions such as:-
  Commissioned service providers have safeguarding standards at least as stringent as our own
  There is a designated lead officer within the commissioned organisation who will report concerns to the commissioner where appropriate

- **Staff Training data** – Additional question added to ensure that data is available to the LSCB for their annual Performance report L+I group in June:-

- **Escalation Policy** – Following the Family A Serious Case Review recommendations in January 2014 , the following question was added regarding escalation procedures:-
  Staff are aware of the LSCB Professional Disputes (Escalation policy) and feel confident to use it where an issue is adversely affecting outcomes for a child or family

Proposed changes to the Section 11 Audit for 2015

An additional question will be added to the audit from January 2015 regarding whether organisations have E-Safety policies and procedures in place including for malicious communications, illegal or unsuitable behaviour and cyber bullying incident reporting.

Further information will be sought from District and Borough Councils when they complete their full audits regarding information for licensees around Child Sexual Exploitation.

Recommendations from the Serious Case Review of Young Person 'C' include how safeguarding arrangements for sub-contracted services can be audited through the Section 11 Process.

These are areas of development for the LSCB in early 2015.

157/175 Education Act 2002 Self Assessments

- There are 369 schools in Suffolk including independent schools
- There are 334 schools in Suffolk excluding independent schools.
- There are 318 maintained schools in Suffolk including Pupil Referral Units.
- There are now 60 Academies in the whole of Suffolk with more opting to covert from Local Authority control. These include 4 Free School Academies and 1 Free Special School Academy.
- There are 4 FE Colleges in Suffolk

91% (319) of all maintained primary, secondary, special schools, residential special schools, pupil referral units, academies and independent schools completed self-evaluation

review assessments within the timescales. Where a formal federation is in place across schools one overarching self-assessment has been submitted. This is the case for approximately eight schools.

The engagement of the independent sector schools in this process has shown an improvement and as a result 10 independent schools chose to submit their self-assessments this year with an increase of 25% since last year. However, with staff turnover we appear to have lost some engagement of the FE colleges with only one of the three submitting a return this year

Overall a response rate of 95% (340) has been received for 2015 which is consistent with last year's response rate. Five schools including two academy schools failed to submit a return this year and plans are in pace to audit those provisions.

Themes from self-review assessments have been identified for areas for improvement and will be monitored accordingly.

10.0 Developing an Effective Safeguarding Workforce

Training and Sufficiency

From the 1st April 2015 until the 31st March 2015, the total number of safeguarding related courses run by CYPS Workforce Development totalled 150. The number of delegates exceeded 2,400.

A very successful Partnership Trainer Support Programme ensures that, alongside the numbers trained by Workforce Development, are those trained by the Safeguarding Leads in Partner Organisations and by the Safeguarding and Quality Assurance Team

Course	Total number of courses delivered	Total number of delegates
Safeguarding Children (for new starters and three year renewals) (Group 2)	24	389
Introduction to Safeguarding for Early Years settings (Group 2)	49	639
Safeguarding: Understanding the Family Journey (Group 3)	9	115
Working Together to Safeguard Children (Groups 3 and 4)	22	449
Child sexual exploitation – full course	3	44
Child sexual exploitation – briefing session for School Nurses	1	50
Child sexual exploitation – briefing for Health Visitors	1	70
Workforce e-safety training for SCC staff	3	31

Safeguarding: Roles and Responsibilities	9	138
Domestic, Sexual and Honour Based Abuse: Foundation Course	5	135
Children and Domestic Abuse: A shift in approach	5	90
Domestic Abuse: Applying Protective Interventions/MARAC	5	96
Working with young people in abusive relationships	2	41
Working with Reluctant, Hostile and Evasive Families	7	139
Attachment based practice	2	48
Understanding Risk with all Families	1	12
Achieving Best Evidence	2	14

In conjunction with the LSCB, CYPS Workforce Development and Community Action Suffolk hosted a two day event supported by University College Suffolk.

The event ran a series of workshops looking at a range of topics across the Adult and Child Safeguarding spectrum.

Workshop	No. of delegates
Working with reluctant, hostile and violent service users	61
Childhood exploitation	27
Private Fostering, sexual exploitation and trafficking	31
Managing digital reputations	20
Challenging assumptions about young people's sexual lives	11
Children, death and society	15
Positive Choices	12
Signs of Safety and Well being	72
Trauma and the Toddler Brain	36
Working with children who display sexually inappropriate behaviour	29
ACCORD Protocol	10
Transitions – moving into adulthood	9
Risk responsibility and resilience (PHSE)	10
Chemical highs	13
Multi agency working: A psychological framework	29
Attachment based practice	34
Getting real about gangs	23
Honour based violence	8
MASH update	20
Improving infant mental health – using VIG	18

Core training course materials have continued to be reviewed and updated to reflect changes in policy and working practice.

Key revisions include:

- Suffolk's Serious Case review and lessons learned
- Signs of Safety and well-being, including the one-page assessment tool and the three houses tool
- Multi Agency Safeguarding Hub

Train the Trainer Programme

New trainers from Suffolk Sport, Ryes College, Belstead Children's Home and Suffolk Libraries have joined the Train the Trainer programme

Regular Trainer Support Forums held. Topics covered included

- Age of consent and children who display sexually inappropriate behaviour
- Child Sexual Exploitation (Rotherham)
- LSCB Thresholds
- Learning from Suffolk Serious Case Review
- MASH

Safeguarding Vulnerable Groups training package has been revised and re-launched.

Multi Agency Safeguarding Hub (MASH)

A workforce development plan is in place for MASH, and the following learning activities have taken place.

Session	Number of Attendees
Carrying out research/data trawl	11
Information Sharing	33
Introduction to MASH	32
LSCB Thresholds	21
Childhood Neglect	26
Child Sexual Exploitation	20
Safeguarding and Education	25
Mental Capacity Act	30
Equality and Diversity	55

Impact/Response to Suffolk Serious Case Review

Two of the courses in the 2014-15 training programme were commissioned in direct response to the Suffolk Serious Case Review. More information on the impact of the training in response to the Serious Case Review can be found under Section 13.

New Courses planned for 2015-16

New courses in development for 2015-16 delivery include:

- Missing Children – being developed following feedback from QA audits around the quality of return interviews. This one day course will focus on wider risks associated with going missing (not just CSE) and will go through the process and good practice of conducting return interviews
- Mental Capacity Act: young people in transition – this half day course aims to raise awareness of the Mental Capacity Act and its application with regard to young people with disabilities, including the importance of the transition process (in line with the Care Act)
- Understanding the impact of parental mental health issues – in the process of being commissioned as part of the Hidden Harm strategy.

11.0 Child Death Overview Panel

According to Working Together (March 2015), The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for ensuring that there are arrangements for:

a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

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

In order to fulfil the LSCB's responsibility as described above, the Child Death Overview Panel (CDOP) is a sub-group of the Board that is responsible for reviewing all deaths of children and young people who are normally resident in Suffolk, from day of birth, up to but not including the age of 18.
The only exceptions to the child death review process are those babies who are stillborn and any death following a planned medical termination of pregnancy carried out within the law.

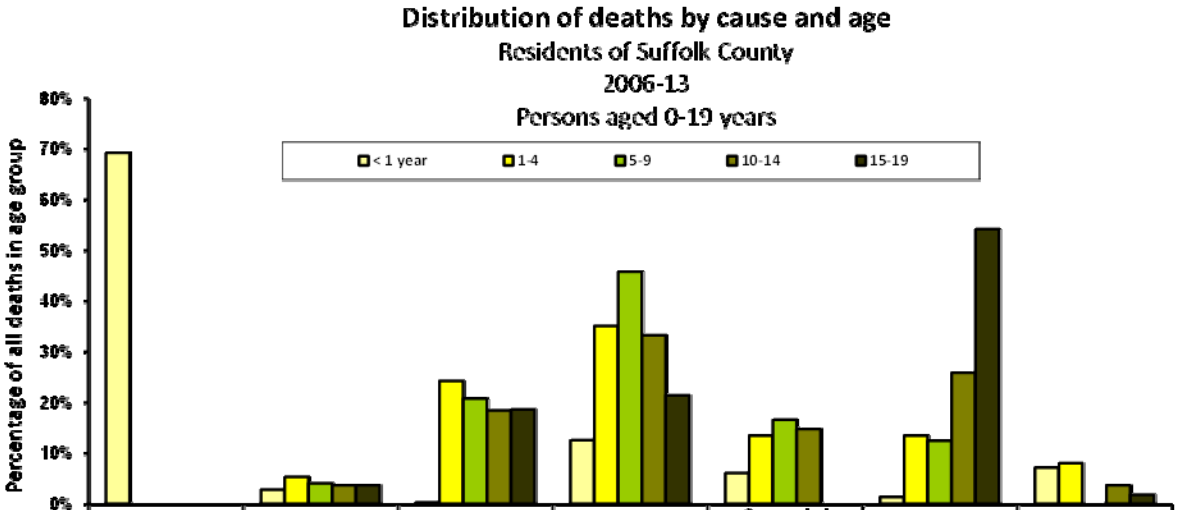
The Suffolk CDOP has been operational from 1st April 2008 with membership of 12 different partner agencies. The Panel is chaired by a Consultant in Public Health, Public Health Suffolk. The Panel's clinical advisory role is held by County Designated Doctor for Safeguarding Children. Business support is provided by the LSCB CDOP Coordinator. The Panel works closely with partner agencies and other organisations to collect, collate and analyse case information to inform the review process.

Suffolk CDOP meets every other month for approximately 3 hours. In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. Progress against learning and improvement recommendations made by the Panel are tracked by a Learning Log which informs a standing item for review at every meeting.

In addition to the above, the countywide LSCB Protocol for Sudden and Unexpected Deaths in Childhood or Infancy (SUDIC) is also monitored through the CDOP.

Issues around local provision of bereavement support for families who have experienced a child death are also discussed within the CDOP, with good practice regularly being shared and commended.

Infant, child and adolescent death rates in the UK have declined substantially and continue to fall. A total of 472 deaths among children aged between 0-19 were reported in Suffolk between 2006 – 2013. Males were slightly over represented females (58%). The death numbers fluctuate between 39 and 63 averaging 59 a year during this reporting period. The lowest number of 39 is reported in 2013. Leading causes of all deaths among children aged between 0-19 in Suffolk during this period were reported to be a neonatal event (aged less than 28 days), accidents (15 -19 years olds) and acute & chronic illness (5-9 years olds) (Figure below). This local picture is in line with regional and national trend.



	Neonatal (age less than 28 days)	Infectious diseases	Cancer	Acute/chronic medical	Congenital malformations (age 28 days and over)	Accidents and trauma	Other causes
< 1 year	69.3%	2.9%	0.4%	12.5%	6.1%	1.4%	7.2%
1-4	0.0%	5.4%	24.3%	35.1%	13.5%	13.5%	8.1%
5-9	0.0%	4.2%	20.8%	45.8%	16.7%	12.5%	0.0%
10-14	0.0%	3.7%	18.5%	33.3%	14.8%	25.9%	3.7%
15-19	0.0%	3.7%	18.7%	21.5%	0.0%	54.2%	1.9%

Source: ONS VS3 tables

Accidents and trauma covers External causes of morbidity and mortality, ICD-10 Chapter XX
Cancer includes all causes in ICD-10 Chapter II
Acute/chronic medical covers ICD-10 Chapter III through to Chapter XVI

During the period 2014-2015, 34 child deaths were notified to the CDOP. This significant reduction in comparison with previous years appears to reflect national and local mortality trends.

During the period 2014-2015, a total of 29 deaths were reviewed by the CDOP. Of these reviews, 21 were outstanding cases from the previous two years. A 'backlog' of delayed reviews occur every year and are anticipated due to the complex nature of external investigations that may take place to establish cause of death and associated Coronial duties. Delays may also occur where case details are difficult to obtain; such as when children die outside of the county.

Learning and Impact includes:

Suffolk CDOP Newsletter

Expected outcome: sharing key preventative messages from local and national child death reviews directly to the public increases parents knowledge and understanding to take positive steps to safeguard their children and potentially prevent further child deaths.

Suffolk CDOP Web Page

During 2014-2015, the CDOP page on the LSCB site has been updated to include links to:

- Suffolk CDOP Newsletter
- Suffolk Safeguarding Children Board CDOP Bereavement Support Directory
- Suffolk CDOP Bereavement Reading List for Professionals: Suffolk County Council Knowledge Centre have kindly researched and compiled a reading list of books and online resources about Death and Bereavement, aimed at children, parents and professionals. Many of these resources are available to loan from Suffolk Libraries or through the Knowledge Centre, which is based in Endeavour House, Ipswich.

Expected outcome: using the CDOP page as a repository for useful links helps to make information about bereavement and working around death and grieving more accessible to professionals.

Commissioning of Public Health Evidence Briefings

The Panel has a strong dialogue with Suffolk Public Health work streams and utilise specialist expertise to 'drill down' on areas of concern and seek assurance. Evidence-based investigations into risk, prevalence and compliance with best practice are commissioned through the Panel in response to cases discussed. Findings are then presented at Panel so that members can formulate their recommendations and/or reassurances or take away single agency actions as required.

Impact: An example of this is a review undertaken for CDOP in May 2015 into links between invasive Group A Streptococcal (iGAS) infection, necrotizing fasciitis (NF) and the chickenpox virus, varicella zoster (VZ) and a discussion around the argument for the national vaccination schedule to be updated to include VZ, as is the case in some other countries, including the US and Japan.

Impact: Another example of the utility of public health briefings for CDOP is a review of aftercare guidance for glandular fever, which helped to inform both the CDOP public newsletter and a briefing sheet for professionals, highlighting the increased risk of ruptured spleen following infection. Specific symptoms of concern were identified with advice to seek immediate medical attention and NICE guidance on aftercare was reiterated (patient to avoid strenuous physical activity for a month).

Young Drivers and Young Passengers

Panel reviewed a small but significant number of local cases across recent years where traffic collisions have involved young drivers (17-24) and young passengers. Context is provided by national data which suggests that young drivers are at a much higher risk of crashing than older drivers. Drivers aged 17-19 only make up 1.5% of UK licence holders, but are involved in 12% of fatal and serious crashes[1].

Impact: Suffolk Constabulary have responded to the national challenge of raising road traffic safety among young people, through developing systems to identify and respond to young drivers and young passengers who are associated with vehicles have raised concern.

Sudden Infant Death Syndrome and Safer Sleep

A package of materials to support professionals to deliver messages about safer sleeping and SIDS risk reduction to the families they work with, consistently and confidently. This was launched at a free training event coordinated by the LSCB and supported by national charity 'The Lullaby Trust' in June 2014. The event was well attended, with over 60 delegates from Health, CYPS, Suffolk Constabulary and the Voluntary and Community Sector.

Resources have been developed and distributed to key professionals, with a very successful multi-agency launch and training event. Feedback from the event:

"Fabulous morning, great speaker"

"Extremely helpful I feel much more confident to discuss with parents. Thank you"

"Very informative lots of new info. Useful resources, lots of new ideas how to promote the message!"

Following on from this initial focus on professionals, Public Health Suffolk have incorporated safer sleep into their perinatal health work stream, developing resources to be delivered directly to all new parents and wider members of the community through universal services and the Public Health Safer Sleeping Communications Strategy. CDOP continues to have an overview of this work as a standing item on its Learning Log.

Impact: ***During 2014-2015 there were no SIDS deaths in Suffolk.***

[1] Transport Research Laboratory, 2014 cited by Brake 2015

Ongoing work for 2015 includes:

In May 2015 CDOP discussed the new revisions to Working Together 2015 and agreed that it would be a timely opportunity to review Panel processes to ensure that they are compliant with government guidance. This development work will be ongoing over the forthcoming year.

CDOP have already reviewed the current practice around neonatal reviews and made recommendations that will improve the process, streamline and ensure that data is fed back to Panel regularly and in a clear and concise format that can be used to formulate recommendations as appropriate. This will inform the way that reviews are coordinated going forward.

12.0 Serious Case Reviews

The Case Review Panel

The LSCB developed a robust framework to track actions of the Family A Serious Case Review published in January 2014 and throughout 2014/15 has monitored progress on the action plan at every LSCB meeting. An evaluation of the process and methodology used to undertake the Serious Case Review and regular progress reports are published on the LSCB website.

IMPACT includes:

LSCB Guidance on working with Hostile and Evasive Families revised to include research links.

Enhanced management oversight to ensure timely progression of cases in the Child Protection system.

Revisions made to Multi Agency Training to include additional information of the assessment framework and Signs of Safety and Wellbeing as an approach. Information on a range of procedures, tools and strategies already in place to support families and the work of the Multi Agency Safeguarding Hub.

Over 1100 multi-agency staff trained in Signs of Safety and Wellbeing

Development of LSCB approved ‘Standards for Child Protection Conferences’, a range of associated targets for 2013/14, changes to the LSCB procedures, priorities for multi-agency practice change and the revised quality assurance process that would include LSCB Board Members observing and grading at least 1 CPC per year.

Within CYPS a process for structured observations of Child Protection Conferences (CPCs) has been agreed that will result in around 25 being evaluated by senior managers per year. LSCB Members have also agreed to observe at least 1 per year so in total around 50 CPC’s will be evaluated per year.

An action for training and an update of policies as part of the review findings resulted in the following:

Working with hard to reach and avoidant families

This was given prominence at our 3-day Continuing Professional Development event in September 2014, where the first keynote speech specifically explored working with reluctant and hostile service users.

In addition, seven sessions were also commissioned from Reconstruct Training. These sessions were entitled 'Working with Reluctant, Hostile and Evasive families' and the aims and objectives were to increase practitioner confidence and skills by providing a variety of tools and techniques for working with service users in challenging situations. The training also looked to explore techniques of 'reflection in action' which allow skilled communication and can defuse escalating hostile and challenging situations and to consider a model of communication to use when faced with a difficult situation.

Evaluations

Delegates completed an electronic evaluation form within a few weeks of attending the event. They are also asked to complete an impact evaluation between 3 and 6 months after the event.

Evaluations for 5 of the 7 sessions delivered are available to date, and a summary is shown below:

58 delegates completed the first evaluations

54 delegates responded that the training would have an impact on their work

Comments included:

> *'I feel much better equipped to deal with difficult service users/families and hopefully this will help me to develop better relationships with the families I work with or meet in the future'*
>
> *'I am now more aware of the need to not let reluctant families slip through and the importance of maintaining regular contact.'*
>
> *'Has raised awareness of how to alter my communication style depending on who I'm talking to and why and to plan which style would best suit my purpose in planning visit etc.'*
>
> *'I have a greater understanding of why some people may be reluctant, hostile or evasive and therefore feel better equipped to deal with situations where these aspects are present'*
>
> *'I will be more confident to persist in the face of resistance and/or non-engagement'*

'I feel I have better understanding of how my own way of speaking has an impact on responses of service users. This workshop helped me to reflect upon how I could respond differently.'

Impact Evaluations:

8 delegates completed the impact evaluations.
7 delegates responded that the way they work has changed as a consequence of attending the event.

Comments on how work has changed, or why it is unchanged, included:

- *Looking at the way families feel that the service is not working for them*
- *Looking at attachment issues whilst working with families*
- *This course reinforced what I had previously learned regarding working with reluctant/resistant families*
- *It has made me thing about changing the way in which I work with families when cases get stuck*
- *It has made me change the way I work with certain families with regard to being more open minded re: working in a different style as the same approach does not work with all families.*

Additional feedback:

From the responses where participants felt the training would not impact on their work, there were two main themes:

- The training was deemed to be mostly aimed at Social Workers and was therefore not deemed to be appropriate for some participants, for example one delegate attended from an Early Years setting
- The course was more focused on dealing with hostile services users rather than engaging reluctant families.

These points will be taken into consideration for future delivery and the programme revised accordingly to ensure it meets the needs of all agencies.

<u>Understanding a parent's own childhood</u>

Changepoint Learning were commissioned to deliver the following training:

- 2 x 3 hour workshops at our 3-day CPD event in September
- 2 x 3-day courses on Adult Attachment – First course delivered in November 2014, and second in January 2015

The objective of these courses was to provide an introduction to contemporary attachment theory, namely the Dynamic Maturational Model.

The course provided a strong emphasis on the development of practical skills, and applying the theory to a professional's own setting.

Evaluations

36 delegates submitted evaluations, and 36 delegates responded that the training will have an impact on their work.
Comments included

'I now have a very clear understanding of the different strategies people use and was able to deliver a summary of the course at my team meeting'.

> *'I am now much more confident in explaining attachment theory to other and applying attachment based techniques'.*
>
> *'It will inform me what will give me the best approach to engaging with parents/young people depending on how they initially present/past information will give me a clue to what attachment strategies are being used in times of trauma/crisis. Will help enormously with parenting assessments'.*
>
> *'I feel better equipped to ask relevant questions to ascertain type of attachment during childhood and how that may impact on their relationships and coping strategies'.*
>
> *'I will be able to use what I have learnt to explore parent's attachment strategies and help them to reflect on what works for them now. I will be able to assess the attachment strategies of the children who are allocated to me, as well as explore those used by carers and adopters. This will help inform my decisions around placements'.*
>
> *'I now have an understanding of attachments and how childhood attachments have an impact on adult attachments, I will use some of the questions from the adult attachment assessment while assessing families'.*
>
> *'It has informed my own practice and supervision practice immediately. I have an increased awareness of how to effectively support children who may be experiencing attachment difficulties and greater understanding of parent's perspective'.*
>
> *'The tutor was amazing and I feel confident to support people due to their attachment style'*

The LSCB commenced work on another Serious Case Review in 2014 and has just published the findings entitled 'Young Person 'C'. Recommendations and themes from the Serious Case review will again, be the subject of a comprehensive action plan, and robustly managed by the LSCB. A key recommendation of this review was that:

Within three months all of the individual agencies involved in this SCR should develop an action plan and audit the incidental learning attributed to their organisation (including those that apply to 'all agencies') in this report to ascertain whether the issues are generalised across their service provision or attention is required in one part of the system only.

The full review and LSCB response can be found on the LSCB website. A full review of the impact of learning from the SCR will be included in the 2015/16 Annual Report.

13.0 Essential Information

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Date of Production:	July 2015
Approval Processes:	LSCB Executive Group, Local Safeguarding Children Board
LSCB Website:	Available from September 2015.

The information contained in this report is taken from, or links to, the following key strategic plans and policies:

1. Suffolk LSCB Full Year Performance Report July 2015
2. Suffolk LSCB Forward Delivery Plan 2014-16
3. The State of Suffolk Report Executive Summary 2015
4. Suffolk County Council CYPS, Private Fostering Annual Report 2014/15 *Phillips H and Harris F June 2015.*
5. Suffolk County Council CYPS, Safeguarding Learning and Quality Assurance Service LADO Annual Report 2014/15*, Burton C. June 2015*
6. Suffolk County Council CYPS, Safeguarding, Learning and Quality Assurance Service. Summary of Safeguarding Training for schools and education based workforce June 2015 and Keeping Children Safe in Education Annual Performance Report*. Jackson L*
7. HM Government: Department for Education 'Working Together to Safeguard Children' 2013 and 2015

Appendix 1 – LSCB Forward Delivery Plan 2015/16

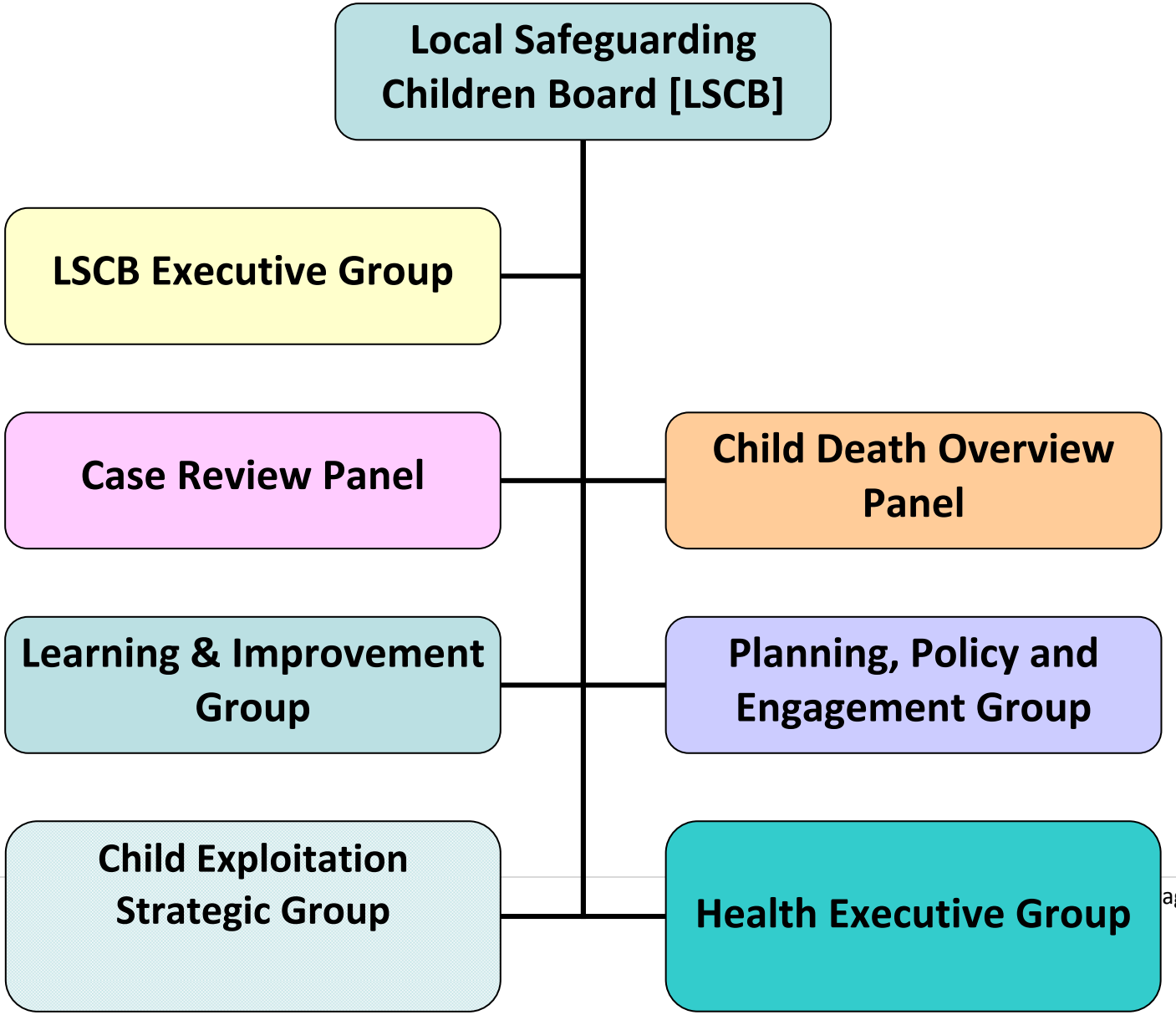
The LSCB Executive Group received a report in March 2015 on the impact of the Forward delivery Plan and outstanding actions. Those outstanding actions, along with information received from audits, priorities agreed by the LSCB and National Legislative drivers have informed a set of outcome focussed priorities for 2015/16 and these were agreed by the Executive Group and for endorsement by the Board April 2015.

The LSCB priorities are as follows:

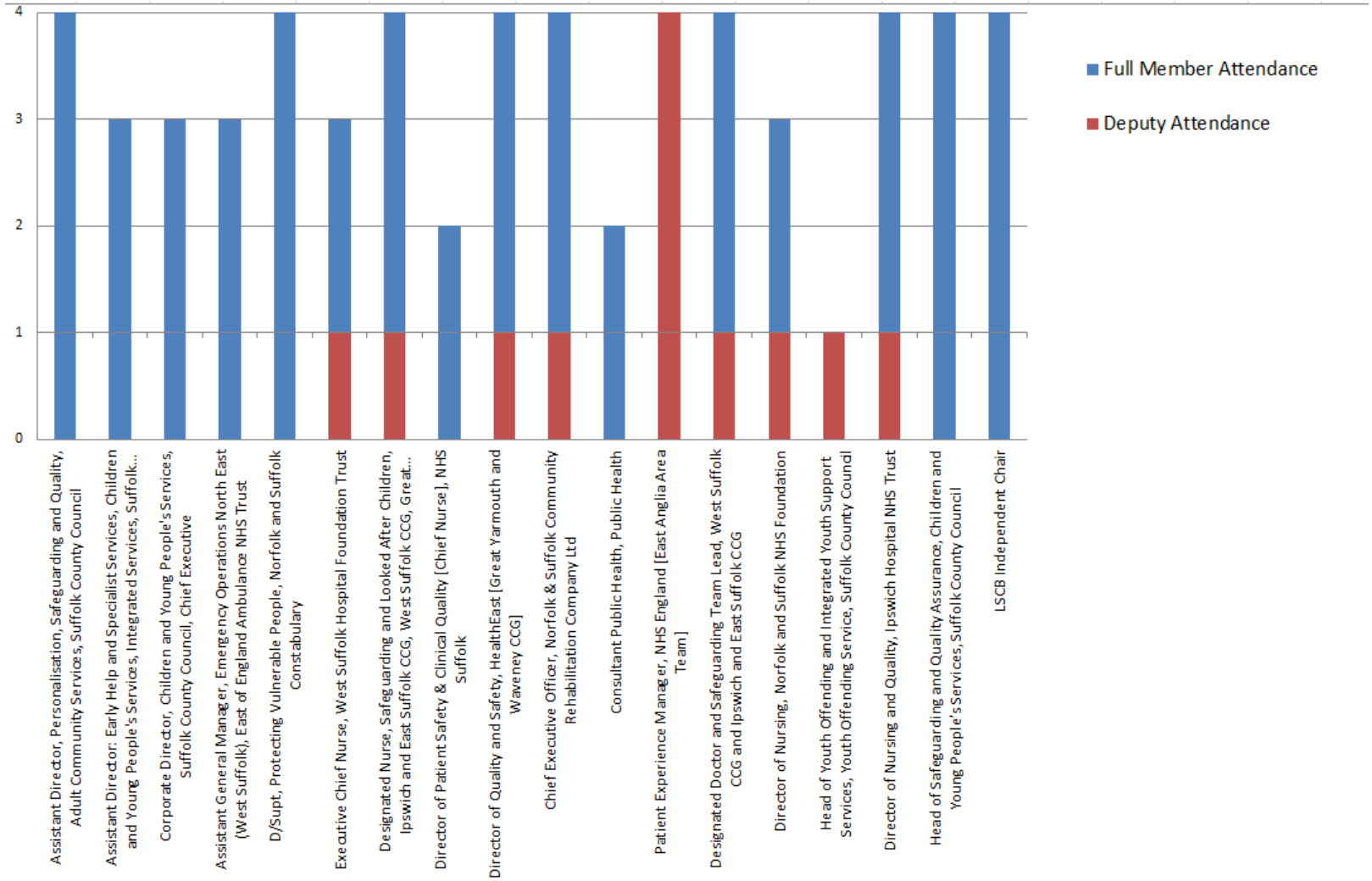
- ✓ Deliver on the agreed CSE Action Plan and monitor the impact on CSE awareness and safeguarding practice across the county;
- ✓ Ensure that the implementation of the Early Help Strategy is achieving successful outcomes for children and their families;
- ✓ Ensure the development of a co-ordinated approach to Domestic Abuse across the partnership with clear strategic ownership in order that the true picture and impact on children of Domestic Abuse can be understood by the LSCB;
- ✓ Evaluate the impact of the Multi Agency Safeguarding Hub'
- ✓ Ensure safeguarding risks across the LSCB partnership, particularly those as a result of increasing demand for services and on-going re-shaping of services are identified and acted upon;
- ✓ Ensure that as much learning as possible is gleaned, shared and embedded from Practice and Serious Case Reviews;
- ✓ Ensure that the implementation of actions arising from the Serious Case Review improve the quality of professional practice

The full LSCB Forward Delivery Plan can be located on the LSCB website within the LSCB Business Publications section at www.suffolkscb.org.uk/information-and-links/lscb-business-publications/

Appendix 2 - LSCB Structure Chart as at 2014



Appendix 3 - Partner Attendance at Board and Executive Meetings - 2014/15



Appendix 4 – Budget for 2014/15

In 2014/15 the LSCB received a total of £202,561 – slightly lower than expected due to closure of Warren Hill YOI. (This figure does not include the possible draw down facility of up to £30,000).
This figure was made up from the following contributions:

2014/15 Partner contributions to LSCB Budget:	**£**
Babergh District Council	5,000
Forest Heath District Council	5,000
Ipswich Borough Council	5,000
Mid Suffolk District Council	5,000
Suffolk Coastal District Council	5,000
St Edmundsbury Borough Council	5,000
Waveney District Council	5,000
CYPS BASE budget	64,611
- DSG Budget	26,900
CAFCASS	550
Suffolk Constabulary	23,500
NHS Suffolk	47,000
Norfolk & Suffolk LDU	4167
Suffolk Probation Services	833
Total:	**202,561**
Additionally, the Executive Group agreed a further £30,000 to be drawn from Reserves if required:- ▪ * Serious Case Review ▪ # LSCB Development	N/A
Overall Income 2014/15:	**202,561**

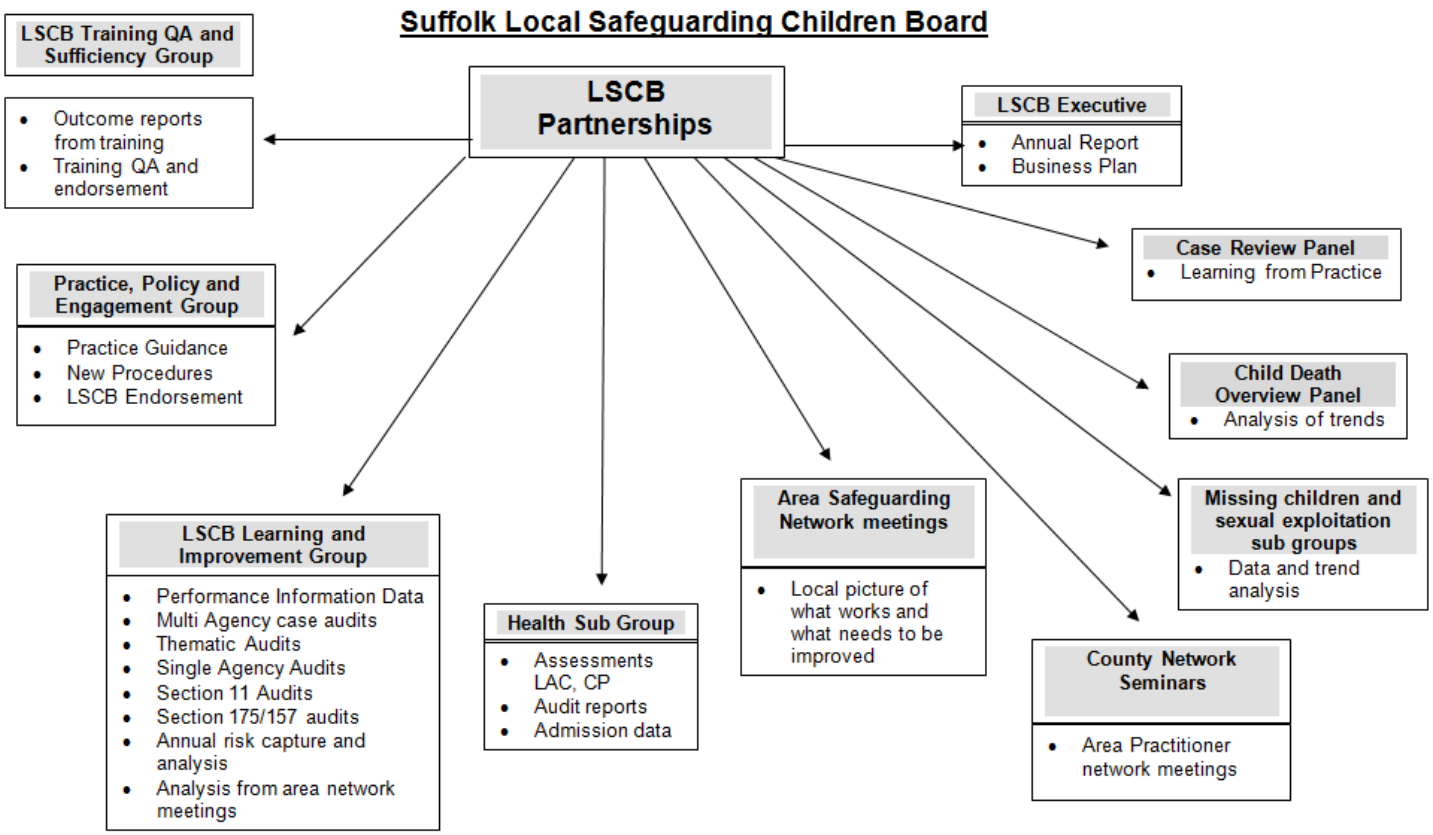
Expenditure as at 31st March 2015:	**£**
Salaries:	161,748
Transport Related Expenses:	1687
Supplies and Services:	37,350
Internal Charges:	29
Total spend:	**200,814**

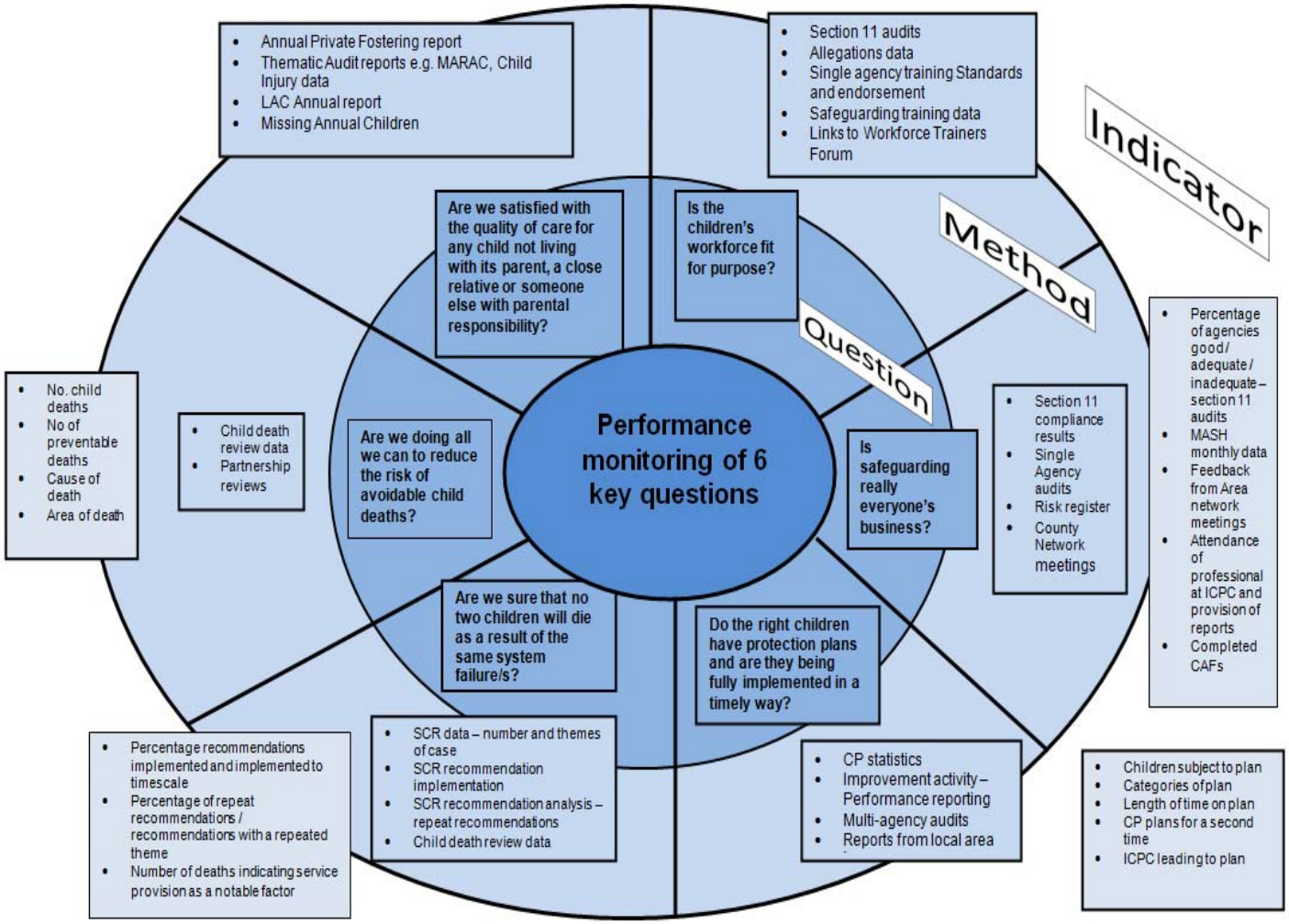
	£
Total Income/Budget including draw down from reserves:	202,561
Expenditure	200,814
Commitments:	
Balance:	**1747 (sent to reserve)**

- Serious Case Review expenditure to 31st March 2015: £1656
- LSCB Development expenditure to 31st March 2015: £3223

Appendix 5 - LSCB Learning and Improvement Framework

The full LSCB Learning and Improvement Framework can be located on the LSCB website within the Learning and Improvement section at www.suffolkscb.org.uk/about-us/learning-and-improvement-group


Suffolk Local Safeguarding Children Board
LSCB Partnerships
LSCB Training QA and Sufficiency Group
Outcome reports from training
Training QA and endorsement
LSCB Executive
Annual Report
Business Plan
Case Review Panel
Learning from Practice
Practice, Policy and Engagement Group
Practice Guidance
New Procedures
LSCB Endorsement
Child Death Overview Panel
Analysis of trends
Missing children and sexual exploitation sub groups
Data and trend analysis
Area Safeguarding Network meetings
Local picture of what works and what needs to be improved
LSCB Learning and Improvement Group
Performance Information Data
Multi Agency case audits
Thematic Audits
Single Agency Audits
Section 11 Audits
Section 175/157 audits
Annual risk capture and analysis
Analysis from area network meetings
Health Sub Group
Assessments LAC, CP
Audit reports
Admission data
County Network Seminars
Area Practitioner network meetings


Performance monitoring of 6 key questions
Question
Indicator
Method
Are we satisfied with the quality of care for any child not living with its parent, a close relative or someone else with parental responsibility?
Is the children's workforce fit for purpose?
Are we doing all we can to reduce the risk of avoidable child deaths?
Is safeguarding really everyone's business?
Are we sure that no two children will die as a result of the same system failure/s?
Do the right children have protection plans and are they being fully implemented in a timely way?
Annual Private Fostering report
Thematic Audit reports e.g. MARAC, Child Injury data
LAC Annual report
Missing Annual Children
Section 11 audits
Allegations data
Single agency training Standards and endorsement
Safeguarding training data
Links to Workforce Trainers Forum
No. child deaths
No of preventable deaths
Cause of death
Area of death
Child death review data
Partnership reviews
Section 11 compliance results
Single Agency audits
Risk register
County Network meetings
Percentage of agencies good/ adequate/ inadequate – section 11 audits
MASH monthly data
Feedback from Area network meetings
Attendance of professional at ICPC and provision of reports
Completed CAFs
Percentage recommendations implemented and implemented to timescale
Percentage of repeat recommendations / recommendations with a repeated theme
Number of deaths indicating service provision as a notable factor
SCR data – number and themes of case
SCR recommendation implementation
SCR recommendation analysis – repeat recommendations
Child death review data
CP statistics
Improvement activity – Performance reporting
Multi-agency audits
Reports from local area
Children subject to plan
Categories of plan
Length of time on plan
CP plans for a second time
ICPC leading to plan