



**Durham**

Local Safeguarding Children Board



# Annual Report 2011/12

## The Effectiveness of Safeguarding in County Durham

Agreed by Durham LSCB August 2011

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**This report is available on the LSCB website**  
[www.durham-lscb.gov.uk](http://www.durham-lscb.gov.uk)

## Section 1 Introduction- Independent Chair

Welcome to Durham LSCB's Annual Report for 2011-2012.

I am delighted to be appointed Durham LSCB's first Independent Chair, to have had an early opportunity to meet with Board members and to contribute to this report. I look forward to working closely with all partners over the next year to ensure delivery of the safeguarding priorities set out in this report and to maximise the impact and effectiveness of the Board in protecting children and promoting their welfare.

This work takes place in a rapidly changing national context, where all agencies working with children and young people have been challenged to target resources more effectively and to demonstrate ever more positive outcomes. The Board has to rise to these challenges, re-affirming its commitment to ensuring agencies remain clearly focused on child safeguarding and further develop co-operative working.

The government commissioned Munro report has endorsed the role of the LSCB as the key statutory body responsible for monitoring how effectively services and professionals work together to safeguard children. This Annual Report describes the work and achievements of the Board over its fifth year of operation. It aims to give partners and local people an up to date view on the performance and effectiveness of local arrangements and agreed priorities for improving and developing these.

This Report demonstrates how the LSCB has focussed on improving agencies practice for children who have suffered or are at risk of abuse or harm. It has also broadened its perspective to identify the specific needs of particular groups of children in collaboration with The Children's Trust. Recent examples include work on safeguarding disabled children and children where there is

evidence of hidden harm, domestic abuse, neglect and children who go missing. These areas will continue to be important along with the new priorities of strengthening early help, sexual exploitation, better information sharing and the impact of parental mental health.

The Board's targets and aspirations for children and young people across County Durham remain rightly ambitious. Keeping children safe requires a culture across agencies where staff are open to challenge and new ideas. By working together we can build upon our successes and robustly address weaker areas so as to help make children safer across County Durham.



**Fran Gosling-Thomas**  
**Independent Chair**

## Section 2: The Role and Function of the LSCB

The LSCB is the statutory process for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in County Durham.

In Professor Eileen Munro's report to the government <sup>1</sup>she confirms that the LSCB will, in accountability terms, continue to scrutinise the work of local partners in ensuring that services safeguard and promote the welfare of children and young people. "LSCBs play an extremely valuable role and will remain uniquely positioned within the local accountability architecture to monitor how professionals and services are working together to safeguard and promote the welfare of children. They are also well placed to identify emerging problems through learning from practice and to oversee efforts to improve services in response"

### Scope

The scope of the LSCB role falls into three categories:

1. To engage in activities that safeguard all children and aim to identify and prevent abuse and ensure that children grow up in circumstances consistent with safe care.
2. To lead and co-ordinate pro-active work that aims to target particular groups.
3. To lead and co-ordinate responsive work to protect children who are suffering or likely to suffer significant harm.

### Function

#### Thresholds, policies and procedures

1. Developing policies and procedures for safeguarding and promoting the welfare of children, including policies and procedures in relation to:
  - the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.
  - working with the Children's Trust to ensure that local arrangements for undertaking the Common Assessment Framework (CAF) are clear and when it is appropriate to refer a possible child in need to Children's Services.

### Training

2. Training of people who work with children or services affecting the safety and welfare of children:
  - LSCB has a responsibility to ensure that single-agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs.
  - LSCBs are required to evaluate the quality of training, and ensure that relevant training is provided. This covers both the training provided by single-agencies to their own staff and multi-agency training organisation.
  - Durham LSCB develops, organises and delivers multi-agency training although this is not a core requirement for LSCBs.

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<sup>1</sup> The Munro Review of Child Protection- A Child Centred System May 2011

## Safe workforce

3. Safe recruitment, management and supervision of people who work with children:
  - Establishing effective safe workforce policies and procedures based on national guidance.
  - Ensuring that robust quality assurance processes are in place to monitor compliance, e.g. audits of vetting practice.
4. Investigation of allegations concerning people working with children:
  - Production of policies and procedures to ensure that allegations are dealt with properly and quickly.
5. Safety and welfare of children who are privately fostered:
  - Ensuring the co-ordination and effective implementation of measures designed to strengthen private fostering notification arrangements

## Communication and raising awareness

Communicating the need to safeguard and promote the welfare of children, raising their awareness of how this can be best done, and encouraging individuals and partners to do so. This should involve listening to and consulting children and young people and ensuring their views are taken into account in planning and delivering services.

## Monitoring and evaluation

Monitoring and evaluating the effectiveness of what is done by the Local Authority and Board partners (individually and collectively) to safeguard and promote the welfare of children and advise them on ways to improve.

## Participating in planning and commissioning

The LSCB must participate in local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account:

- This is achieved to a large extent by contributing to the Children and Young People's Plan, and ensuring in discussion with The Children's Trust and agency leaders that planning and commissioning of services for children takes account of their responsibility to safeguard and promote the welfare of children.
- The LSCB is the responsible authority for matters relating to the protection of children from harm.

## Child Death Review Function

From 1 April 2008 the LSCB acquired the compulsory functions regarding all child deaths. These include:

- Collecting and analysing information about the deaths of all children normally resident in County Durham and Darlington with a view to:
  - identifying any matters of concern including any case giving rise to the need for a Serious Case Review.
  - identifying any general public health or safety concerns arising from the deaths of children.

## Section 3 Governance Arrangements

### Chairing and Membership Arrangements

In June 2011 the LSCB appointed an independent chair of the Board this has further developed the independent strategic lead for Safeguarding in County Durham

The LSCB were also successful in recruiting a County Durham resident as lay member to the board. The lay member participates fully in the work of the board provides a local voice in shaping and directing the work of the LSCB.

It is always a challenge to ensure agencies providing services to children are members of the board while maintaining a board that is both effective and manageable.

In County Durham we have a broad membership including county council services, health trusts, probation, police, voluntary services, school, colleges and faith representation.

The LSCB sees the engagement of young people as an extremely important factor in developing the work of the Board. The LSCB actively work with young people using a variety of methods including the use of blogs.

### Relationship between the LSCB and the Children's Trust (Children's Executive Board)

The LSCB role is to ensure the effectiveness of the arrangements made by the partnership and individual agencies to safeguard and promote the welfare of children. Whilst the work of the LSCB contributes to the wider goals of improving the wellbeing of children, it has a narrower focus on safeguarding and protecting children.

The Children and Young People's Plan 2009-2012 produced by the Children's Executive Board states that the Children's Trust in County Durham is committed to ensuring that 'Staying Safe' is accorded the highest priority in the way in which services are delivered and by the practitioners who deliver them

- **The LSCB is not subordinate to nor subsumed within the Children's Trust arrangements.**
- **The LSCB has a separate identity and an independent voice.**
- **The LSCB is able to challenge and scrutinise effectively the work of the Children's Trust and partners.**
- **The LSCB forms a view of the quality of local safeguarding activity.**
- **The LSCB challenges organisations with an independent voice.**
- **The LSCB must be formally consulted during the development of the Children and Young People's Plan.**

Safeguarding is a standing item on the Children's Executive Board agenda. The Trust draw on support and challenge from the LSCB to ensure that the Children and Young People's Plan reflects both the strengths and weaknesses of safeguarding arrangements and practices and what more needs to be done by each partner to improve safeguarding.

The Children's Executive Board needs to draw on the advice and evidence in this report to inform the development and review of the Children and Young People's Plan and should show in the plan how it intends to respond to the issues raised by the LSCB.

The LSCB Chair/vice chair sits on the Children's Executive Board and the Chair of the Children's Executive Board is a member of the LSCB. The Children's Executive Board formally reports to the LSCB Board as a standing item on alternate Board meetings.

## **Role of Elected Members and Director of Children's Services**

- The LSCB Chair/vice chair reports on an annual basis to the Overview and Scrutiny Committee for Children and Young People. It is provided the opportunity to both challenge and ask questions about the effectiveness of the Board's activities.
- The Lead Member for Children's Services is a member of the LSCB and has a role to ensure that effective quality assurance systems for safeguarding are in place and functioning effectively.
- The Corporate Parenting Panel receives regular updates from the LSCB Vice Chair.
- The Corporate Director, Children & Young People's Service, ensures that all Local Authority services engage effectively with the LSCB.

- The Corporate Director, Children & Young People's Service, is held to account for the effective working of the LSCB by the Chief Executive and challenged where appropriate by the Lead Member.

## **Local Inspection Framework**

Professor Eileen Munro <sup>2</sup>describes the importance of an inspection system that understands the contribution of all agencies to child protection. The local inspection framework plays an important role in reinforcing the ongoing monitoring role of the LSCB. Unannounced inspections ideally based on a multi-inspectorate model should address the input of agencies from the perspective of the child, examining the 'child's journey'

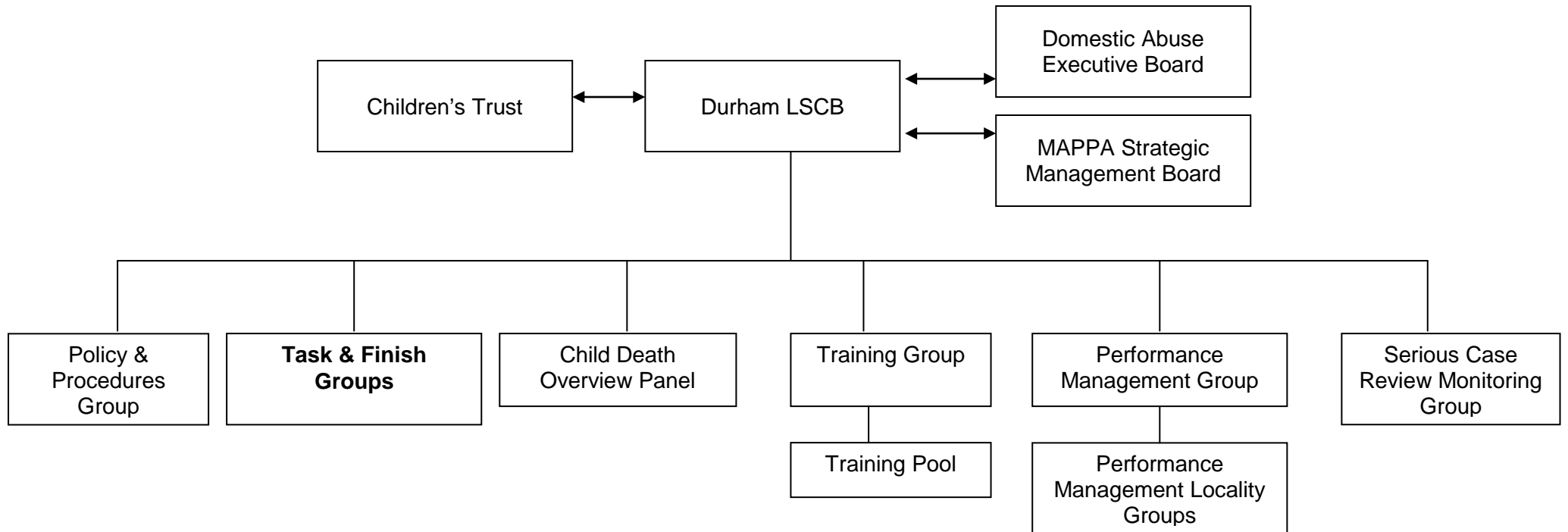
The LSCB will provide views to inspectorate bodies on the quality and effectiveness of work to safeguard and promote the welfare of children. The effectiveness of the LSCB itself will inform part of the judgement of the inspectorates.

It will be for the Local Authority to lead in taking action, if the LSCB's own processes are judged to be insufficiently robust.

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<sup>2</sup> The Munro Review of Child Protection May 2011

# LSCB, Sub-Groups and Task Groups



## Section 4: Safeguarding in County Durham - Performance Management

### Safeguarding Activity- the picture in Durham

During the year 2010-2011, the LSCB has continued to collect data about Child Protection, Safeguarding and Promoting the Welfare of Children. The following information is illustrative of some of the activities with children and families carried out in 2010-11 compared to that of previous years:

	2008-9	2009-10	2010-11	% change from 2008 to 2011
Number of CAFs completed	*	*	1457	N/A
Number of Initial Contacts to Children's Social Care	9073	12435	15279	68.4
Number of Referrals	3350	3871	4066	21.4
Number of Section 47s completed	821	894	752	-8.4
Number of Initial Assessments completed	3160	3680	3991	26.3
Number of Core Assessments completed	874	1204	1434	64.1
Number of Children with a child protection Plan as of 31 March	288	446	439	52.4
Number of Legal Orders as of 31 March				
Police Protection	3	1	1	n/a due to low figures
Emergency Protection Order	0	1	1	n/a due to low figures
Interim Care Order	44	71	62	40.9
Care Order	204	212	215	5.4
Placement Order	40	44	54	35.0

\*not previously collated

In April 2011, the new data set was introduced to the Board for the first time. The set includes key indicators about the safety and welfare of children and young people from a range of agencies rather than focussed on social care processes. It was agreed that the data set would be presented annually and the messages arising from the data would be considered in identifying the LSCB priorities to be taken forward into the next planning year.

The data collected in 2010-2011 indicates the following strengths:

- Despite the large increases in referral rates, the numbers of Initial and Core Assessments have also risen.
- Numbers of children with a child protection plan have risen significantly since 2008 but the rise appears to have now reached a plateau.
- The number of legal orders has kept pace with the rise in numbers of children with a Child Protection Plan.
- 99% of Initial Child Protection Conferences are held within timescales.
- There is increased involvement of GPs in Child Protection Conferences.
- There is increased participation of young people in Child Protection Conferences.
- Gun and knife crime figures indicate that this is not a problem for Durham at this time. Similarly, gang activity is not a significant issue that needs to concern the LSCB at this time.
- There are no recorded cases of child trafficking in County Durham with less than 10 recorded regionally. However, agencies still need to be vigilant, and the LSCB will continue to monitor this activity.

The data highlights the following areas for improvement and/or further analysis:

- The number of Section 47 investigations appears to have fallen significantly, despite a rise in safeguarding referrals. Early indications, however, would indicate that this may be a recording issue.
- Domestic abuse has featured in 50.2 % of cases leading to Child Protection Plans and continues to be a major challenge.
- Parental mental ill health has consistently featured highly in Child Protection Plans and has risen by 7% since 2009/10. For the period January 2010 to July 2011 parental mental ill health featured in 31% of Child Protection Plans. It is for this reason that it has been agreed as an LSCB priority for 2011-2012.
- Alcohol and drug misuse continues to feature highly as a risk factor in 67.4% of child protection cases. Currently, the LSCB are carrying out an evaluation of how agencies work together to protect children from Hidden Harm.
- Low numbers of children continue to be notified as privately fostered children, despite considerable focus on raising awareness.
- 563 children were reported as missing between April 2010-February 2011 a 9% increase on the previous year. The LSCB have undertaken work to recently establish protocols to respond. The work of the Missing and Exploited group will allow the LSCB to monitor the effect of changing practice
- Police reports indicate that over the past 12 months there has been an increase in offences of internet grooming. No figures are available regarding the exact number of incidents that cause concern to parents and professionals although the LSCB now have processes in place to capture this information through the monitoring function of the e-safety designated officers and the LSCB Performance Manager. An e-safety audit will monitor how LSCB partners are complying with the agreed strategy to keep young people safe online

## **Performance Management Framework**

The LSCB has a robust performance management framework to assist in understanding the manner in which agencies work both individually and together to safeguard the welfare of children and young people in Durham.

Information is obtained from a variety of sources including:

- Audits.
- Serious Case Reviews/Management Reviews.
- Self Assessment.
- Concerns and complaints from children and families.
- Data collection at child protection conferences and core groups that assists the LSCB to understand the effectiveness of these crucial decision making activities.
- Multi-agency safeguarding data set.
- Local direct contact with hundreds of multi-agency staff attending training, workshops and conferences.

The LSCB has a Performance Management Sub-Group, which examines issues on a countywide and strategic basis and three Locality Groups, which look at improving performance across the professional disciplines on a local operational basis. All four groups meet quarterly.

**Figures showing the numbers of children subject to a child protection plan and the categories of abuse up to July 2011:**

Number of children with a CP Plan at 31/07/2011 = 431

Children with a Child Protection Plan by Category –  
1 January 2009 to 31 July 2011

Category of Abuse	31/01/09	31/01/10	31/01/11	31/07/11
Neglect and Likelihood of Neglect	169 (45%)	258 (48%)	314 (68%)	284 (66%)
Physical and Likelihood of Physical	98 (26%)	130 (24%)	145 (31.5%)	118 (27%)
Emotional and Likelihood of Emotional	67 (18%)	95 (17%)	75 (16.3%)	102 (23%)
Sexual and Likelihood of Sexual	41 (11%)	58 (11%)	27 (5.8%)	20 (4.6%)

(one child may have several categories)

The percentage of children on the List as a result of Neglect rose by 20% since January 2010. Currently, 66% of children on Child Protection List are there because of neglect.

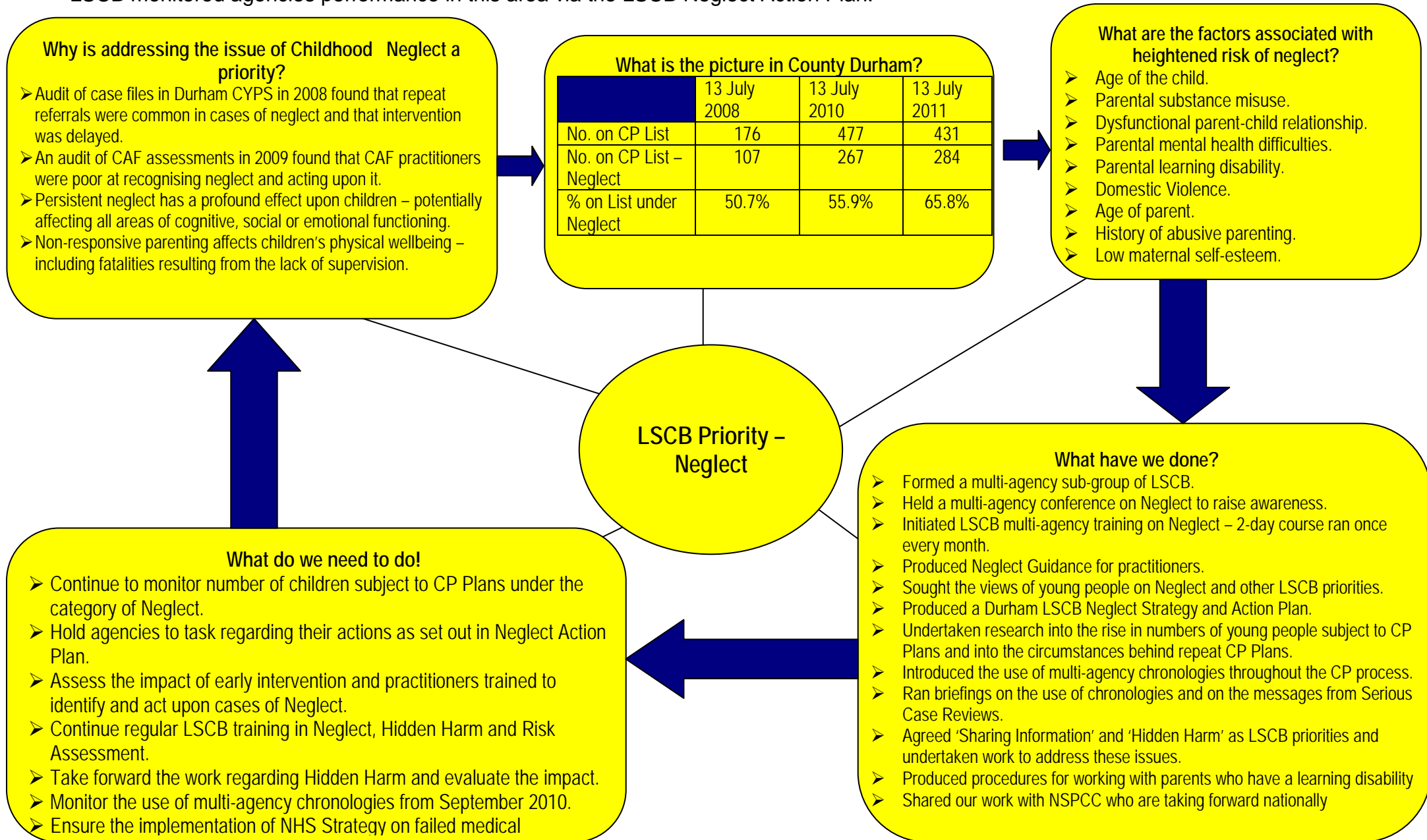
The incidence of children subject to a Child Protection Plan because of sexual abuse has more than halved. This will be monitored closely by the LSCB performance groups.

**Performance Management Activities 2010-2011:**

- Monitoring and evaluating the effectiveness of safeguarding arrangements within and across LSCB agencies.
- Ensuring staff and volunteers from all agencies receive training to enable them to fulfil their safeguarding responsibility.
- Continuing to check that all agencies comply with safe recruitment practices.
- Auditing the effectiveness of Core Groups.
- Auditing CAF training.
- Monitoring the numbers of completed CAFs.
- Monitoring the implementation of the Neglect Strategy Action Plan.
- Working to ensure greater involvement in child protection processes by GPs.
- Ensuring that the work of the LSCB fully incorporated a child centred perspective by continuing to develop strategies which fully embed views of young people and opportunities for young people to shape services in relation to safeguarding.
- An Audit into the use of multi-agency chronologies to ensure consideration of historical information on children subject to child protection plans is currently underway (August 2011)
- An evaluation of how agencies work together to address safeguarding issues created by parental substance misuse and domestic abuse.

## Neglect

In 2010-2011, a priority for the LSCB was neglect. The story board illustrates how neglect was tackled by the LSCB and the measurement of children subject to a Child Protection Plan, which demonstrates the increase in recognition of neglect by all agencies. Until July 2011, the LSCB monitored agencies performance in this area via the LSCB Neglect Action Plan.



## **Increased involvement of young people in Child Protection Conferences**

The data collected also makes clear the level of involvement children and young people have in the arrangements to formulate their individual child protection plans. As a result, the percentage of young people giving their views to child protection conferences increased from 8% in 07/08 when performance information was first gathered, to 66% in 2010/11.

## **Consultation with Young People**

In 2010 /11, the LSCB actively sought children's views on wider safeguarding issues in Durham and a consultation exercise with young people focussed on the priorities of the LSCB. Consultation enabled the LSCB to take into account the views of 250 young people aged 11 to 19 on domestic violence and neglect.

In 2011/12 it is planned to further consult young people via a blog and in meetings regarding the priorities for the LSCB during this year:

- Sexual Exploitation
- Early Intervention
- Mental Health
- Information sharing

Engagement by young people will develop as LSCB members identify further topics for consultation.

## Increased Involvement of GP's in Child Protection Conferences

The analysis of performance data highlighted the lack of involvement in child protection processes by GPs, and so work was undertaken to address this issue. The second story board in this report illustrates the improvement in receipt of GP reports to child protection conferences.

### Why is involving GPs in child protection processes important!!

- Data collected since 2007 regarding professional involvement at CP conferences has consistently shown GPs to be performing significantly below the performance of other professionals (attendance and report submission.)
- Information GPs hold about a child and his or her family is crucial to robust risk assessment.
- Studies of Serious Case Reviews both nationally and locally have highlighted the risk of professionals keeping information on vulnerable families in their own professional silo.
- 'Information Sharing' is a priority for the LSCB in 2010/11 and 2011/12.
- A Serious Case Review in Durham revealed that the child's GP had not recognised an indicator of abuse, and had not made the appropriate referrals to protect the child.

### What do we need to do?

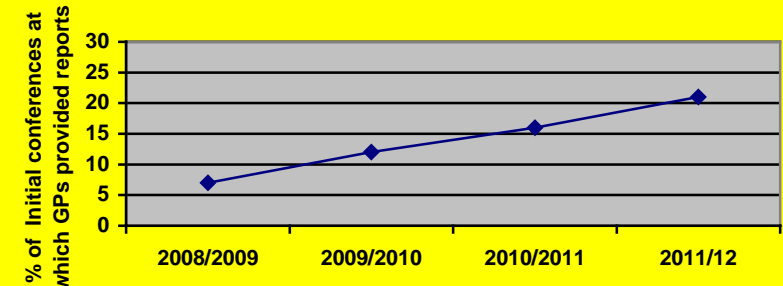
- Continue to monitor GP performance at CP conferences through data collection.
- Continue to attend Named GP Group in order to address issues as they emerge.
- Continue to provide and promote multi-disciplinary training that GPs can access.
- Breakdown data into areas to identify hotspots.
- Continue to communicate with local GPs about issues such as recommendations from Serious Case Reviews

### What have we done??

- LSCB Performance Manager attends Named GP Group.
- All GPs in Durham have now received safeguarding training.
- All GP Practices now have a safeguarding lead.
- Workshops on outcomes of Serious Case Reviews carried out to a multi-agency audience including GPs.
- Regional training carried out on safeguarding and LAC.
- GP toolkit and proforma for CP reports on GPs, LSCB and NHS websites
- Agreed with GPs through their Local Medical Committee an invite letter to conferences that was more appropriate to their needs

## GP Involvement in the Child Protection Process

### What is the picture in County Durham?



### Commentary of Performance

- Attendance at CP Conferences by GPs is extremely poor compared to that of other professional groups in Durham.
- The incidence of report submission to conferences is very low.
- GPs have a duty to share information about the child and family where there are safeguarding concerns.
- GPs have historically been reluctant to take part in CP processes.
- GPs have indicated reluctance to recognise CP as part of their role, have been uncertain about sharing information and had not been adequately trained in this area.

### **LSCB Policies and Procedures**

The Policy & Procedures Group have approved revisions and developed new procedures. Procedures were updated in September 2010 and include the following:

- Changes in line with Working Together to Safeguard Children published in March 2010.
- Development of procedures to be followed prior to postponement of child protection conferences.
- Procedures for Dual Process updated.
- Procedures for photographic images of children.
- Sub-regional procedure for undertaking Serious Case Reviews in line with Working Together to Safeguard Children March 2010.
- Procedure to produce multi-agency chronologies to be pro-actively used in Core Groups.
- Revision to 'Persons who pose a risk to children' procedures.
- Inclusion of Violent Offender Orders.
- Update of Neglect procedures.
- E-safety procedures.

The following revisions have also been completed and will be added to the LSCB Safeguarding Procedures in September 2011

- Development of procedures for managing difference in professional opinion.
- Strengthened the procedures for sharing reports with parents/carers
- No longer use multiple and likelihood categories of abuse in child protection conferences in line with Working Together to Safeguard Children
- Updated Female Genital Mutilation procedures to reflect the Foreign & Commonwealth Office Multi-Agency Guidance.
- Revision of the Safeguarding Disabled Children procedures following the work of the Task & Finish Group.
- Updated the Trafficking of Children procedures to link to the London SCB guidance and toolkits for safeguarding trafficked children.

The LSCB website has been reviewed and updated to improve access and navigation

## LSCB Training

The LSCB is committed to delivering a high quality inter-agency training programme, which supports professionals, volunteers and the independent sector in their work to safeguard and promote the welfare of children and young people.

There are three levels of multi-agency training currently provided by the LSCB

Level 1 Delivered via e.learning packages

- Child abuse and Neglect
- Hidden Harm
- Sexual exploitation

Level 2 Safeguarding is everyone's responsibility, a one day training course

Level 3 Specialist Courses dealing with specific safeguarding issues

- Hidden Harm
- Domestic Abuse
- Initial Child Protection Conference
- Neglect
- Risk assessment
- Safe workforce

## Training Year 2010 January 1<sup>st</sup> –December 31<sup>st</sup>

It has been a successful training year with 86 courses taking place

- Level 2 21
- Hidden Harm 15
- CP conference 12
- Safe workforce 9
- Neglect (2 day course) 10
- Risk Assessment 11
- Domestic Abuse 8

This represents a 12% increase in the number of courses delivered the previous year

A new evaluation was designed to ensure that the courses could be developed and improved. All the courses were reviewed and amended and agreed by the LSCB strategic group.

In addition to the training listed above the LSCB delivered briefings covering the following topics.

	Attendance
The New Working Together 2010	814
Use of Chronologies	479

Half day conferences were also delivered regarding Lessons from Serious Case Reviews 321

243 evaluation forms were completed by participants attending Lessons from the Child Death and Serious Case Reviews. Of these

92% considered the session to be very/quite useful with 86% stating it would be very likely or quite likely to improve their practice.

392 participants attending the chronology briefings completed evaluations of these 67% thought it was very/quite useful and 64% identified it would be very likely or quite likely improve their practice.

The concept of 'Work Together, Train Together' was introduced in 2009. This continues to be one of the strengths of the LSCB training and enables multi agency teams who work in the same locality to train together.

Information sharing (a board priority) is an important component of all the training and every course contains information the importance and appropriateness of sharing information to keep children safe.

Key local and national messages from Serious Case Reviews are woven into all LSCB courses. This is well received and introduces the work of LSCB's to a wider audience.

### **Training Developments 2011-12**

The training strategy 2011/12 has identified the following priorities:

Priority 1  
Identify gaps in training and to support agencies in meeting their responsibilities under Working Together to Safeguard Children  
Priority 2

To ensure that the multi agency training provided by the LSCB reflects the LSCB priorities and the current needs of the multi agency workforce.

The LSCB to recognize the organisational changes of service delivery and new partnerships and respond to the changing needs of the workforce.

Priority 3

To ensure that LSCB Training is making a contribution to improving outcomes for children within partner agencies

- o Training 2011/12 is programmed up to December 2012 and work is ongoing to project training demand and costs in 2013. The LSCB Strategic Training Group will work with partner agencies to identify single agency Safeguarding training availability and standards
- o Three new courses are to be developed
  1. Safeguarding children who are deaf or have a disability.
  2. The effect on parenting capacity of adult mental health problems. Both these courses will be co presented with partner agencies.
  3. Sexual Exploitation.

These will be incorporated in the programme for 2012

- o The LSCB have worked closely with Children's Early Years Provision to agree the development and delivery of bespoke safeguarding training commencing in December 2012.

## **LSCB Development work 2010/11**

### **Missing children**

Work has been finalised and includes the following:

- New operating procedures have been finalised including 'return interviews' with young people to help understand and deal with the issues faced by young people who run away. The return interview record makes the link with the risks from child sexual exploitation and may result in strategy meetings and care planning meetings.
- A multi-agency Missing and Exploited group has been established. Membership includes multi-agency senior managers. Meeting quarterly this group considers performance data around missing episodes across the county, compliance with the missing children procedures and discusses individual cases where strategic intervention may be required.
- Assessment of information sharing practices between partner agencies to ensure information is transferred when children move across educational boundaries.
- School nursing service is now represented on the "education at home panel"

Outcomes for children are:

- Improved information sharing and accountability between agencies to respond to missing episodes. The outcome is ultimately improving a child's safety.
- Return interviews may identify risks in a child's development or more specific risks e.g. Child sexual exploitation, bullying.

### **Hidden Harm**

Work has been finalised and includes the following:

- The drugs and alcohol services are now represented on each of the five Local Child Resource Groups, with membership assisting in the development of local networks of services collaborating to reduce the risks to children arising from parental abuse of drugs or alcohol.
- Through the work of the Local Child Resource Groups there is accountability for the monitoring of agency performance in respect of early intervention and the use of CAFs. Within the County Alcohol Service there is a dedicated early intervention team of children's workers who work with families where parents have alcohol problems. Whilst this is not the case with the drug service their workers have been trained in pre-CAF assessments and are considering training in CAF itself.
- Information sharing contact operating practices have been developed which identify single points of contact within the drugs and alcohol services and safeguarding services. These arrangements are intended to identify effective routes for information exchange to discuss concerns around a child and

also to identify the most appropriate attendance at child protection conferences or the production of reports.

- When assessing clients for their services, the drugs and alcohol services ask their clients whether they are parents and have children living with them. This early identification could lead to CAF completion or a safeguarding referral.
- The LSCBs continue to deliver level 3 hidden harm training which is well attended and the feed back is positive.

The aim of the work was to improve child safety by:

- Improvement in multi agency information sharing and networking to address children's safety.
- Improvement in identifying early intervention opportunities.
- Greater agency awareness around the risks to children from parental alcohol or substance misuse.

During July and August 2011 there will be an evaluation of the effectiveness of this work..

### **Domestic abuse**

Work has been finalised and includes the following;

- Domestic abuse service is represented on each of the Local Child Resource Groups (as above)
- Information contact operating practices include the domestic abuse services (as above)
- There has been an agreed multi-agency definition of what constitutes "teenage partner violence" with close monitoring of

any incidents. This definition has been agreed in the absence of any national definition.

- A review has been completed of the Constabulary working practices for the notification of domestic violence incidents to safeguarding services to distinguish and prioritise those requiring action and those forwarded for information only purposes.
- Level 3 LSCB training on domestic abuse continues with good attendance and feedback across partners.
- Scoping work has been completed about the availability of specialist services for children witnessing /experiencing domestic abuse. This work will be taken forward through commissioning work by the Domestic Abuse Executive Group.

The aim of the work was to improve child safety by:

- Improvement in multi-agency information sharing
- Greater awareness amongst professionals regarding the impact of domestic abuse on children.
- Multi-agency response to incidents of teenage partner violence similar to arrangements for adults.

During July/August 2011 there will be an evaluation of the effectiveness of this work

## Sharing Information

The findings from Serious Case Reviews both locally and nationally highlight the importance of sharing information in protecting children from harm.

In August 2010 the Board agreed that Information Sharing would be a priority and agreed an Information Sharing Strategy to promote information sharing to safeguard children by concentrating on issues identified by staff and managers at multi-agency conferences held in 2010

Significant work had been undertaken by agencies to raise awareness of good information sharing practice:

### Summary of work undertaken

The agencies that undertook the work advised that they have taken forward many of the actions identified in the strategy. Information sharing has a key place at senior management meetings and there is a network of role models/champions at various levels within organisations. Police, Access and Inclusion, Safeguarding and Specialist Services and Adults, Wellbeing and Health have identified barriers to effective information sharing and have a plan to overcome these. They have confirmed that they have taken actions to improve staff confidence to share information and share good practice.

Much work has been undertaken to raise awareness of information sharing good practice and staff and managers have been reminded

of the serious consequences when information is not shared or sought to safeguard children.

- The LSCB multi-agency conferences held in 2010 'Learning Lessons from Serious Case Reviews' had a strong focus on information sharing.
  - The Eight Golden Rules of Information Sharing continue to be widely distributed at each LSCB multi-agency training course.
  - The LSCB website has been updated to include an information sharing menu bar providing access to The Eight Golden Rules, The Working Together Protocol, and The Government Information Sharing Toolkit.
  - Information sharing features in all multi agency courses delivered by the LSCB.
  - LSCB contacts have been updated on the LSCB website.
  - LSCB procedures concerning multi- agency chronologies have been launched at briefings across the county.
  - An audit of safeguarding cases addressing information sharing and the use of multi-agency chronologies has been added to the LSCB Performance Management Framework.
- Further work will be necessary in 2011/12 to monitor and evaluate progress

## Private fostering

Despite a significant awareness-raising programme regarding private fostering in Spring 2009 notifications have continued to decline. The challenge for agencies in Durham is to produce a strategy that is effective in identifying this vulnerable group. Any strategy must feature increased awareness of and notification from professionals, e.g. schools and GPs.

A task group is specifically identifying blockages to notification and how this can be managed.

## Child Death Reviews

There are two interrelated processes for reviewing child deaths:

1. **Rapid Response** by a group of key professionals who come together for the purpose of enquiring into and evaluating each **unexpected death; and**
2. An overview of **all deaths** up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) in Durham and Darlington areas, undertaken by a panel.

A Child Death Overview Panel (CDOP) was established by County Durham Local Safeguarding Children Board and Darlington Safeguarding Children Board to ensure that each child death had an appropriate review.

35 children resident in Durham and 9 children in Darlington died between 1 April 2010 and 31 March 2011.

Of the 44 child deaths:

- 15 deaths resulted in a Rapid Response being instigated.
- 14 deaths have been or will be considered at a Local Case Discussion meeting.
- 4 deaths are subject to Sudden Unexplained Infant/Perinatal meetings.
- 3 child deaths are subject to a Serious Case Review.

The Child Death Review Overview Panel highlighted issues that have resulted in the following:

- Mandatory training for midwives and obstetric doctors in interpretation of this foetal monitoring
- Improved quality assurance mechanisms of the antenatal ultrasound scans. Regular meetings take place between the sonographers, obstetricians and the foetal medicine specialists to review scans and to improve the training and experience of antenatal staff
- Psychiatrists to discuss with mothers taking medication the dangers of sharing a bed with their baby because of the increased risk of sudden infant death

- Paediatricians were all requested to explicitly discuss bathing arrangements with families of disabled children to ensure safe practices were adopted in the home

The Rapid Response Teams involvement following the sudden and unexpected death of a child has proven to be extremely helpful to the families and professionals involved.

A copy of the Child Death Review Annual report can be found at [www.durham-lscb.gov.uk](http://www.durham-lscb.gov.uk)

### **Serious Case Reviews**

When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a Serious Case Review. The LSCB should consider undertaking a review whenever a child has been seriously harmed and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the welfare of the child.

Three deaths of children in County Durham have resulted in Serious Case Reviews in 2010/11 of these one has been evaluated by Ofsted, receiving a 'good' judgement. The findings of these reviews will be published at the conclusion of criminal and coronial investigations.

These reviews will be published in full although redacted where appropriate to remove personal family information not relevant to the review findings.

Much work has been undertaken to further raise the standards of Individual Management Reviews completed by agencies (IMRs), and Overview Reports which form the basis of robust Serious Case Reviews:

IMR training and practice guidance has been further reviewed and developed to ensure we offer the best advice possible to authors..

The training pack and good practice guidance developed by Durham LSCB has been disseminated regionally

### **Monitoring and Evaluation of Serious Case Reviews**

Lessons learned from serious case reviews are robustly monitored by the LSCB Serious Case Review Monitoring Group using a specially developed Thematic Monitoring Tool. This process not only ensures that actions resulting from SCRs are completed but also provides an opportunity to analyse key themes that have arisen over time enabling the LSCB to understand how well lessons are being embedded into practice

This process also provides evidence necessary to drive forward and challenge agencies that are not robustly bringing about change and has resulted in a much improved focus on completing actions.

### Raising Awareness of Lessons from Serious Case Reviews

It is the responsibility of each partner agency to ensure that lessons from Serious Case Reviews are disseminated to both managers and frontline staff.

To augment this process, the LSCB hold annual multi-agency conferences to report on the findings of SCRs and involve staff and managers in the learning process.

As a result of their success, the LSCB has established a programme for 2010/11 of multi-agency conferences to review lessons from Serious Case Reviews in Durham.

In 2010 these conferences focussed on the importance of Information Sharing. Group work undertaken at the conferences identified issues which were used to develop the LSCB Information Strategy

### Changing Philosophy about Learning Lessons

Professor Munro<sup>3</sup> recommends that LSCBs adopt 'system' methodology in conducting SCRs in order to move beyond identifying what happened to explain why it happened.

In its response the government has clearly agreed that such approaches should inform further consideration

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<sup>3</sup> Professor Eileen Munro-Review of Child Protection A child-centred system May 2011

Durham has recognised for some years that there is a need to transfer valuable energy and resources from lengthy investigation processes to understanding and developing systems and practice that will help keep children safe.

Durham LSCB has taken the opportunity to pilot a more facilitative and reflective process to review a case which did not meet the criteria for a mandatory SCR, but where it was considered lessons could be learned. An independent person was asked to lead the process which engaged both front line practitioners and managers in a reflective process of learning and action planning. The response from those directly involved in the process was very positive.

Although Durham LSCB will continue to undertake SCRs in accordance with government guidance<sup>4</sup> where opportunities exist to trial other processes to learn lessons we will do so. The results clearly indicate that agencies need to reinforce the lessons learned to ensure that lessons are not forgotten over time. Processes and actions taken to improve practice should be subject to compliance, monitoring and audit by partner agencies.

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<sup>4</sup> Working Together to Safeguard Children DFE 2010

## Section 6: Priorities 2011/12

'Working Together to Safeguard Children 2010' states that the LSCB should have a clear work programme including measurable objectives. The activities of the Board should fit clearly within the framework of the Children and Young People's Plan and the voice and experiences of young people should strongly inform the LSCB's work programme.

The following information has been used to predict the work programme and priorities for Durham LSCB 2011/12:

- Progress of the LSCB work programme 2010/11.
- Matters emerging from the new LSCB Dataset
- Knowledge of Government drivers and developments.
- Local knowledge.
- The Children and Young People's Plan.

**Durham LSCB agreed the following priorities at the Board held in April 2011:**

**Sexual Exploitation**

**Sharing Information**

**Early Help**

**Mental Health – impact on parenting**

## **LSCB Priorities 2011/12**

### **Child Sexual Exploitation (CSE)**

The data set highlights that there has been a noticeable increase in offences of internet grooming relating to young females engaged in conversations on social networking sites.

The Child Exploitation and Online Protection Centre have published their strategic overview into the threat of child online sexual abuse. The threat is described as “significant” with offenders exploiting opportunities presented by social networking sites and increased risk taking by children.

The County Safer Durham Partnership is developing a Sexual Violence strategy for the County, which includes addressing the risks to children from all forms of sexual violence, not just the threat from online offending. There is an expectation that the LSCB will lead on actions relating to the sexual exploitation of children.

Nationally, there have been a number of high profile police investigations around organised sexual abuse of children, often linked to missing children. The impact of sexual exploitation of children is emerging as a high safeguarding priority.

The LSCB work will primarily focus on:

- Multi-agency analysis of the risks of CSE in County Durham to identify the extent of the risk and improved understanding of the problem. This will be undertaken by a police analytical team following the production of an intelligence collection plan which all LSCB agencies will be invited to contribute to.
- Identifying a training plan for multi-agency training and awareness around CSE, particularly the identification of the risk indicators of offenders and victims. This will consider general awareness and the necessity for more specific training.
- Review of existing LSCB child protection procedures ensuring that there are clear working practices for agencies to follow.
- Establishing clear links with the Missing from Home and Exploited Group to oversee the work around CSE in the County.

### **Mental Health**

In County Durham, Mental health, as a parental risk factor, has consistently featured highly in Child protection plans. For the period January 2010 to February 2011 mental health featured in 31% of Child Protection Plans.

Mental health issues are identified in the DfE Biennial Review as one of the “toxic three” parental risk factors alongside, drugs and alcohol and domestic abuse.” They have been highlighted as major risk factors, often operating in combination, leading to Child Protection Plans. In Durham our experience is that often all three risk factors have been raised as concerns in the convening of child protection conferences for individual children.

In respect of “hidden harm” and domestic abuse, the LSCB has been proactive in prioritising this work; this has not been the case for mental health it is therefore our intention to address this in 2011/2012.

A priority for Durham LSCB will be to focus on

- Addressing an improvement in professional’s understanding of both children’s and mental health services working practices, thresholds for intervention and referral routes.
- Establishing locality agency networks through service single points of contact mirroring those arrangements for drugs, alcohol and domestic abuse services.
- Improved information sharing.

## **Early Help**

Nationally, there have been a number of strategic reports which support the value of early intervention in the protection of children. The recent review of child protection by Eileen Munro introduced the concept of “early help”, focussing on a child’s early years in life and also focussing on early action, if problems were to emerge.

Intervening and supporting children at an earlier stage is known to have major benefits in preventing the need for more intensive and costly resources at a later stage.

Specifically, for Local Safeguarding Children Boards, the Munro review identified that the LSCB should take account of the effectiveness of the help being provided to children and families and the effectiveness of multi-agency training to safeguard and promote the welfare of children.

The LSCB priority of “early help” coincides with the introduction of multi-agency integrated teams across County Durham, with a focus on early intervention, coinciding with a revision of child in need procedures and multi agency working practices. In addition, the LSCB has agreed to deliver bespoke training for early years providers.

A priority for Durham LSCB will be to focus on:

- Making operational and procedural links with the new integrated teams, ensuring effective practice across multi-agency partners.
- Developing a programme of training specifically for early years providers, ensuring understanding of LSCB child protection procedures and operating practices.

## **Information Sharing**

The key to effective safeguarding is timely sharing of relevant information. Failure to do so can have extremely serious consequences. Serious Case Reviews continue to highlight this issue both nationally and locally.

Although information sharing was a priority in 2010/11 and some partner agencies have done significant work to progress this issue further work will be necessary to maintain momentum and ensure that the strategies make a difference.

Further work will focus on:

- Monitoring agencies progress in completing actions in relation to the Information Sharing Strategy
- Understanding particular areas of success
- Understanding particular challenges and how these can be overcome.

# Section 7: The Challenge for the Children's Trust in County Durham

## Information sharing to protect children

The key to effective safeguarding is timely sharing of relevant information. Failure to do so can have extremely serious consequences. Serious Case Reviews continue to highlight this issue both nationally and locally.

Although information sharing was a priority in 2010/11 and some partner agencies have done significant work to progress this issue further work will be necessary to maintain momentum and ensure that the strategies make a difference.

Improvements in information sharing will only happen if blockages to good practice and poor practice are known and addressed. Experience has shown that this process is not automatic; it needs to be lead and managed by senior officers to ensure that systems and processes exist to promote information sharing and deal with issues which prevent this.

**A key challenge is in building the confidence of staff to both seek and share information to safeguard children when faced with data protection processes and regulations that may be perceived as preventing this.**

**A further challenge is to ensure staff know who to contact when sharing or seeking information.**

## Child Sexual Exploitation

Nationally, there have been a number of high profile police investigations around organised sexual abuse of children, often linked to missing children.

The impact of sexual exploitation of children is emerging as a high safeguarding priority in certain areas of the country. In Durham data suggests that there has been a noticeable increase in offences of internet grooming relating to young females engaged in conversations on social networking sites.

A high profile murder in a neighbouring Local authority reminds us of the possible serious outcomes from such activity.

**The challenge for the Children's Trust will be to understand the nature of activity in Durham and ensure we have systems and processes that raise awareness of such activity, allow early intervention and enable agencies to respond effectively.**

## Early intervention

Early intervention is key to the protection of children and young people. Successful application of the Common Assessment Framework and the introduction of Integrated Teams in September 2011 will be instrumental in identifying help at an early stage.

**The Challenge for the Children's Trust is to understand the number and quality of CAFs. To ensure thresholds for intervention at different levels are clearly understood and**

implemented and that staff in all agencies are prepared to ask questions of parents, carers and others in order to understand when and how to intervene.

## **Mental Health**

This is identified as one of the “toxic three” parental risk factors alongside, drugs and alcohol and domestic abuse. The LSCB have undertaken a great deal of work to address risks to children related to domestic abuse and parental substance abuse.

**The challenge for the Children’s Trust is to support work across all agencies to improve recognition of the impact of mental health on parenting and understanding the importance of information sharing and collaborative working.**

## **Serious Case Reviews/Learning Lessons**

Durham LSCB has supported the use of alternate processes to learn lessons when the criteria for a statutory review is not met . This has proven to reduce demand on agency resources while fully engaging those involved in timely, reflective and facilitative learning processes. Unfortunately initial experience using this model highlighted delays in agencies providing their action plans to address the learning.

**The challenge for the Trust is to ensure that such processes do not encourage reduced importance/priority being given to action planning and improvement**

## **Child Protection Training**

Levels of multi-agency training has significantly increased to meet demand. To augment the training courses e-learning training has been developed and commissioned with the result that greater numbers can access training. E-learning is an expensive resource but is cost effective in that it delivers training to large numbers of staff from a wide range of services.

LSCB data monitoring shows that there are a significant number of e-learning licences that are applied for, opened but not completed. This was identified as a challenge previously but continues to be an issue.

**The Challenge for the Trust is to ensure that agencies value this resource as a method of providing large numbers of staff with Safeguarding training and ensure they use and benefit from it.**

## **Financial Contributions**

The LSCB is funded from agency contributions as detailed on page 29 of this report. Not all member agencies contribute to this funding however all members give time and effort to ensuring that safeguarding children and young people remains a priority in County Durham.

Safeguarding is afforded a high priority within the Children and Young People’s Plan, acknowledging that the LSCB coordinates

local work to safeguard and promote the welfare of children and young people, ensuring that the work carried out by partner agencies is effective.

The Children and Young People's Plan refers to the importance that all agencies need to give to this area of work and the serious implications of getting it wrong.

**In these times of austerity the Children's Trust will be faced with choices and challenges to respond to competing priorities**

## Section 8: Agency Contributions

### Partner Contributions

	2011/12 contributions
DURHAM COUNTY COUNCIL	£180,636
CAFCASS	£669
HASSOCKFIELD SECURE TRAINING CENTRE	£2,680
DURHAM TEESSIDE PROBATION TRUST	£2,680
NHS COUNTY DURHAM & DARLINGTON	£100,110
COUNTY DURHAM & DARLINGTON NHS FOUNDATION TRUST	£2,680
NORTH TEES & HARTLEPOOL NHS FOUNDATION TRUST	£2,680
DURHAM CONSTABULARY	£33,085
FURTHER EDUCATION COLLEGES	£2,800
<b>TOTAL INCOME</b>	<b>£328,020</b>

## Section 9: Current Membership

### **Independent Chair**

Fran Gosling-Thomas

### **Lay Member**

Bill Worth

### **Durham Children & Young People's Service**

Gail Hopper Vice Chair

Head of Safeguarding & Specialist Services

David Williams

Corporate Director – Children & Young People's Service

Maureen Clare

Head of Countywide Services

Gill Eshelby

Head of County Durham Youth Offending Service

Carole Payne

Head of Early Intervention & Partnership Services

### **Lead Member for Children's Services**

Claire Vasey

Lead Member for Children's Services

Board papers only - can attend on request

**Durham Adult, Wellbeing & Health**

Lesley Jeavons

Head of Adult Care  
Adults, Wellbeing & Health

**Durham Constabulary**

DCI Paul Goundry

Force Lead for Safeguarding  
Durham Constabulary

**National Probation Service**

Carina Carey

Director of Probation Services  
Durham Tees Valley Probation Trust

**Durham County Council Leisure Services**

Julie Russell

Area Leisure Manager  
Durham County Council

**Prison Service**

Trevor Wilson-Smith

Director  
Hassockfield Secure Training Centre

## Health Services

Sam Cramond	Strategic Head of Child & Maternal Health Services North East Strategic Health Authority
Anna Lynch	Director of Public Health NHS County Durham
Kath Vasey	Clinical Divisional Manager Children's Services (Community) County Durham & Darlington NHS Foundation Trust
Mark Harrison	Manager County Durham Drug & Alcohol Action Team
Lesley Mawson	Associate Director of Nursing and Governance Tees, Esk & Wear Valleys NHS Foundation Trust
Dr Stephen Cronin	Designated Paediatrician County Durham & Darlington NHS Foundation Trust
Diane Richardson	Designated Nurse Safeguarding Children NHS County Durham
Maureen Grieveson	Associate Director of Patient Experience & Safeguarding County Durham & Darlington NHS Foundation Trust
Dr Mike Lavender	Chair of County Durham and Darlington Child Death Overview Panel
Cath Siddle	Deputy Director of Nursing North Tees and Hartlepool NHS Foundation Trust



**Cafcass**

Janice Deakin

Service Manager  
Cafcass

**Durham Diocese**

Elsi Hampton

Child Protection Advisor  
Diocese of Durham

**Voluntary Sector**

Rod Weston-Bartholomew

Assistant Director Children's Services  
Barnardo's North East

**Housing**

Lynn Hall

Housing Solutions Manager  
Durham County Council

**Schools**

Gerard Moran

Representative of Secondary Heads

**Further Education**

John Widdowson

Representative of Durham Colleges  
Principal & Chief Executive of New College Durham

**LSCB Officers**

Suzanne Welsh

Chris O'Reilly

Julie Hogg

Ian Scott

Emma Maynard

Business Manager  
Durham LSCB

Quality & Performance Manager  
Durham LSCB

Training Co-ordinator  
Durham LSCB

Development Officer  
Durham LSCB

Minutes Taker  
Durham LSCB Admin Co-ordinator

**LSCB Advisers**

Kelsey Clayton

Marilyn Brown

Principal Solicitor  
Durham County Council

Safeguarding Manager  
Local Authority Designated Officer  
Durham Safeguarding & Specialist Services

## Section 10: Core Business 2011/12

Core business planning is detailed in individual strategies and monitored through LSCB sub-groups and General Board

### Key Responsibilities for LSCB

#### Standard 1

##### Children are safeguarded and protected

All agencies have clear strategic plans and policies that prioritise the safeguarding of children and promote their welfare, and involve users and their representatives in the development of these plans.

- LSCB partnership/ownership
- Involvement/participation of service users
- Child centred perspective
- Equal access to quality services
- Recruitment and supervision and workforce management of people who work with children

#### Outcome

- All agencies demonstrate compliance with Section 11 of the Children Act
- All partnership agencies demonstrate ownership of LSCB policies and procedures.
- The work of the LSCB fully incorporates a child centred perspective.
- All professionals are aware of the functions of the LSCB and have an opportunity to inform and contribute the work of the LSCB.
- All agencies provide demonstrable evidence that they actively involve children, parents and their carers in the development of strategic plans.
- All agencies have explicit written policies to promote equalities issues.
- All training opportunities incorporate equality issues as described within agency's policies.
- All training provided by the LSCB incorporates equality issues.
- Staff and volunteers from all agencies are aware of their responsibilities to ensure the safeguarding of children and have received training to enable them to fulfil this responsibility.

- Staff (including volunteers) have their safeguarding checks updated as required by legislation and guidance and these are properly recorded.
- Record keeping records confirm that checks are current on all existing and newly appointed staff and volunteers.
- The workforce is properly supervised and concerns are acted upon appropriately.
- All agencies have safe recruitment practices
- Staff are effectively supported and protected from danger and/or the risk of violence.
- Staff safety issues are reflected in training.
- Managers understand the importance of enabling staff to carry out their duties in the safest way possible.
- Agencies have effective and efficient processes to deal with allegations against staff, volunteers and others with the care of children.

## Standard 2

### The safeguarding of children in all settings and circumstances

Agencies have local policies and procedures that address the safeguarding of children living away from home and in other circumstances where they are known to be particularly vulnerable

- Young people in secure environments
- Children and young people exposed to domestic abuse
- Disabled children and young people
- Children and young people with substance abusing parents
- Children and young people in private fostering
- Children and young people who self-harm/misuse substances
- Children and young people at risk of sexual exploitation
- Unaccompanied children and young people
- Children and young people missing from education
- Children and young people in residential special schools
- Children and young people in long term special schools
- Children and young people in temporary accommodation
- Children and young people at risk of forced marriage
- Children and young people who are missing
- Children and young people who are unaccompanied

## Outcome

- The LSCB has protocols in place to safeguard young people within secure environments in Durham and for young people normally resident in Durham who are placed in secure settings outside of the County.  
The LSCB ensures that all agencies have effective and appropriate process to identify and refer to appropriate services concerns of Sexual Exploitation
- e-Safety Young people will have the knowledge, awareness and support to keep themselves safe in a digital world
- The LSCB works with other agencies to ensure that responses to issues of domestic abuse address child safeguarding issues.
- The LSCB, working with others, has proactively addressed and put in place strategies to address the needs of vulnerable children as identified :

## Standard 3

### The co-ordination and monitoring of the child protection system

The LSCB ensures agencies work collaboratively to develop and implement joint systems for ensuring the safeguarding of children, and monitors and evaluates the effectiveness of the child protection services

- LSCB ensures agencies work collaboratively
- LSCB monitors and evaluates the effectiveness and efficiency of the LSCB working arrangements
- LSCB monitors and evaluates single and inter-agency safeguarding practice

## Outcome

- The LSCB is constituted by *Working Together to Safeguard Children* and has appropriate representation from all relevant agencies including those from the voluntary sector at an appropriate level of seniority.
- LSCB is adequately funded to fulfil its responsibilities
- The LSCB has put in place a Performance Management Framework based on clear standards and performance indicators for child protection, and uses management information in respect of child protection and safeguarding of children to improve services.

## Standard 4 Effectiveness of Local Arrangements to Safeguard Children

Safeguarding concerns are identified and responded to appropriately and sensitively with agencies working in partnership to ensure children are effectively safeguarded

- Consistent understanding of thresholds
- Procedures are accessible and quality of practice known and managed
- Activities focus on child
- Performance management at point of service delivery

### Outcome

- Staff undertake a Common Assessment (CAF) to address the needs of children
- Staff of all services have a consistent understanding of the thresholds for sharing information with and referral to Safeguarding & Specialist Services/Police, and the undertaking of an Initial Assessment to identify if the child is in need and, if so, if the child's welfare is being safeguarded.
- Responses to safeguarding concerns are conducted in accordance with the LSCB Child Protection Procedures
- All safeguarding activities focus on the child (What must life be like for a child living in this household)

## Standard 5 Recording and information sharing

Record keeping and information sharing for the purposes of safeguarding children

- Protocols for sharing information
- Baseline recording standards

### Outcome

- There are clear protocols between the LSCB partner agencies for the sharing of information.
- Staff are aware of data protection and information sharing issues

## Standard 6 Knowledge and skills

The LSCB ensures that staff (of the constituent bodies of the LSCB) who undertake work to safeguard children are well informed in respect of good practice and are appropriately skilled for the tasks

- Strategic plan – inter-agency training
- Delivery of inter-agency training

### Outcome

- The LSCB has a strategic plan for inter-agency training of staff
- Partner agencies have the opportunity to attend a series of workshops to promote the work of the LSCB, share good practice and learn lessons. Staff of all LSCB constituent agencies are trained and supported in their work to protect children, and that this training is based upon up to date knowledge and skills
- Staff of all LSCB constituent agencies are trained and supported in their work to protect children, and that this training is based upon up to date knowledge and skills

## Standard 7

### Serious Case Reviews and Child Death Review processes

The LSCB conducts case reviews under the guidance of Working Together to Safeguard Children effectively and ensures that appropriate lessons are learnt and changes to practice implemented to maximise safeguarding for children

- Learning lessons
- Focus on actions and embedding change
- Monitoring processes
- Child Death Reviews

### Outcome

- A Serious Case Review is undertaken in accordance with regulation 5 and Working Together 2010
- Parents are given every opportunity to contribute to Serious Case Reviews
- Agencies use the lessons learned from Serious Case Reviews to improve inter-agency working and improve practice to better safeguard and promote the welfare of children.
- Where the criteria for holding a Serious Case Review is not met, but it is considered by the Serious Case Review Panel that there are lessons to be learned, the Serious Case Review Panel will agree the appropriate action.
- Partner agencies have the opportunity to attend a series of workshops to share good practice and learn lessons.
- Action plans are implemented and their effectiveness monitored.
- All deaths of children and young people are reviewed by the Child death Overview Panel. Unexpected deaths are subject to local review

## Standard 8

### Reduce risk from potentially dangerous people

The police and probation service in collaboration with other relevant agencies ensure that effective arrangements to assess and manage the risks posed to children by potentially dangerous people are being established, monitored and reviewed

- Strategic and operational links
- Clear systems and processes

### Outcomes

- Strategic and operational links exist between MAPPA and LSCB
- Clear systems are in place for the identification, tracking and management of people who are considered to present a risk to harm to children