Blackburn with Darwen
Local Safeguarding Children Board (LSCB)

Annual Report (2015-16)
Business Plan (2016-17)

Contents

Introduction by the Independent Chair

Dear Colleagues,

I am pleased to introduce Blackburn with Darwen LSCB Annual Report for the year 2015 - 2016.

I would like to start by taking this opportunity to recognise and commend the dedication and commitment of all the staff across the LSCB partner agencies in working tirelessly to safeguard our children and young people and to improve outcomes for them.

This has been a productive year for the LSCB with partners engaging in a wide ranging work programme across all the LSCB committees where good progress has been achieved against the Board's objectives.

A successful programme of multi-agency audits has been completed, allowing the LSCB to identify areas for further improvement in key aspects of partners' work with progress having been made against these findings.

Attendance and participation in the Board and committees has been largely improved against the previous year and a full participation record across all committees is included in this report.

Training uptake has been a particular success for the LSCB, including the revised online training offer implemented this year. Across both the LSCB and the LSAB, a total of around 5000 training places have been taken up. This is the highest number to date. Non-attendance rates are vastly reduced, recognising the value and importance of training offered.

Although there has been variable demand across partners for safeguarding interventions, demand for high level and complex child protection services has continued to rise, causing significant pressure on services to meet demand and safeguard children in a continuing climate of diminishing budgets.

Agencies have completed a Section 11 audit in year and a number of gaps in compliance have been identified in some agencies who are now working to redress these.

An independent review of LSCBs was commissioned by central government and completed at the end of this year. Some legislative amendments are underway and the LSCB looks forward to negotiating and implementing the required changes during the 2016-17 period.

Nancy Palmer
Independent Chair, Blackburn with Darwen LSCB

Governance and Accountability

The objectives of each of the groups that make up the Blackburn with Darwen (BwD) Local Safeguarding Children Board (LSCB) are provided below:

LSCB (Chair: Independent Chair)

- Strategic oversight of the Board's fulfilment of its statutory functions
- Strategic Partnership reporting on their fulfilment of their safeguarding responsibilities – Health & Wellbeing Board, Children's Partnership Board, Community Safety Partnership, Youth Justice Service, Engage, Multi Agency Public Protection Arrangements (MAPPA), Domestic Violence partnerships, Local Family Justice Board, etc.
- Examination and scrutiny of key safeguarding and child protection themes to identify how multi-agency arrangements can be improved and ensure the effectiveness of safeguarding arrangements and services

Business Group (Chair: Independent LSAB or LSCB Chair)

- Co-ordinate the business and set the agenda of the Boards
- Co-ordinate and monitor the business of the committees
- Provide guidance and direction to the LSAB/LSCB business of the Safeguarding Unit
- Production of annual reports
- Strategic sign-off for serious case reviews (SCRs) and safeguarding adult reviews (SARs)

Pan-Lancashire Child Death Overview Process (CDOP) (Chair: Lancashire County Council Public Health)

- Undertake comprehensive and multi-disciplinary reviews of child deaths so that the LSCB better understands how and why children in the area have died, use the findings to prevent other deaths and improve the health and safety of children
- Identify from death reviews significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the area
- Ensure all unexpected deaths of children receive a co-ordinated response from all relevant agencies

Governance and Accountability

Communication & Engagement Committee (Chair: Lancashire Constabulary)

- Multi-agency alignment of public safety messages, communication and engagement activities
- Raise the profile of the Boards' activities on training and safety messages
- Communication to practitioners and public of strategic and operational planning messages
- Multi-agency practitioner awareness of lessons from reviews, training opportunities and practice change
- Multi-agency co-ordination of messages from participation and engagement of service users
- Direction on the maintenance and development of Board websites and use of social media and technology for dissemination of safety messages

Workforce Development Committee (Chair: Safeguarding Unit)

- Monitor the effectiveness of single agency and multi-agency training provision
- Plan and provide LSCB/LSAB training courses (workshops, briefings and online learning) through the Training Needs Analysis
- Collate and report single agency and multi-agency training activity data
- Use training evaluations and impact assessments to revise and improve multi-agency training courses and recommend improvements to single agency training
- Development and implementation of a Learning & Development Strategy
- Development of online learning packages and monitor their effectiveness, impact and reach
- Inform and implement the Learning and Improvement Framework

Serious Case Review (SCR) Consideration Panel (Chair: Safeguarding Unit)

- Consider if cases meet the statutory threshold for undertaking a SCR
- Commission SCRs
- Recommend cases for multi-agency reviews or individual agency reviews where they do not meet the threshold for SCRs

Children's Quality Assurance Committee (Chair: LSCB Independent Chair)

- Provide the LSCB with information and improvement recommendations about the quality, effectiveness and impact of inter-agency working in safeguarding and promoting the welfare of children
- Undertake and analyse Section 11 audits
- Collate findings from case reviews, audits and multi-professional discussion forums (MPDFs) to inform the Learning & Improvement Framework
- Monitor action plans from the case reviews through the Learning & Improvement Framework

Governance and Accountability

Child Sexual Exploitation (CSE) & Missing From Home Committee (MFH) (Chair: LSCB Independent Chair)

- Strategic oversight on the operational effectiveness to tackle CSE, MFH, Trafficking/Modern Slavery and respond to Online Safeguarding
- Provide strategic and operational direction to the work of the Engage Team
- Promote local and Pan-Lancashire co-operation on CSE, MFH, Trafficking/Modern Slavery and Online Safeguarding

Safeguarding in Education Committee (Chair: Training 2000)

- Monitor the effectiveness with which schools, colleges and other educational establishments fulfil their safeguarding responsibilities
- Ensure effective safeguarding arrangements for children in education and learning settings outside maintained schools
- Facilitate multi-agency working on digital and e-safety in learning settings
- Lead on safer working practices and tackle issues relating to the safeguarding culture in educational establishments
- Monitor and develop safeguarding arrangements in line with statutory guidance including Ofsted inspection framework and disclosure and barring regulations

Pan-Lancashire & Cumbria Chairs & Business Managers Group (Chair: Pan-Lancashire LSCB Chairs)

- Strategic direction on cross border/sub-regional work on safeguarding issues
- Sub-regional consultation on national safeguarding issues
- Commission sub-regional protocols, policies and procedures
- Share learning across the sub-region on board leadership and governance issues

Pan-Lancashire & Cumbria Policies & Procedures Group (Chair: LSCB Business Managers)

- Develop and launch multi-agency policies and procedures on how different organisations will work together on safeguarding and promoting the welfare of children and young people
- Revise multi-agency policies and procedures informed by learning and improvement work findings, communication/participation findings, national guidance, research and best practice
- Develop policies and procedures across a wider footprint (sub-regional and regional) that ensures consistency for service users and service providers whilst retaining local determination of practice and management oversight.

Governance and Accountability

Relationship of LSCB with other partnership Boards

The LSCB, through the Independent Chair and officers within the Safeguarding Unit, attend and contribute to the working of a number of partnership meetings where children's safeguarding is a significant area of business. The key partnerships outlined in ***Working Together to Safeguard Children*** are listed below with a brief description of bi-lateral reporting arrangements.

Health and Wellbeing Board & Children's Partnership Board – The Independent Chair of the LSCB attends the Health and Wellbeing Board to present the LSCB's Annual Report. The Director of Children's Services and Executive Member for Children's Services are both members of the Health and Wellbeing Board. Officers from the Public Health team (who manage the business of the Health and Wellbeing Board), are members of the LSCB.

The Health & Wellbeing Strategy for the 2015-18 period outlines the following outcomes for the borough's residents (related to taking action to enable all children to have the best outcomes as expressed in the statutory definition of safeguarding):

- Increase the life expectancy of residents and narrow the life expectancy gaps within the borough and with the rest of England
- Pursue policies that will maximise the number of years spent in good health
- Improve children and young people's emotional health and wellbeing
- Shift investment from treatment and care to prevention
- Ensure the borough has healthy places to live work and play.

The Children's Partnership Board is a sub-group of the Health & Wellbeing Board that leads on the priority area of 'Start Well'. The Start Well area has four priority areas of action that are:

- Ensure an effective multi-agency early help offer provides the right help at the right time
- Support families through a consistent approach to parenting skills and support
- Improve children and young people's emotional health and wellbeing
- Embed routine enquiry about childhood adversity into everyday practice.

To ensure that work is effective at both the strategic and operational levels, the LSCB's officers maintain a number of links with the CPB and its priority areas. At the strategic level, the Independent Chair of the LSCB is a member of the Children's Partnership Board. The Head of Operations & Safeguarding and the Safeguarding Development Manager are members of a number of groups that monitor the priority areas, including groups constituted for short periods to undertake joint strategic needs analysis on the priority areas.

The Director of Children's Services (DCS) is the chair of the Children's Partnership Board who attends the LSCB and provides regular updates on progress in relation to the priorities. The LSCB is consulted and has contributed to the joint strategic needs analysis and the priority setting in the Health & Wellbeing Strategy (2015-18).

Governance and Accountability

Community Safety Partnership (CSP) – The Head of Operations & Safeguarding attends the Community Safety Partnership and the following links are made with groups within the partnership:

- The DCS chairs the Youth Justice Service (YJS) Management Board
- The Head of Operations & Safeguarding chairs the Channel Panel (referral panel to identify preventative work for children and young people at risk of extremism)
- The Service Lead for the Youth Justice Service is a member of the Lancashire MAPPA Strategic Management Board
- The Head of Operations & Safeguarding attends the Strategic Domestic Abuse Group and the Safeguarding Development Managers (Children and Adults) advise on the domestic homicide review process and the extremism agenda
- The Safeguarding Development Manager (Adults) attends the Operational Domestic Abuse Group
- The CSP Manager attends the LSCB's committee on Child Sexual Exploitation (CSE), Missing from Home (MFH) and other sub-groups that collate intelligence on CSE victims, perpetrators and locations – the LSCB CSE/MFH Committee also monitors local arrangements on trafficking/modern slavery and online safety.
- The CSP Manager attends the LSCB & LSAB Quality Assurance Committees.

Governance and Accountability

Family Justice Board – CAFCASS (Children and Family Court Advisory and Support Service), the Local Authority's Legal Services and Children's Services are all members of the Local Family Justice Board (LFJB). Board members from CAFCASS and Legal Services report annually to the board on the progress made by the LFJB with the implementation of the reforms from the Family Justice Review. The updates provide an overview of the local and regional co-operation between the services, the oversight by the Judiciary in improving services and improving the timeliness of services for children and families subject to proceedings in both public and private law processes.

Regional and Pan-Lancashire Groups – The Safeguarding Unit officers maintain a close link with regional (North West England) and sub-regional (Pan-Lancashire and where applicable with Cumbria) groups to co-operate on joint initiatives and the sharing of knowledge/good practice. These groups allow the board to be involved in, and on occasions lead on, changes to safeguarding arrangements.

LSCB Independent Chair and Chief Officers – The LSCB Chair meets quarterly with the Chief Executive of the Local Authority and with the Director of Children's Services. Through the board's Business Group, the LSCB Chair also meets on a quarterly basis with the Independent Chair of the LSAB and the Director of Adult Services. The Independent Chairs of the children and adult boards maintain contact so that learning can be discussed and joint work can be agreed across the two safeguarding agendas.

Annually the LSCB & LSAB Chairs with the Chief Executive of the Local Authority host a meeting with chief executives of all the statutory partners of the board. This meeting allows the chief executives to discuss local and national safeguarding developments to identify key risk/improvement areas requiring chief officer oversight and individual/collective commitment to the agenda.

Prevent Governance – The Head of Operations & Safeguarding chairs the Lancashire Channel Panel. The Head of Operations & Safeguarding attends the Prevent Delivery Group and the Contest Board reporting regularly to the LSCB.

Multi-Agency Public Protection Arrangement (MAPPA) – The Service Lead for the Youth Justice Service represents Blackburn with Darwen at the MAPPA Strategic Management Board.

Relationship of the LSCB with Political Structures - The Executive Member for Children's Services attends the LSCB (as a 'participating observer') and the DCS reports through the Local Authority's accountability structure to the Leader of the Council, Opposition Lead Member, Executive Team and Council Committees (including scrutiny committee and corporate parenting structures). The LSCB Independent Chair attends Council Committees where required to present this report.

Budget & Resources

The Safeguarding Unit is funded by a range of agencies to deliver the functions of the boards across both the children and adult safeguarding agendas. Agreed contributions by partner agencies for 2015-16, including ad-hoc contributions were as follows:

Children's Services & Education	£95,300
Adult Services	£50,000
NHS BwD Clinical Commissioning Group	£50,000
Primary & Secondary Schools	£33,650
Lancashire Constabulary	£23,260
National Probation Service	£2,980
Community Rehabilitation Company	£2,980
Blackburn College	£4,000
Training 2000	£1,500
CAFCASS	£550
Training Charges	£11,000
Total	**£275,220**

Contributions by most partner agencies for the 2016-17 year will remain broadly similar with a reduction from the National Probation Service and increase from Lancashire Constabulary. Contributions through training charges are expected to be lower as agencies improve attendance at training. As well as the above financial contributions, many LSCB agencies provide their staff to deliver the multi-agency training programmes and agencies commit staff time to attending as members of the committees.

The Safeguarding Unit's staffing and costs were approximately £293,000 in 2015-16. Below is a breakdown of the Safeguarding Unit's spending for the year:

Salaries	£211,437
Fees: Independent Facilitators, CDOP, TRI-X Site & Website	£66,874
Training Costs	£12,400
Office, Travel, Committee & Meeting cost	£2415
Total	**£293,126**

The additional £17,906 spent by the Unit has been met from reserves from previous year under-spends.

Attendance at Board Meetings

The acceptable attendance rate at board and committee meetings remains at 75%. The Independent Chair and Committee Chairs challenge throughout the year attendance likely to fall below the acceptable rate by any agency. In the table below, all agencies that attend the main board have their attendance at board and committee meetings published. At the committee level, there are other agencies that will attend meetings, but who do not attend the board meetings – for brevity these agencies have not all been listed in the table below to focus on those agencies statutorily required to participate in the work of the LSCB. The overall attendance for each meeting is provided in the final line of the table inclusive of the agencies not listed in the table.

Agency	Board	CSE/MFH	Quality Assurance	Workforce Development	Communication & Engagement	Safeguarding in Education
Children's Services & Education, BwDBC	100%	100%	100%	100%	75%	100%
Lancashire Constabulary	100%	75%	75%	25%	25%	50%
BwD NHS Clinical Commissioning Group	100%	100%	100%	N/A	N/A	N/A
Adult Services, BwDBC	80%	N/A	N/A	25%	25%	N/A
Public Health, BwDBC	100%	75%	75%	N/A	75%	N/A
NHS England	80%	N/A	N/A	N/A	N/A	N/A
Lancashire Care NHS Foundation Trust	100%	100%	100%	100%	75%	25%
East Lancashire Hospitals NHS Trust	100%	N/A	100%	25%	N/A	N/A
Change, Grow Live (Substance Misuse Service Provider)	100%	100%	100%	100%	N/A	N/A
National Probation Service	100%	N/A	50%	N/A	N/A	N/A
Community Rehabilitation Company	100%	N/A	75%	N/A	N/A	N/A
Youth Justice Service, BwDBC	100%	75%	N/A	N/A	N/A	N/A
CAFCASS	100%	N/A	N/A	N/A	N/A	N/A
BwD Voluntary Community Faith (VCF) Sector	100%	100%	75%	100%	100%	50%
Lay Members	100%	N/A	N/A	N/A	N/A	N/A
Schools	100%	75%	50%	N/A	N/A	100%
Blackburn College	N/A	N/A	N/A	100%	N/A	75%
Training 2000	100%	N/A	N/A	N/A	N/A	100%
Average Attendance for the meeting (inclusive of those partners listed and not listed in the table)	98%	79%	85%	69%	60%	58%

Blackburn with Darwen:
the place, the people and their needs

The Integrated Strategic Needs Assessment (ISNA) by the Public Health and Policy teams of the local authority has produced the summary assessment below of the borough to identify priorities to improve the outcomes for children and young people in the borough.

The 2011 Census revealed that the borough had approximately 57,453 households and 147,489 residents, which was an increase on previous estimates. Blackburn with Darwen continues to have a younger than average age profile, with 28.8% of its population aged under 20, which is the fourth highest proportion in England. Based on the proportion of under-15 year-olds, Eurostat has identified it as one of the youngest towns in Europe. The borough's population is diverse, with 13.4% of residents having Indian heritage and 12.1% Pakistani. These are respectively the 11th highest and 6th highest proportions of any local authority in England.

Deprivation scores continue to be based on the 2010 Index of Multiple Deprivation, which ranks Blackburn with Darwen as the 17th most deprived borough in England. The borough has eight of its 91 Lower Super Output Areas (LSOAs) falling within the most deprived 1% nationally, and 31 falling within the most deprived 10%. The generally high levels of deprivation have consequences for the borough as a whole, and the contrast between neighbourhoods also leads to significant internal health and social care inequalities. Research also identifies that in the borough, 12% of the adult population are impacted by four or more adverse childhood experiences (from a list of nine experiences that range from parental separation, parental substance misuse, parental criminal involvement or domestic, physical, sexual or emotional abuse) compared to 9% nationally. 47% of the borough's population had not experienced any adverse childhood experiences compared to 52% nationally.

Across a range of indicators (poverty, families with multiple problems, children involved in risk taking behaviours, child/infant mortality, emotional health, sexual health, oral health, road traffic accidents, violent and sexual crimes) there remains challenges for the borough to ensure children receive the best start and foundation for their adult lives.

Key partners in Blackburn with Darwen across the public sector and the voluntary sector have been developing an approach to integrated service delivery based on a localities model. The aim is for the partner agencies to work in each of the four localities to manage the particular demands of those communities so that services are targeted at the prevention or early help end of need rather than rely on high-cost protection services. Through the Health and Wellbeing Board three strands of work in particular are contributing to this new delivery model:

- Prevention & Early Help
- Transforming Lives
- Integrated health and social care.

Monitoring Activity of the LSCB

Case File and Practice Audits

The Quality Assurance Committee timetabled the following areas for auditing and monitoring during the 2015-16 year:

- Partner understanding of Continuum of Need & Response (CoNR) framework
- Prevent duty
- Schools compliance with s.157/175 safeguarding duties
- Missing From Home (MFH) & Child Sexual Exploitation (CSE).

Partner Understanding of Continuum of Need & Response (CoNR)

The audit analysed how partners understood and applied the multi-agency referrals received at level 2, 3 and 4 of the local CoNR framework. 75 referrals received by the Transforming Lives Panel and the Multi-Agency Safeguarding Hub (MASH) were audited by staff from a range of agencies examining the information provided by the referrer to determine how well they understood local thresholds for services.

For level 2 cases referred to the Transforming Lives Panel, the vast majority of referrals were submitted on correct forms, outlining the presenting concerns, providing information about the family's current functioning and services required to address unmet need. In all these cases, consent from the family was recorded in the form or in the child's file.

For level 3 and 4 cases referred to the MASH, half of referrals were submitted using the MASH referral form and just over quarter were referred through the police's 'vulnerable child' form. This left a fifth of referrals that were submitted without using the correct form. In cases that were referred to MASH without the correct form, auditors found that they were more likely to contain less information about the family's current functioning than referrals using a referral form. Despite this, in the all of the referrals, auditors could identify what the reason for referral was. In 85% of referrals, the presenting concern was clearly articulated.

In a third of referrals at levels 3 and 4, consent was clearly recorded; in a further third there was clear information why consent could not be obtained, and in the final third of cases no consent was recorded, or reason for not recording it.

In only around a half of referrals audited was there clear information about the family's functioning using the domains in the national assessment framework.

From the range of information audited within each referral, auditors felt that in 81% of referrals, the agency had a good understanding of local thresholds. In the cases where the referring agency had not understood thresholds, the cases were mainly referred in at levels 3 and 4 when the family were requiring services at level 2. There was evidence that the cases were then passed on to the Transforming Lives Panel.

The findings have been communicated to the relevant teams and action taken within the MASH to improve practice.

Monitoring Activity of the LSCB

Prevent Duty

The board level agencies undertook a self-assessment of how well the Prevent duties were being implemented since they came into force in July 2015. The range of arrangements under the Prevent duty were summarised into five statements and agencies provided feedback on how well they had either implemented the arrangements, or if planning was in place to implement them. A description of the arrangements and the learning is provided in the table below:

Agency Arrangements	Learning
Leaders in the agency have ensured that staff in the agency understand the risk of radicalisation in the area and have built capabilities to deal with it	General compliance for most agencies – secondary schools reported that the specific local extremism/radicalisation risks contained in Counter Terrorism Local Profiles (CTLPs) may require wider circulation so that both designated teachers and head teachers can be fully aware of them
There is co-operation with local and sector Prevent co-ordinators, police, the local authority and Community Safety Partnerships to agree risk and co-ordinate Prevent activity	Good compliance in this area and the role of the new Prevent Co-ordinator in the Community Safety Team will add capacity to ensure partnership and co-operation can be strengthened further
Agency's safeguarding arrangements take into account the policies and procedures of the LSCB – staff are aware of the Prevent guidance and are knowledgeable about how to access and use the relevant policies and procedures (including how to refer to Channel Panel)	Good compliance – secondary schools identified that some support is required to ensure schools are provided with the right content to include in their safeguarding policies
Where counter-terrorism local profiles (CTLPs) identify local risks of radicalisation, a Prevent action plan is in place that addresses how the risks will be mitigated	Action planning across all agencies has been completed. Community Saftey Partnership already has an existing action plan that will be regularly updated and disseminated.
All staff in your agency (Governors/Board members through to frontline staff) have received Prevent training - all safeguarding and Prevent leads have completed Workshop to Raise Awareness of Prevent (WRAP) and all other staff have completed the Channel General Awareness e-learning module	There is good awareness of the training courses available and will require monitoring on an ongoing basis to ensure staff are accessing and completing the training. Secondary schools identified that the LSCB's Designated Teacher training would benefit with a section on Prevent so that school safeguarding leads are trained on their duties

During the year, the LSCB's policy on 'Children who may be Vulnerable to Terrorism or Extremism' has been amended twice to keep pace of the national changes in this area of public protection and child protection. Actions from the learning have all been implemented during the year.

Monitoring Activity of the LSCB

Schools Compliance with s.157/175 Safeguarding Duties

The LSCB circulated a self-assessment to all schools and Further Education establishments in the borough requesting they outline their safeguarding arrangements in a number of areas that are listed below:

- General safeguarding requirement and policies
- Recognition of safeguarding concerns
- Reporting mechanisms
- Prevent
- CSE
- E-safety/online safety
- Allegations
- Governor responsibilities
- Training.

73% of schools responded to the request for information with lower than expected response rates from Academies, Free schools and Independent Faith schools. 100% of Further Education establishments responded.

All schools and Further Education providers had relevant safeguarding policies and procedures in place, though a quarter needed to update the CSE section and two in five needed to update the Prevent section. The vast majority of the schools that needed to update sections of their safeguarding policy were primary level schools.

A very small minority of schools identified that parts of their safeguarding process to recognise (5%) and report (15%) signs of abuse/abuse required updating.

Compliance with general safeguarding training was 99% and additional training on CSE (30%) and Prevent (15%) was identified as required by a small number of schools. Where additional training remained to be completed, it was mainly primary level schools that required actions to complete.

All actions to support schools: providing a template safeguarding policy document; updating LSCB training; disseminating information to schools through a variety of head teacher, governor or Designated Safeguarding Leads' networks; and providing support on e-safety have been completed and have been continuously reviewed through the Safeguarding in Education Committee.

Missing From Home (MFH) & Child Sexual Exploitation (CSE)

The LSCB had requested that the 2013-14 MFH audit work be followed up to monitor how the revised statutory guidance from 2014 is being embedded in practice. The LSCB also requested that the MFH incidents and subsequent enquiries are also quality assured for their identification and links with CSE.

85 incidents of missing from home were audited that related to 49 children. Incidents of missing from home for the children's cases ranged between 1 and 12 episodes in the selected period.

Monitoring Activity of the LSCB

In the vast majority of cases where a child went missing, police conducted a safe and well check on the child's return. Where a safe and well check was completed, just under three-quarters were deemed to be of a good quality; those not of a good quality were usually due to the officer conducting the check not articulating how any risks required a service response.

In 92% of children missing incidents a return home interview interviewed was offered and in 90% of these cases the interview was accepted and completed. Three-quarters of return home interviews were completed in the statutory timescales. Where interviews were not offered or not conducted in timescales, only a small number did not record reasons for non-completion of statutory processes. In 87% of cases where an interview was completed, the quality of the interview met expected standards. In all the cases where the quality of the interview was below the expected standard, the children were open cases to social care (two-thirds were looked-after children) and later reviews of their cases demonstrated services were provided for the earlier unaddressed issues.

In just under half of return home interviews, unmet need or risks were identified and in 83% of these cases additional service provision was put in place to address them. In the cases where service provision was felt to be below standard, it was the view of auditors that that the child's plan was not of the quality required and recording of how health or education needs were being addressed was not recorded clearly.

In just under a quarter of the missing from home incidents, risk factors relating to CSE were identified by auditors. In just under three-quarters of these incidents where CSE risks were identified, there was clear evidence that the children's plans were updated and services put in place to reduce risk immediately. In the remaining cases, there was some delay in identifying the risks which were addressed as evidenced by auditors in later case records.

Recommendations to improve practice have been agreed by partner agencies and implementation will be monitored through the LSCB's CSE/MFH Committee and Quality Assurance Committee.

Female Genital Mutilation (FGM)

In addition to the timetabled audit work, the Board also undertook a review of the likely prevalence of FGM in the borough following the publication of updated national research. The national research identifies that FGM is known to be a cultural practice in around 30 countries around the world. In the borough families from around 18 of these countries are known to be residents; some from countries where the FGM prevalence rate is fairly small to other countries where it is very common that women/girls experience the abuse.

The review found that the prevalence rate estimated by the national research is likely to be accurate based on the diverse populations known to be living in the borough and the number of cases being referred in by health services, education and through self-referral.

The review recommended that the LSCB policy on FGM is updated with information on the diverse populations that reside in the borough and the types of FGM practised by these communities to aid identification and reporting. This work has now been completed. Ongoing monitoring of how many cases agencies identify and the training of practitioners will be undertaken by the LSCB Quality Assurance Committee.

Monitoring Activity of the LSCB

Serious Case Reviews (SCRs)

There were two SCR referrals received by the LSCB in 2015-16 from partner agencies; both incidents were also reported by the local authority through the Serious Incident Notification process. There were no reports received from youth justice services of serious incident notifications that they had to make to the Youth Justice Board. One case was commissioned as a SCR by the LSCB. In the second case, the National Panel of Independent Experts on SCRs agreed with the LSCB's decision that the case did not meet the criteria for a SCR. The one case commissioned as a SCR will be published in 2016-17 and a summary of its findings and action required to strengthen the local safeguarding system will also be available in the next annual report.

The LSCB has also contributed to SCRs in two other authorities. In both these cases, learning to improve practice on the transfer of case records has been identified and is being implemented.

Multi-Agency Concise Reviews (MACRs)

In the 2015-16 year there were no referrals submitted to the LSCB to consider undertaking a MACR.

Monitoring Activity of the LSCB

Performance Monitoring & Quality Assurance
The LSCB's Performance Monitoring and Quality Assurance Declaration is used to collate performance information and quality assurance information from individual agencies. The declaration seeks data on the volume of safeguarding activity that takes place within agencies and seeks analysis on what that information means (the impact safeguarding activity has made to children's outcomes, the impact activity has made in improving the quality of practice and improving the safety of the local multi-agency safeguarding system).

Children's Services & Education – The number of children referred for multi-agency early help services remained steady through the year and at similar levels to the previous year. The characteristics of the children subject to a Child and Family Plan showed no change to previous years, however the partner agencies leading on the cases has shifted more to public sector agencies (82% held by schools, Children's Services and Health providers) away from the Voluntary, Community, Faith sector agencies (cases led by the sector fell by 49% compared to the previous year). This shift is a likely consequence of the embedding-in of the local Transforming Lives Panel and alignment with the Troubled Families service; in a third of cases managed by the service, the VCF sector agencies are the lead professional.

The number of contacts that services and members of the public make to Children's Services for services requiring social work assessment has fallen by 5% during the year. This has meant that the number deemed to be appropriate at this intensive level has also fallen by 4% and the total number of cases being managed by social workers fallen by 8%. This trend averaged across the 2015-16 has been reversed in the first quarter of 2016-17 when demand has started to rise and caseloads have increased.

Despite these headline falls in demand, other data indicates that the nature of what is being referred in is more appropriate and far more complex – 98% of what is deemed appropriate to refer in now results in an assessment being completed meaning that whilst demand for assessments may have decreased, the number of assessments initiated has not changed; 40% of assessments completed by social workers are now at section 47 level compared to just under a third in 2014-15. The increase in section 47 assessments has resulted in 10% more children being subject to child protection plans and contributed to the 10% more children becoming looked after compared to 2014-15.

At the referral stage, 23% of referrals are now repeat referrals and at the child protection plan stage, the same proportion for children with repeat plans. The additional demand for the more complex end of child protection work has impacted on the timeliness of key safeguarding processes – for example, assessments completed in statutory timescales has fallen from 74% in timescale in 2014-15 to 68% in timescale in 2015-16; statutory reviews of children subject to child protection plans completed in timescales has fallen from 92% in 2014-15 to 80% in 2015-16; complexity of cases is increasing as nearly 2% of children subject to child protection plans are on the plan for a period of more than 2 years; the ratio of children becoming looked after to being discharged from public care was 1.26 (nearly quarter more children discharged from public care) in 2014-15 to 0.81 in 2015-16 (fifth more staying in care). Despite these pressures on the social work service, performance indicators on a range of early help, child in need, child protection and looked after children remain relatively strong when compared to national and regional averages; with marginal increases in performance from last year. The service describes that in addition to the complexity of demand there are also factors in supply that are impacting on the ability to meet target timescales of key processes: shrinkage in back-office administrative capacity; increasing expectations from family courts in completing care proceedings in new statutory timescales; and reliance on more detailed reports from social workers with input from experts, replacing expert reports from specialists commissioned by the courts.

Monitoring Activity of the LSCB

Just over a half of looked after children are placed within the borough and around four-fifths of children placed outside the borough are placed within 20 miles.

Over the year, a range of tools have been developed by the Independent Review Officers (IROs) to support implementation of child centred reviews. This has resulted in more children and young people actively participating in their review (increase in number of children who are involved in the decision making or chairing their review). Improvements have also been made to the development of child-friendly care plans and provided an opportunity contribute to the decisions that are being made about their lives. A lead IRO has been identified to ensure participation work continues to develop within the service. Specialist IRO leads have also been identified as leads for cases that involve CSE/MFH, extremism and children with disabilities. This has enabled the consistency in chairing conferences and managing reviews as well as increasing knowledge across the IRO team.

The IRO/social work dispute resolution procedure has been revised which has resulted in improvements to efficiency, recording and reporting. Currently, the majority of challenges are resolved at the informal stage with only a few escalating to formal procedures.

Regional best practice guidance in respect of role of IRO in pre-proceedings work has been implemented. This has resulted in improved awareness of requirements in relation to ensuring IROs receive relevant information and all care plans are ratified before being submitted to court.

The number of contacts made with the Local Authority Designated Officer (LADO) in relation to allegations against adults working with children has increased by 16% during the year. A quarter of these contacts result in a consultation taking place or advice being provided. The number of appropriate referrals has increased by nearly a third since 2014-15; the third consecutive year where the increase is a third more than the previous year. Three-quarters of referrals are made by statutory services (four-fifths of these by Children's Services, early years and schools/colleges); under a tenth made by Ofsted; and the remainder by agencies in the voluntary, community or faith sector (VCF). Over half the referrals relate to adults working in education, foster care or early years settings; 10% relating to adults working in faith settings; and the remainder working in a mix of statutory public or VCF sectors. Three quarters of referrals related to allegations of physical abuse or where the adult posed a risk of harm relating to activities in their personal lives; 15% related to allegations of sexual abuse (majority of these relate to sexual assault); and the remaining 10% relate to allegations of neglect or emotional abuse.

In 45% of referrals where investigations had concluded, the allegation was substantiated; in 55% of referrals the allegation was deemed to be unsubstantiated, unfounded or malicious. In just over a half of cases, the outcome was for the agency to use a variety of human resources (HR) processes; a recommendation to provide additional training in a fifth of cases; and the remaining cases the agency recommended to improve elements of their safeguarding practices. In under a tenth of cases where HR processes were initiated, a referral to the Disclosure & Barring Service (DBS) was made. In 93% of cases that achieved an outcome, it was achieved within three months of the referral being made to the LADO.

Monitoring Activity of the LSCB

During the 2015-16 year, the number of children the Engage Team (child sexual exploitation) has been actively working with has increased by a third between quarter one and quarter four. The assessed level of risk for these children has not substantially differed at the high risk level with 10% of cases at this level; some changes at the medium risk level, now at two-fifths of cases compared to half in quarter one; and low risk cases increasing to two-fifths from a just over a third in quarter one. The complexity of cases has increased during the year with just over a quarter of cases having previously received a service from Engage, up from a fifth in the first quarter of the year; and under a quarter of cases where the child has a child protection plan, up from just under 10% in quarter one. Girls make up just under four-fifths of cases; boys now just under a quarter of cases, up from 15% in quarter one. The implementation of changes in processes and procedures following last year's reviews of the service are now embedding in, resulting in the higher number of cases and improvements in the range of cases that are being managed.

The number of children reported as being missing from home has fallen by a fifth compared to 2014-15, however the number of missing incidents these children have been involved in has only fallen by 5% - meaning that some of the children missing on multiple incidents has increased. The increase in cases for the Engage team and children going missing on multiple occasions has meant that performance indicators on the proportion of children offered return to home interviews, and the proportion offered interviews that are completed in statutory timescales, have remained the same since 2014-15.

The local authority received eight notifications of private fostering arrangements during the year and following initial enquiries, an assessment was completed in five cases where a social worker was allocated to monitor the arrangements. The service also continued to manage two notifications from 2014-15. Five of the seven arrangements managed during the year, ceased during the year. The three notifications not resulting in assessment led to information sharing in two cases (one case where the private fostering arrangement was referred to another local authority for assessment) and legal advice obtained in another case that verified the relationship between the child and carer did not fall within the definition of private fostering. The service has undertaken its self-assessment against the national minimum standards and found six of the seven standards to be well embedded with one standard where further audit activity is required to confirm arrangements are well embedded.

Findings from audit activity within the department show that despite the increased demand for complex child protection work and factors affecting supply, the quality of practice has improved – in 2014-15, two-thirds of audited cases met or exceeded expected standards; in 2015-16 this had increased to just over three-quarters of audited cases. Quality of assessments, reflecting the child's voice in the case recording and provision of services, and the involvement of partners were all areas where practice has improved during the year.

Through the year, a number of early years settings and registered homes (Whalley New Road, Lytham Road & Appletrees) run by the local authority have received outstanding grades for their provision by Ofsted. A growing number of services have also achieved or been re-accredited as 'Investors in Children' – in total, 16 local authority, commissioned and partner services have now achieved the accreditation with five more services in the process of achieving the accreditation. The evidence provided by services to achieve accreditation is verified through a number of processes by an independent assessor and by children and young people. The decision to accredit a service is finally made by children and young people.

Monitoring Activity of the LSCB

Positive feedback from services continues to outnumber complaints and the service user feedback demonstrates the positive impact services have made on family functioning, parent's awareness of risk reduction and where to access local services.

Of the cases reported by schools to education services of children missing education (CME) in the second half of 2015-16, four-fifths have been located with nine out of ten of these children located within the UK. Two-thirds of located children are located within 20 days of the referral from the school. In the 10% of cases where a child is located abroad, none of the children were located in any conflict zones around the world. Children who remain to be located are either suspected to be abroad or are travelling within the UK with family and these cases remain on an active list until verification is received of their location. The service liaises and shares information with social care, health, housing, asylum services, UK Visa & Immigration Agency and other local authority CME teams to locate children. Between the calendar years 2014 and 2015, the number of cases referred by schools had increased by a third – reasons identified by the service for the increase include better reporting by schools; improved recording and staffing within the service; and higher levels of transience within Central/ Eastern European and traveller communities.

Further Education & Training Providers – Recent Ofsted inspections of providers in the sector have found that safeguarding arrangements are robust and the organisations take an active part in local partnerships across the safeguarding and child protection agenda. The returns to the LSCB on quality assurance and performance identifies that the organisations are adept at learning from their incidents and strive to change systems and processes from even the very small levels of non-compliance that they find. For example, at Blackburn College, 98% of students felt safe in the College and the organisation undertook a consultation of the 2% that reported not feeling safe resulting in new communications and participation events. The organisations retain a high proportion of their students in education who have been the subject of additional services through safeguarding leads/pastoral services; 90% at Blackburn College and 84% at Training 2000 – again both organisations seek to learn about how these retention rates can be improved. Within Blackburn College, demand for safeguarding services has continued to rise (up by 71% from the previous year); at Training 2000 smaller numbers means annual variation. The College has increased the capacity in the teams and added new pastoral services to ensure learners have access to services and can continue their studies. Another positive safeguarding example from the College highlights both their learning from cases and partnership working – within the increase in safeguarding cases has been an increase in boys/young men with behavioural or mental health concerns; analysis by the College of the circumstances has identified significant numbers of boys/young men with adverse childhood experiences resulting in isolation – the College has then partnered with Lancashire Mind to provide services to these boys/young people to address the adverse impact, improve behaviour and refer to mental health services where required.

Troubled Families - The delivery in Blackburn with Darwen is embedded within the Transforming Lives approach and locality delivery model. Families who meet the criteria are identified through the Transforming Lives Panel and progress is monitored through the Locality Multi-Disciplinary Teams (MDTs). Transforming Lives is a multi agency team of staff who provide triage for cases on a weekly basis. This enables front line workers across partners to seek advice and guidance on cases that are causing concern, but not yet at the acute stage and to access Early Support through a single point. It brings professional skills and perspectives together to make good judgements about support required. The Locality Case Management Hubs are four multi-agency local hubs that receive cases from the Transforming Lives Panel, allocate cases to the most appropriate lead worker and ensure

Monitoring Activity of the LSCB

joined up delivery. Services are co-located where feasible and a weekly monitoring meeting is held to review and progress cases, identify gaps in service provision and avoid service duplication.

In 2015-16, just fewer than 300 referrals were received by the Troubled Families service and around 4% of these were repeat referrals. The service uses six nationally directed criteria of unmet need or indicators of emerging problems in the family; where a family meets two of the criteria, a service is offered. Of the referrals received, 66% had unmet health needs; 65% were families known to social care; 64% where adults in the family were out of work; 49% where domestic abuse was present in the family environment; 45% where offending/criminality was present in the family; and 32% where school attendance was an area of need.

Cases are allocated to the services' key workers or a range of local partners – just over a third led by Troubled Families' key workers, over a third led by agencies in the voluntary, community or faith (VCF) sector and under a third by public sector agencies (mainly Children's Services with a fifth of these by criminal justice sector services). A handful of cases were led by schools and health services.

As part of the implementation of the borough's parenting strategy actions, referrals have started to be received in quarter four of the year on the Strengthening Families programme. Referrals for the programme were from a range of services and facilitation of the sessions has been equally supported by a range of agencies. 90% of families engaged with the programme and early indicators of outcomes include cases being closed to social care, improved confidence in parents and parents putting into place strategies learnt on the programme.

The service has undertaken its own case file audit that has identified improvements required in recording actions and outcomes, and introduction of a multi-agency decision process to close cases through the Transforming Lives Panel. The service has also been audited by the Council's audit team who graded the service as providing 'substantial assurance' with no recommendations made for improvements.

All practitioners that lead on case management have been trained and have achieved a level 4 qualification in 'Working with Families with Complex Needs'. Staff have been trained on delivering the Strengthening Families Programme and also undertake safeguarding training (CSE, Prevent, Information Governance etc).

The service is a payments by results programme and in the last results claim in January 2016, outcomes were evidenced for 70 families – 54% improved school attendance; 53% improved emotional health & wellbeing; 41% had cases stepped down from child protection or child in need levels; in around a quarter of cases the families had been supported to address domestic abuse, progressed to work/training/volunteering, debts had been managed or re-offending and anti-social behaviour reduced; and in one in ten cases, continuous employment had been secured by a member of the family. The council's audit of the service included an audit of the payment claims that found the claims to be accurate and supported with evidence.

Monitoring Activity of the LSCB

Health Commissioners and Providers

Blackburn with Darwen NHS Clinical Commissioning Group (CCG) – The CCG commissions a wide array of health services directly, or as an associate commissioner where another CCG within Lancashire acts as the lead. Services include acute hospital services, emotional and mental health services, GP services (including out of hours GPs), ambulatory services, nursing care and specialist residential care (learning difficulties, disabilities etc) as part of the Continuing Health Care (CHC) framework. In addition to direct health services, the CCG also commissions support services that assist with quality assurance mechanisms and provision of assessment/ monitoring of the CHC framework.

The performance monitoring of health services has a robust framework of governance that provides the CCG with a regular schedule of rich data supported by targets and red/amber/green (RAG) rated monitoring. This includes safeguarding training compliance data. The quality assurance framework has been substantially revised during 2015-16 to ensure adult safeguarding can also be monitored as effectively as children's safeguarding following the implementation of the Care Act.

The headline performance data is measured by a suite of indicators that are categorised as NHS Constitution Indicators and for Blackburn with Darwen, nearly all of these indicators are RAG'd green (meeting or exceeding performance targets) except ambulatory care, cancer treatment waiting times, A&E waiting times and prevalence, recovery rates and waiting times for community mental health services.

Health assessments for looked after children remains a key area of service provision that the CCG monitor – performance to complete review health assessments is within targets, however completion of initial health assessments in timescale remain below target levels and during the year a range of actions have been implemented with internal, provider and Children's Services system improvements to address the targets being missed.

Safeguarding training is measured across the range of services commissioned and compliance rates with general children's safeguarding training remains strong across all provider services – for example, 84% in GP surgeries. Where services have provided additional data on practitioners completing training in specific areas of children's safeguarding (domestic abuse, CSE, Prevent etc.) the performance is much more variable. For example detailed data for GP practices is provided on Prevent and CSE training – Prevent has 73% completion, whereas for CSE only one out of 27 GP surgeries are fully compliant with training all levels of staff.

The performance and quality monitoring also includes monitoring of CQC inspection findings of services; only one provider (Calderstones) is rated as requiring enforcement action and three providers with improvements identified; the vast majority are meeting the safe quality standards. The CCG has identified that their direct quality monitoring of safeguarding in commissioned support services is to be strengthened and actions have been put in place to develop systems in 2016-17. An area of priority for the CCG in 2016-17 is ensuring GP surgeries access and complete CSE training.

The CCG has played a pivotal role as one of the statutory safeguarding partners in local partnership initiatives on early help, targeted prevention and child protection.

Monitoring Activity of the LSCB

Public Health – Public Health commissions a variety of services aimed at improving health over the life course and preventing health needs from arising that may then require CCG or NHS England commissioned services. In terms of impacting on safeguarding and wellbeing, services include: child health services, sexual health services, smoking cessation; alcohol and drug misuse; nutrition, obesity, physical activity services and healthy lifestyle services aimed at preventing poor health and premature death; accident prevention; suicide prevention; community safety and violence prevention; and preventing social exclusion. To impact on the social and environmental determinants of improving health outcomes, the Public Health team are represented at a range of local partnerships and commission partnership services within the public and voluntary, community or faith sector (VCF). All contracts for services commissioned by the team are monitored on a regular basis, including safeguarding indicators and breaches resulting in enforcement activities. Collation of data from contract monitoring into a quality assurance framework has not developed sufficiently to enable regular reporting to the LSCB. A similar position is also evident for the extensive service user work commissioned by the team.

NHS England - NHS England North (Lancashire) works at a local, regional and national level across the NHS England priority areas for safeguarding e.g. Prevent and FGM. There is regular feedback from national and regional safeguarding groups to inform the local safeguarding team in Blackburn with Darwen; there is also the opportunity, due to these links, to influence the regional and national agenda on safeguarding via the work that safeguarding professionals in Blackburn with Darwen are undertaking. An example of this are the Prevent arrangements in Blackburn with Darwen – the good practice has been recognised and Lancashire are now undertaking a national pilot to ensure that local authorities take a leadership and management role in the running of the Channel process and the development of community support for Prevent.

NHS England as part of its safeguarding assurance function holds a quarterly Safeguarding Forum where all those responsible within their organisations come together to share best practice but also to provide assurance that across health safeguarding compliance is being maintained. Over the past 12 months a comprehensive review of CCG compliance has taken place in line with the Safeguarding Accountability and Assurance Framework. The results of this review are awaited. The services that NHS England commissions e.g. immunisation services, young offenders' health services, etc are monitored on a monthly basis via quality contract meetings. These providers are required to provide robust data in respect of all elements of service provision including safeguarding. Similarly, primary care contractors are now jointly commissioned by NHS England and Blackburn with Darwen CCG; they are required to declare that they are compliant with the requirements in respect of safeguarding practice. In BwD, 100% of practices have declared their compliance. All practices are required to have a lead GP for safeguarding and these GPs are responsible for ensuring that their practice remains up-to-date with their statutory responsibilities. NHS England is responsible for ensuring that all GPs undertake revalidation. Locally the revalidation discussion includes safeguarding and other elements of quality clinical care.

Over the past 12 months NHS England North has delivered a number of safeguarding conferences and events in the north of England to ensure that current information and learning is shared e.g. National CSE Conference in Manchester in March 2015 and a conference on the Challenges for Modern Safeguarding Practice held in Leeds on the 11th March 2016 which focused on modern slavery, trafficking and FGM.

Monitoring Activity of the LSCB

Lancashire Care NHS Foundation Trust (LCFT) – the agency has provided its 2015-16 Annual Report on safeguarding and the organisation's safeguarding vision as its evidence for quality assurance and performance monitoring. The two documents provide broad descriptions on performance (demand for child safeguarding has increased at the child protection and looked after children levels of the system where additional capacity has been added to assist school nurses with completing reports for child protection meetings; strong performance in completing review health assessments for looked after children at 80% completed in timescale; and alignment of recording systems with social care to ensure health and social care records of children known to the Engage team can be accessed) and assurance that processes and governance are in place internally and with local partners to ensure children's safeguarding, mental health, domestic abuse, extremism, CSE, public care and other safeguarding themes are prioritised.

The CCG's detailed performance report provides an array of indicators used under the NHS Constitution and as already highlighted, targets have been missed by LCFT in community mental services relating to prevalence, recovery rates and waiting times.

The CCG reports there is good compliance overall with community health services commissioned from LCFT. Training compliance for level 1 safeguarding is at 86% across the range of services provided by the agency. For staff requiring level 2 training, compliance is slightly lower at around 75%; at level 3, lower again at 67% (due to level 3 training in the adult mental health services having variable compliance). Compliance levels for Prevent & WRAP training, to recognise and respond to extremism are 37% and 14% respectively. CSE training is categorised as essential training by the agency in their Annual Report with a compliance rate of 47% for additional training above that already covered in levels 1 to 3 training.

East Lancashire NHS Hospitals Trust (ELHT) – The Safeguarding Team within the trust has been dealing with increasing number of contacts from their internal clinical teams and from partner agencies – these contacts may simply seek advice on identifying concerns around safeguarding through to complex case management. For partner agencies it may involve being part of multi-agency service provision, acting as lead professional through to provision of reports for child protection assessments and family court proceedings. All these areas of work have seen an increase in demand in the past year. The safeguarding team monitor what outputs and outcomes they deliver for each contact – the main outcome being that information is shared or a referral made to another service. Audit activity has identified that the use of the child risk assessment tool, an area for improvement highlighted in previous CQC inspection, has improved to between 90 and 100%.

Action is being taken with the CCG to address capacity issues to complete initial health assessments for looked after children in statutory timescales. The service is provided by paediatric services within the Trust.

Monitoring Activity of the LSCB

North West Ambulance Service (NWAS) – The service provides ambulatory care across the North West region from Cumbria to Cheshire. Safeguarding referral data is broken down by three sub-regions; Cumbria & Lancashire being one sub-region. Across the North West region, the service made just under 4,800 referrals to Children's Services in the 2015-16 year with only 5% of these referrals not accepted. The main reasons for not accepting the referral tended to be duplicate referrals of siblings or referrals sent to the wrong local authority area. The service also audits the quality of calls it receives and call staff's ability to identify and record effectively safeguarding indicators – early results from the audit show good identification, recording and information sharing with some learning required. Safeguarding training is mandatory for staff including specialist courses on Prevent, CSE, Modern slavery/Trafficking and Domestic Abuse. Specialist courses are mandated each year for prioritisation. Compliance in mandated courses is above 90%.

Criminal Justice (Youth Justice, Probation, Police & Community Safety) - The youth justice data identifies that on a range of nationally reported indicators (first time entrants to the justice system, number receiving custodial sentences and re-offending rates) performance is very strong. For indicators based on small numbers of children, there continues to be year on year variability (offending rate of LAC, children committing violent offences). Where referrals in to specialist services to meet education and health needs (including emotional health), or prevent further criminal activity are made, engagement is high and successful reduction of risks remains a positive for the service. The Multi-Agency Risk Management (MARM) Panel focuses on cases where the child's vulnerability or risk level is high. The Panel is well established and is the key forum for making risk management decisions. Performance of the Blackburn with Darwen Youth Justice Service (YJS) is within the best performing YJS' in the country.

National Probation Service (NPS) – Just under a quarter of cases managed by the service in the borough have flags where the offender poses a risk to children due to their offences. In 5% of cases, children of these offenders (or children of their partners or living in the same household) are currently being monitored through child protection plans and in 9% of cases there are concerns about the welfare of the offender's children (or children of their partners or living in the same household). In the last six months of 2015-16, referrals screened within the MASH across Lancashire have identified that the NPS is currently supervising 13% of adults, with 23% known to the service in the last six months. The practitioners in the BwD office have received briefings on local safeguarding referral pathways and safeguarding children training is mandatory for all staff. Training on domestic abuse, CSE and Prevent is also mandatory with high levels of compliance. Audit activity monitors the quality of risk assessments and audits on specific themes of practice are undertaken by the service including the work of MASH.

Community Rehabilitation Company (CRC) – In just under a quarter of cases managed by the service in the borough, the offender is known to be a perpetrator of domestic abuse. In 8% of cases there are concerns about the welfare of the offender's children (or children of their partners or children living in the same household). In 3% of cases, children of offenders (or children of their partners or living in the same household) are currently being monitored through child protection plans. The service commissions a number of accredited programmes to help offenders reduce their offending behaviour, including programmes on domestic abuse; these programmes have been audited in the last year and RAG rated green (meeting service expectations and performance targets). Children's safeguarding training is compulsory for all staff with officers requiring at least level 2 training – the service currently is in the process of collating compliance data. As performance and audit systems develop in the service, it is anticipated that future data returns to the LSCB should contain more information

Monitoring Activity of the LSCB

Lancashire Constabulary – the police refer child safeguarding concerns through the vulnerable child referral mechanism and the force reports that demand through the year remains high. Just over four-fifths of referrals made by the police relate to physical abuse, neglect, sexual abuse, child sexual exploitation, domestic abuse and children reported missing from home. In the remaining fifth of cases, forced marriage, honour-based abuse, trafficking and financial abuse were the concerns identified.

The police confirm that they have prioritised the child safeguarding agenda through various actions taken by the Public Protection teams: resources at strategic and operational levels have been committed to ensuring safeguarding issues are reported by the public; resources in teams are being continually reviewed to meet demand (CSE and historical sexual offence investigations) and respond to emerging safeguarding themes (online offences); resources provided to train staff on specialist investigation techniques; and resources committed to the multi-agency system and working with partners (especially within the MASH and Engage teams and across a range of existing safeguarding themes like domestic abuse and emerging themes like extremism and trafficking).

Internal auditing by the police during the year highlights that identification of safeguarding risks, information sharing and joint working is well evidenced; where crimes are committed the correct procedures are being used. The audit highlighted that record keeping about decisions made in cases and what supervision (of cases) has taken place requires improving; the actions to address learning have already been implemented during the year.

In December 2015, Her Majesty's Inspectorate of Constabularies (HMIC) inspected the force on their 'vulnerability' effectiveness (effectiveness to keep people safe and reduce crime). The force's performance was judged to be good during the inspection with the following summaries:

- Clear processes in place to identify repeat and vulnerable victims
- Accurate assessments of risk are made with responses being consistent
- The Force works effectively with partners to tailor individual responses to risk and devise support programmes for vulnerable people
- The Force has invested substantially in CSE teams and making good progress at targeting organised crime groups; and
- The Force has made good progress on previous HMIC inspection recommendations.

The police return to the LSCB identifies a number of work streams that are already prioritising the learning from the HMIC inspection.

Monitoring Activity of the LSCB

Community Safety Partnership (CSP) - The community safety team provides and commissions services in support of vulnerable people with a focus on those persons that are victims of crime, domestic abuse or anti-social behaviour. This includes persons vulnerable to extremism or terrorism. Data provided by the Community Safety Team from a range of data sources shows that overall reported crime incidents have increased by 3% in 2015-16 compared to 2014-15. The increase in overall crime has been driven by an increase in violent offences (assaults, both domestic and non-domestic; harassment; and sexual offences). Sexual offences against children have increased by 37% in 2015-16 from their 2014-15 levels, driven by increasing number of historic crimes being reported. Domestic abuse incidents reported to the police have increased by just 1%, however referrals to MARAC for high risk cases have increased by 29% (relating to complex cases with co-morbidity issues of mental health, substance misuse and sexual offences within domestic abuse incidents). Repeat cases at MARAC have declined to 24% in 2015-16 compared to 27% in 2014-15.

Anti-social behaviour incidents have reduced by 4% between 2014-15 and 2015-16. The ASBRAC Panel that operated in Blackburn with Darwen now functions through the Transforming Lives Panel (since February 2016) to ensure appropriate connections can be made with a range of early help services to prevent escalation to child protection services and ensure connections are made with services delivered through Troubled Families.

As outlined in the Governance and Accountability section of this report, the CSP governs the accountability of several partnerships dealing with key complex safeguarding themes (Prevent, Domestic Abuse, Forced Marriage, Honour Based Abuse, FGM, Trafficking/Modern Slavery) and contributes significantly, including through resources, to other safeguarding themes (Early Help, Transforming Lives, CSE, MFH, Safeguarding in out of school education settings, E-Safeguarding etc). During the 2015-16 year the CSP has involved the Safeguarding Unit closely in the work they are undertaking to review the local Domestic Abuse Strategy, including completing the needs assessment.

Family Justice (Legal Services & CAFCASS) – The demand for Legal Services within the Council relating to Public Law Outline work (before care proceedings) has increased by 44% from the previous year and demand for care proceedings work has increased by 71%. CAFCASS has also experienced an increase in demand: between the first half of 2015-16 and second half of the year, demand for public law cases increased by 22%. Demand for private law work cannot be broken down to the borough level, but national data highlights an 11% increase in demand in the 2015-16 period. The Courts Service publishes data on the timeliness of public law proceedings against the national target to conclude cases within 26 weeks; 69% of Lancashire cases are completed within the target timescale compared to 59% nationally. Across the year there has been significant improvement towards the national target: in quarter one, the average time to conclude cases in court, across all cases was 29 weeks reducing to an average of 26 weeks by quarter one. Both services have internal monitoring systems that support meeting nationally set targets and both work together locally and with partners (particularly Children's Services) to ensure there is regular communication about cases and understanding between practitioners about working practices.

Monitoring Activity of the LSCB

Voluntary, Community, Faith Sector Agencies – There has been a particularly good response rate from agencies providing commissioned services from the VCF sector. The returns are detailed and answer the questions raised by the LSCB about safeguarding activity, trends, quality of practice and outcomes to reduce risk/address need. Some key information from the returns is provided below:

- Change, Grow, Live (CGL) – during the first year of operating within the borough, the extent of safeguarding needs/risks identified in clients has increased through the year. In quarter one of the year, 3% of adult client cases were considered to contain child safeguarding risks; by quarter four this had increased to 8% with the overall caseloads in the adult service increasing by 14% within the year. In the young people's service, the overall caseload increased by 44% across the year; safeguarding risks within these cases was 18% in quarter one, increasing to 50% by quarter four. As it is the first year of the service being in operation, familiarity of staff to record safeguarding issues in case records, assessment skills and identifying appropriate referral to services have been issues identified from performance management and quality assurance systems that have required improving and by quarter four of the year there were already signs of improving practice. For example the service regularly attends a number of local multi-agency panels that identify young people with targeted and preventative service needs, increased referrals made for services to address domestic abuse and mental health, and has attended more multi-agency case management meetings for individual young people with unmet need. The majority of practitioners in the agency have received training on safeguarding children, on undertaking home visits and receive safeguarding supervision that additionally explores quality of record keeping. To avoid drift and ensure risk management is appropriate, a policy on not attending appointments and a process of daily risk management have been implemented; both already demonstrating improvements in client engagement and appropriate risk management. During the year the service has significantly improved outcomes for their practitioners (improvement in skills and confidence) and improved outcomes in local partnerships (attendance and contribution to multi-agency working).

- Changing Lives – The data return from the service provides some limited data on demand for services – the average number of referrals received by the service per month has been between the range of 200 and 250. Approximately 8% of these children were known to be receiving multi-agency services at levels two (Early Help) to four (Child Protection) of the Continuum. As the service is starting to embed in the authority, it is likely that performance monitoring systems will take time to develop and provide a more meaningful picture of demand and how outcomes are improved. Caseloads for Independent Domestic Violence Advocates (IDVA) caseloads are currently (end of year 2015-16) at 473 cases which is three and a half times the recommended level by SafeLives. The service has recently been awarded funds through the Big Lottery fund to enhance long term support for families stepping down from Child Protection level to Early Help multi-agency services.

Monitoring Activity of the LSCB

- Blackburn Darwen District Without Abuse (BDDWA) – Referrals continue to be received from a range of sources (over a third are self-referrals; remainder from public services across housing, social care, health, substance misuse and police sectors), however due to the change in the local authority's commissioning of domestic abuse services, referrals have dropped by 57% compared to 2014-15. The agency's helpline has received over 15,000 calls - 1,500 victims/perpetrators were directly supported with services; a small proportion resulting in self-referral or emergency accommodation; and the remainder seeking advice/ support. The service provides specialist IDVAs for domestic abuse issues in the BME community and victims with co-morbidity of substance misuse, mental health and/or sexual abuse with domestic abuse. Over a third of referrals received for direct services in the second half of the year were classed as high risk, a sixth of these requiring discussion and management at MARACs ; 20% of referrals assessed as high risk were repeat cases, double the proportion of all cases meaning that repeat service provision is essential in the more complex/severe cases. All staff and volunteers in the service have accessed children's safeguarding training, with a proportion of staff also completing training on mental health, substance misuse, deprivation of liberty, CSE, Prevent and suicide prevention. Quality assurance and management oversight activity is undertaken within the agency to ensure practice meets standards and learning for improving practice and processes can be identified. Around a quarter of victims referred to the service volunteer to attend programmes to reduce their victimisation and 3% of perpetrators associated with the referrals attend voluntary behaviour change programme offered by the agency. 98% of victims referred to the service engage with service provision; this with a lower number of overall referrals has meant IDVAs and volunteers have had greater amount of time to spend with clients and have reduced repeat referrals from 46% in 2014-15 to 10% in 2015-16. Through training and management oversight, improvements have been made to practitioner outcomes; through involvement with multi-agency child protection and early intervention panels, the agency has contributed to partnership outcomes.

- Child Action North West (CANW) – the service provides a variety of services commissioned through local authorities, youth justice services and schools. The commissioned service for local authorities includes fostering services. All services identify safeguarding concerns that are reported internally and reported to the commissioner, including where referrals for multi-agency support are undertaken. Following such referrals, the service reviews each incident to identify any prevention lessons and lessons on improving case management. With the strong emphasis on learning about early intervention and prevention, the service is involved in a variety of early help panels in the borough and with the LSCB.

- Together Housing Group – Referrals as a percentage of housing customers is a very small percentage and fluctuate year on year, with referrals in 2015-16 being the lowest in a four year period. The organisation prioritises safeguarding training to ensure all staff can identify signs of abuse/neglect and early help, ensure the internal 'cause of concern' form is completed and attend relevant child protection meetings as required. The organisation regularly attends a number of local multi-agency panels that identify young people and families with targeted and preventative service needs. Whilst quality assurance activity is not routine, the organisation does undertake reviews of cases that raise concern – an area team from outside BwD has reviewed a case that has identified learning about risk management, communication and information sharing that has been disseminated across other geographical areas in which the group operates.

Monitoring Activity of the LSCB

- Nightsafe – In 2015-16 over a thousand young people accessed housing and support services offered by the agency, a third of these young people were 16-17 years of age. In terms of the daycentre services (laundry facilities, shower, storage, lunch and delivers a range of life skills and health workshops) over 5,000 attendances were recorded in the year. In addition to supporting young people with services associated with housing needs, referrals are made to support physical health needs, mental health needs, substance misuse and domestic abuse. The organisation regularly attends a number of local multi-agency panels that identify young people with targeted and preventative service needs. Safeguarding children, substance misuse and domestic abuse training has been accessed by staff.

- Young People's Services (YPS) - Current prevention work in the service focuses on two strands of risk taking behaviour - substance misuse and healthy relationships (with focus around CSE). The demand on the Targeted Youth Support element of the service is dictated by the number of referrals from the Transforming Lives Panel – YPS currently has the capacity to manage 100 cases and during the year, demand has been greater then capacity at some points by nearly 20%. The service also works closely with other services to refer on issues like substance misuse and sexual health. Monitoring of training that practitioners complete within the service is improving – recent analysis identifying that CSE training and safeguarding training for senior managers requires additional prioritisation.

Monitoring Activity of the LSCB

Section 11 Audits

All statutory agencies of the board responded to a request to complete a section 11 audit. A number of agencies outside of the statutory agencies that are key local partners also provided returns, as did some services commissioned by public sector agencies or partnerships.

The average across all agencies identifies that around 89% of s.11 standards are being met when measured using the agency's own self-rating. Once this is moderated to take into account the evidence provided for each standard, the rate falls slightly to 82% meeting standards. There are several agencies that fully evidenced their compliance with s.11 standards. There were also agencies whose statements were clear about their compliance, but evidence was required to support the statements.

The areas common to most agencies where improvements are required in standards are:

- Commissioners of services, besides the CCG, had limited, or no evidence that their providers were section 11 compliant
- Once scores were moderated, less than a third of agencies could fully evidence compliance data on mandatory safeguarding training showing that staff were sufficiently trained; a number of agencies provided data that identified outstanding work on this standard
- Three-fifths of agencies can fully evidence the standards on safe recruitment are being met. The shortfall was mainly on agency recruitment staff not having completed safe recruitment training
- Three-fifths of agencies can evidence that information sharing procedures are available that are in line with the LSCB Protocol and training is accessed by practitioners – all agencies had a policy, but its link to the LSCB Protocol and training on the policy was not as evident.

Whilst agencies identified areas of remedial action in most areas and the shortfalls were due to lack of evidence being provided rather than arrangements not being in place, the two greatest areas of learning from the analysis of the returns appear to be:

- Variation in compliance within the Council from three service areas having near complete compliance, to several areas with basic issues like safeguarding policies to still develop; and
- Commissioners of services (Children's Services, Public Health, CSP, Adult Services, Police and CRC/NPS) do not have processes in place requiring providers to report to them on s.11 compliance – for many services checks are undertaken at the point contracts are awarded and provisions exist in contracts to abide by LSCB policies, but systematic processes of regular s.11 reviews need to be put in place.

Participation

To identify what issues and safeguarding arrangements require priority for improvement, the LSCB collates information from direct and indirect participation activities with practitioners, children and their parents/carers.

The LSCB undertakes direct work with practitioners through Multi-Professional Discussion Forums and asks frontline practitioners and their managers about how safeguarding arrangements within a particular theme can be improved by the LSCB.

The LSCB uses the participation work of partnership bodies like the Health & Wellbeing Board, Children's Partnership Board and the borough's multi-agency Participation Steering Group to identify what children and their parents/carers would like to be prioritised for service and process improvement.

Multi-professional Discussion Forums (MPDFs)

The LSCB has undertaken six MPDFS during the 2015-16 year covering the following themes:

- Missing From Home (MFH)
- Social Media
- Children and young people with challenging/harmful behaviours
- Forced Marriage, Honour-Based Abuse & Female Genital Mutilation (FGM)
- Children with Disabilities
- Domestic Abuse.

A common theme that has been identified across all the six MPDFs has been about communication – ensuring changes made to policies are communicated to the frontline; ensuring up-to-date information is available about the range of services in the borough; ensuring information on websites and intranets is easily accessible; and clarity in guidance and communication materials. The use of the new 'safeguarding snapshots' as a quick one page briefing has been welcomed by staff as a way of disseminating key messages and where to access further support.

In a number of MPDFs, practitioners identified that additional information on multi-agency training was required; in the MPDF on domestic abuse, frontline practitioners requested that domestic abuse training becomes mandatory in the borough.

The MPDFs have not identified that additional services are required or that more policies/ procedures should be prescribed.

Practitioners who attended the MPDFs have been contacted with a summary of the learning they had identified and informed about what action is being taken to implement the learning.

Participation

Child and Parent/Carer Consultations

Children and young people have been involved in a range of activities where their participation has been sought that can be categorised as follows:

- Involvement in recruitment and ownership of meetings – involvement in panels and decision making to recruit staff
- Consultations regarding new/revised services
- Development of policies, communication tools and training of staff
- Involvement in conferences and communication campaigns – to ensure the voice of the child is reflected in awareness campaigns so that their experience of abuse/neglect is heard effectively and explain how services can assist.

Through the variety of consultations, four issues can be identified as the most important (most commonly mentioned) for children and young people in improving safeguarding arrangements:

- Accessing appropriate health services
- Availability of youth services and activities for children and young people
- Services for improving emotional and mental health to be accessible
- Involving children and young people into consultation events about policies, services and processes.

The multi-agency Participation Steering Group chaired by the Director of Children's Services has a number of priorities each year to improve participation activities within partner agencies. The Group's annual report for 2015-16 outlines the activities a whole range of agencies have undertaken to increase the levels of participation and embed participation in all the services partners provide and processes used to deliver them. The outcomes from the Participation Stearing Group's work are summarised, including that 16 local authority, commissioned and partner services have now achieved the accreditation (with five more services in the process of achieving the accreditation) as Investors in Children.

The LSCB has funded Total Respect training to improve knowledge of how to increase participation. Additional sessions of the training will be provided in 2016-17 to meet demand.

Training Provision

In Blackburn with Darwen there is a joint local safeguarding children and adults training programme which sets out the multi-agency training, briefings and online learning available to all statutory and non-statutory agencies to access.

The joint LSCB and LSAB Workforce Development Committee has the responsibility for the development, planning and coordination of multi-agency safeguarding training provision. This includes the commissioning of training resources and evaluation of training delivered.

The charging policy that was implemented in 2014-15 has had a positive effect on the 'did not attend' rates, with overall attendance increasing at face to face courses by 7%, up to 91% in 2015-16.

The tables below highlight the attendance data across all face to face training topics in 2015-16:

Course	No. of Places Offered	Attended	Did Not Attend (on day)	% overall of attendance (on day)
Blast- Not Just Our Daughters Male CSE training	30	30	0	100
Sexual Abuse & Grooming	300	203	15	93
Working Together To Safeguard Children	233	178	19	93
Designated Safeguarding Lead (Education)	120	109	5	96
Engaging Children & Young People Affected by Domestic Abuse	25	22	2	92
Domestic Abuse Awareness & Effects On Children & Adults	75	59	7	89
Multi-Agency Risk Assessment Conference	50	46	3	94
Forced Marriage, Honour Based Violence & Female Genital Mutilation	75	66	4	94
Self-Care for Workers in Domestic Abuse Settings	25	18	2	90
Domestic Abuse & Adult Safeguarding	25	23	2	92
Information Sharing & Domestic Abuse	25	18	4	82
Managing Allegations (LSCB course)	75	61	3	95
Safeguarding & Safer Recruitment	50	40	3	93
Mental Health Issues – Children & Adults	50	41	9	82
Working With Young People Who Self Harm	75	50	11	82
Safeguarding Adults - What you need to know	250	230	23	91
Grand Totals	**1473**	**1194**	**112**	**91%**

In 2014-15, 11 face to face courses were offered; this increased to 16 in the 2015-16 year. The additional courses and additional dates for some courses resulted in a 20% increase in the number of training places that were available. The 112 training places where practitioners failed to attend training represented a 40% drop in 'did not attends' compared to 2014-15. Overall this resulted in 7% more people being trained by the Safeguarding Boards.

Training Provision

Short Briefings

These events have not been included in the above table as these were generally short two hour briefings:

- E-Safety Live Online Safety Briefing - This was delivered by the UK Safer Internet Centre who aims to provide up to date information on how professionals can safeguard children and young people on the internet. It was hosted by Westholme School and over 200 practitioners attended. This event will run again in 2017.
- Prevent in Practice - This briefing enabled practitioners to use learning from Prevent Training/Workshops and discuss how to use learning in practice; 35 practitioners attended.

Impact Assessment

Impact assessment has continued this year with regular updates provided to the Workforce Development Committee. The final report is not available until December each year due to the way in which it is evaluated, however the recommendations from the 2014-15 report were as follows and these are either ongoing or have been completed:

- To receive feedback from line managers to fully validate the data (this will be reported in the Workforce Development Committee in December 2016)
- Discuss with trainers on a quarterly basis the qualitative recommendations received from delegates for both immediate post course and impact assessments (ongoing)
- Continue to offer short multi-agency briefings (2 hour sessions) on topics which arise throughout the year and/or short half day training sessions (this was achieved)
- Review survey questions for 2015/16 based on further discussion of this report with the Workforce Development Committee particularly around 'poor' responses (see below on how we can improve further).

A few examples of how practitioners have utilised the skills and knowledge (learning) into safeguarding practice are as follows:

- "More aware of how to spot when a person is being abused or abusing themselves, and can take the necessary actions of referring to the Safeguarding Team"
- "Fed back to team"
- "I have made a referral since attending the course as I identified possible risk factors relating to a family"
- "Be more aware and help my staff to put it in practice when at work"
- "Follow these policies and procedures in my day to day work".

How practitioners felt we could improve further:

- "Maybe more examples of every day safeguarding issues that may be tougher to identify"
- "Perhaps more interactive learning".

Training Provision

Online Learning

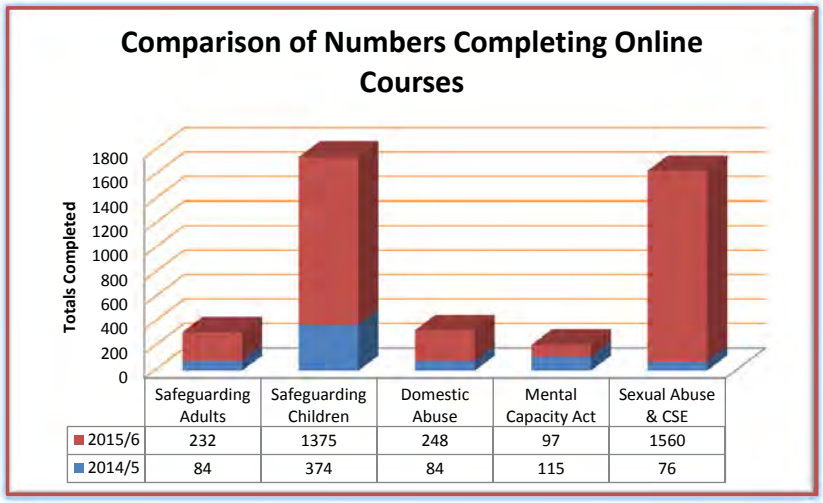
Five courses continued as part of our joint LSCB and LSAB online learning commission, these are:

- Safeguarding Children
- Sexual Abuse (and Introduction to Child Sexual Exploitation)
- Domestic Abuse Awareness
- Safeguarding Adults
- Mental Capacity Act.

The Sexual Abuse (and Introduction to CSE) saw the largest increase across all the courses. This was due to the LSCB making CSE training mandatory for local partner agencies.

There were 993 completions in the first three months of the new online programme as reported in our last annual report and over the last year (April 1st 2015 to March 31st 2016) there have been a further 3,512 completions.

The following chart outlines the number of courses that have been completed in total since the commencement of the new online platform in January 2015:



	Safeguarding Adults	Safeguarding Children	Domestic Abuse	Mental Capacity Act	Sexual Abuse & CSE
2015/6	232	1375	248	97	1560
2014/5	84	374	84	115	76

There has been a large increase in numbers completing safeguarding children courses.

In 2016-17 the number of online safeguarding courses will increase again in collaboration with the local authority's Workforce Development department. This will ensure that all staff across the borough will have access to the same safeguarding training courses which allows for consistent messages to be implemented across all services.

Training Provision

Safeguarding Workbook

The Safeguarding Children Workbook was refreshed to include specific information on CSE, Modern Slavery and the Prevent duty. This is available on the LSCB website and can be used by those practitioners with limited access to the internet or those not as confident in using the online resource.

Taxi Driver/Private Hire Training

An introduction to safeguarding adults and children has been delivered to all new taxi and private hire drivers during their mandatory licencing training since January 2015. The programme was further updated in January 2016 to include statutory guidance on the Modern Slavery Act.

The number of drivers who have received this training in the last year is 177 which includes a significant number of operators/owners of taxi firms who are often the first point of contact if a driver has a concern.

Child Death Overview Panel

There were 20 child death notifications for the borough in the 2015-16 year. For 10 of these deaths, the Child Death Overview Panel (CDOP) was able to complete the review of the death within the year. Overall CDOP reviewed 13 deaths for Blackburn with Darwen in 2015-16 (3 related to deaths prior to 2015-16). Reviews relating to 10 deaths in 2015-16 and one death from 2014-15 remain to be completed.

In total, in the period 2008-16 since CDOP has been operational, 155 deaths of children have been reviewed.

The CDOP, on reviewing each death, categorises the death using a standard typology and in the tables below the categorisation is presented for the past year and the six year period since CDOP has been functioning:

For the deaths reviewed in 2015-16:

Category 4 - Malignancy	Below 5
Category 7 - Chromosomal, genetic and congenital anomalies	7
Category 8 - Perinatal/neonatal event	Below 5
Category 9 - Infection	Below 5
Total	13

For the 2008-16 period, all deaths were categorised as:

Category 1 - Deliberately inflicted injury, abuse or neglect	Below 5
Category 2 – Suicide or deliberate self-inflicted harm	Below 5
Category 3 - Trauma and other external factors	Below 5
Category 4 - Malignancy	8
Category 5 - Acute medical or surgical condition	Below 5
Category 6 - Chronic medical condition	7
Category 7 - Chromosomal, genetic and congenital anomalies	62
Category 8 - Perinatal/neonatal event	40
Category 9 - Infection	12
Category 10 - Sudden unexpected, unexplained death	15
Total	142

For the 2008-16 period, 21% of Blackburn with Darwen deaths reviewed were found to have modifiable factors compared to 25% Pan-Lancashire and 22% nationally (national figure based on 2012-16 reviews). The most common modifiable factors/risk factors in the family and the child's environment identified from all the reviews of local deaths were:

- 60% of cases identified smoking as a risk factor (smoking in pregnancy and in the household by a parent/carer)
- 25% of cases where sleeping arrangements for the child were unsafe
- 15% of cases identified having issues relating to service provision (access to health, social care or housing services) and knowledge of services available for targeted support.

Child Death Overview Panel

CDOP Key Successes (2015-16)

In order that the panel fulfils its statutory functions, it identifies through its own annual reporting process a number of priority areas of action. Below is a summary of the key achievements in the 2015-16 year:

- Safer Sleep Campaign - The campaign has continued to supply professionals with materials to support them in providing consistent messages to parents/carers across pan-Lancashire. A pharmacy campaign was also commissioned across pan-Lancashire in November with Public Health colleagues. A bulk order of the materials was placed with regional colleagues buying into the campaign, this significantly reduced the cost for pan-Lancashire and provided regionally consistent messages and reduced cross-border differences particularly for acute trusts. The group developed a family friendly risk assessment tool that encompasses a checklist for risks around the home for children up to the age of two. This is being disseminated pan-Lancashire with frontline workers.

- Safer Sleep Guidelines - The Safer Sleep Guidelines were amended and ratified by CDOP members and the final guidance was disseminated to the pan-Lancashire workforce. The guidance was recognised by NICE as an example of good practice and shared on their learning website.

- Public Health Data Analysis Report - Public Health analysts from Pan-Lancashire local authorities undertook a data analysis of CDOP data from April 2008 to March 2014. The recommendations drawn from the report will be added to the 2016-17 priorities.

- Development of learning briefs - The CDOP developed several learning briefs including one for GPs on prescribing anti-epileptics. This has been circulated Pan-Lancashire.

- Northwest Sector Led Improvement Self-Assessment - CDOP contributed data and supporting information to the Northwest Sector Led Improvement Self-Assessment on infant mortality. Subsequently, action plans are being developed across pan-Lancashire public health teams. This will be made as an additional item on the 2016-17 CDOP priorities.

Examples of Multi-Agency Work and Outcomes

Local Authority Designated Officer (LADO) Case Study for LSCB
The initial referral was made by a LADO in another area. The alleged perpetrator had been arrested for sexual offences and downloading a large number of indecent images. The alleged perpetrator worked in another town and was not employed in a regulated activity, but lived in Blackburn with Darwen and had two young children. In addition they were thought to be a volunteer within a youth organisation.

During the course of the case the LADO liaised with the following organisations:

- Police – from a different area
- LADO from another area
- Employers
- National safeguarding lead for a youth organisation
- Blackburn with Darwen Borough Council, Children's Social Care who undertook an assessment in respect of the alleged perpetrator's own children.

Outcomes:
The alleged perpetrator was arrested, tried, convicted and was dismissed from their employment. The youth organisation terminated the volunteering and notified the Disclosure and Barring Service (DBS).

Children's social care undertook an assessment in relation to the person's own children. A plan for each child was then developed. The children's plan involved social care, school, probation, health and mental health services. The children were appropriately safeguarded and their needs addressed. One aspect of the plan was that the children received individual support in relation to their emotional wellbeing.

Your Support, Your Choice, Disabilities Case Study
A mother with a child who has a learning difficulty had been recently placed in the borough through dispersed housing due to fleeing domestic abuse. Whilst visiting an event at a local library about the learning difficulty, the mother was signposted to the Your Support, Your Choice service to assist in getting familiar with local services.

The service provided the mother with information and assistance in a number of areas: applying for school places for the child and her other children; advice on applying for benefits; information about support services in the borough to assist her child access leisure and recreational services outside of the home and school environment; information about transport facilities in the borough and vouchers for foodbank services; access to a befriending volunteer for the mother; access to the Carer's Service for the mother resulting in her becoming a peer support in the service; and access to youth services in the borough for the other children in the family. The family's welfare has been improved through accessing services.

Examples of Multi-Agency Work and Outcomes

Community Rehabilitation Company (CRC) Case Study
At a monthly child safeguarding meeting held at Blackburn Probation Office by Cumbria and Lancashire CRC, the probation officer discussed a case to access peer support. Following the meeting the case was discussed with the social worker who had case responsibility of the offender's child. This enabled the probation officer to reflect on the case and share best practice.

Both parents had received a Community Order in relation to child neglect offences. The probation officer worked with a number of agencies including social care, the children's school, mental health service, domestic abuse service, voluntary sector community wellbeing centre and drug services.

The parents initially worked well with the Child Protection plan - their progress was monitored closely in a multi-agency remit through Core Groups at the children's school and Child Protection Conferences. The parents attempted to disengage from services through non-attendance at various meetings and appointments. Through communication and information sharing, these non-attendances were challenged and enforced through their Community Order.

The probation officer undertook a number of announced and unannounced visits to the family home. These occurred alone and with the social worker assigned to the case.

At one particular unannounced home visit, prompted by the parent's disengagement at appointments, the probation officer identified various concerns. The probation officer reported these concerns to her manager and an action plan was initiated. Through liaising with the children's school, mental health services and the social worker, a coordinated approach was formed using real-time information.

A positive outcome was achieved in this case as the children were swiftly protected by children's social care.

Examples of Multi-Agency Work and Outcomes

Working in Early Help
During a pregnancy booking appointment with the hospital, the midwife identified that the young mother (to be) could benefit from additional support services. The mother provided consent to the midwife to share her information with a children's centre and on receipt of the information, a member of staff from the Early Help Outreach team was allocated to undertake a home visit. At the home visit, initial screening and assessment identified unmet needs in the areas of: unsuitable sleeping arrangements for mother in family home and need for own tenancy but unable to secure this due to young age; no income as cannot access benefits due to being in education; single parent; and low moods as the social circumstances made mother feel chaotic.

The Outreach worker liaised with midwifery services to ensure the mother received a more targeted midwifery service and agreed with the Health Visiting service to ensure antenatal services, including regular mood checks were provided. The Children's Centre provided support to access benefits, secure a tenancy and access to mother/baby groups to improve mother's knowledge of baby's needs.

Examples of Multi-Agency Work and Outcomes

Engage Team Case Study

A young person's social worker had concerns relating to their vulnerability and risk of child sexual exploitation (CSE). This was due to the young person's associations with other young people known to be involved in CSE and a number of other risk indicators established through the social work assessment.

The social worker referred the case to the Engage team which resulted in a young people's worker being allocated to work with the young person to identify and address the concerns. This involved regular direct work with the young person attempting to raise their awareness of CSE and how to make safer choices in their lifestyle.

Whilst open to the Engage Team the young person was given a health assessment through the specialist nurses in the team which allowed them to provide advice on sexual health and become aware of other health services appropriate for them.

During a session with the young person the worker gathered information that the young person was spending time with a much older person outside of the family circle and concerns were identified that the older person may be grooming or sexually exploiting the young person. The young person, at that time, refused to divulge details about the older person.

This information was shared with the police who undertook investigations to establish who the older person was. A Child Abduction Act warning was then served on the older person advising them that they would be arrested if they had further contact with the young person.

The young person's parents were allocated a PACE (Parents against Child Sexual Exploitation) worker to support them to understand the needs of their child and the actions they could take to try and keep the young person safe. The parents became more active in reporting missing from home incidents to the police and began sharing information with their PACE worker that allowed intelligence to be gathered by the police to build a clearer picture of what was happening for the young person.

The social worker managed this case on a Child Protection plan and there were ongoing Core Groups and Child Protection Conferences where the progress of the plan was reviewed. The social worker continued to work with the family as a whole to deal with some of the issues and tensions within the home which were contributing to 'push' factors for the young person.

During further work with the young people's worker about the risks of CSE, the young person made a disclosure of engaging in sexual activity with the older person in return for drugs and alcohol. This information was shared with the police and the young person was supported by a member of the Engage Team to complete a police interview. This led to a successful conviction of the perpetrator. The parents continued to be supported by the PACE worker during this time.

Children's social care managed the case and supported further referrals to other agencies to support the family with the issues they had. Positive outcomes include: the young person is now no longer experiencing CSE, with better awareness of the grooming process and how to make safer choices in her life; the young person is now aware of services that can support young people with improving safety and addressing health needs; the young person has been given support to deal with the abuse suffered; the perpetrator has been convicted resulting in a prison sentence; the parents were educated in CSE and how to keep their children safe from CSE; and the parents received support regarding housing, finances and healthy relationships.

Examples of Multi-Agency Work and Outcomes

CAFCASS & Social Work Joint Working

The service has a student social worker exchange scheme that has been developed with Blackburn with Darwen Council. This gives Cafcass students the opportunity to shadow Section 47 investigations directly and student social workers in the council have the opportunity to spend time with Cafcass practitioners to gain an understanding of the role of the Children's Guardian.

The two services had a joint training/liaison event in December 2015 with Cafcass Service Managers, Enhanced Practitioners and Children's Guardians joining Blackburn with Darwen Children's Services team managers, advanced social work practitioners and social workers. This was aimed at improving communication and joint working. Following the joint training event in January and February 2016 Children's Guardians put themselves forward to offer mentoring and have made individual links during March 2016. This assists the newly qualified social workers to develop court skills and Cafcass Guardians to share their experience and knowledge. There has been excellent joint working in the planning of all this as well as the individual pieces of work. The December 2015 event was seen by both agencies as successful with an aim to repeat it again.

CAFCASS Private Law Case Study

In a private law case the Family Court Advisor (FCA) had to make a referral to children's social care as the child was suspected to be suffering emotional harm caused by the family disputes.

The referral led to a Child Protection Case Conference and there was communication between the social worker and FCA in clarifying respective roles and acknowledging that both organisations had responsibilities towards providing services to safeguard the child.

There was also helpful input from the child's school which was able to advise as to the child's day to day experience from their perspective and assist in providing a venue to meet with the child.

Examples of Multi-Agency Work and Outcomes

Housing Case Study

Prior to moving into a supported housing project the family had resided in a private rented property. A referral was received from the council's housing needs team stating the family were facing eviction due to anti-social behaviour issues and rent arrears. The family were also involved with the Troubled Families project and a referral was made to Children's Services as a result of the threat of becoming homeless. The eldest daughter was pregnant and known to be taking legal highs (also known as psychoactive substances) and smoking cannabis. She was also under the supervision of the Youth Justice Service having committed an offence.

High risk indicators at the time of referral were: older daughter's offending behaviour and tendency to gravitate towards other young people who have similar substance misuse issues; mother's inability to keep her children safe when living independently.

Underlying risk factors were: youngest daughter being exposed to inappropriate/frightening adult behaviours; older daughter's pregnancy; previous anti-social behaviour.

A range of agencies were involved to ensure the children's needs and mother's risks could be addressed. They included children's social care, supported housing project, youth justice services, health services (midwifery, mental health, teenage pregnancy, school nurse), schools, education and training services, drug/alcohol harm reduction services and voluntary sector social service advocates.

The family struggled initially moving into the supported housing project and it was difficult to engage with them, in particular the eldest daughter. She was still taking legal highs at this time although had expressed a desire to come off them.

Over a period of time the family began to actively engage with services provided directly at the housing project and with other agencies. Mother's supervision of her children showed significant improvement and the youngest daughter's attendance at nursery improved, although this could be very sporadic at times. Eldest daughter engaged with the drug and alcohol team midwife and her drug/alcohol service worker to address her use of legal highs and cannabis use. Initially she missed several appointments with them, but again this improved significantly over time with support and encouragement.

The family were initially supervised by a social worker through a Child In Need plan and as risks reduced and the family addressed their needs it was later changed to a CAF (Child & Family Plan led by a Lead Professional). All agencies involved with the family believed at this stage that service provision could be managed at the non-statutory level due to the family's engagement and continued progress.

A Multi-Agency Safeguarding Hub (MASH) child protection referral was later submitted following threats made to the eldest daughter by an ex-partner. He was well known to both children's services and the police and had a history of domestic violence against ex-partners. He had threatened her and her unborn with violence. Given his history and the eldest daughter's vulnerability the case was escalated to child protection.

Examples of Multi-Agency Work and Outcomes

Outcomes:
The family are still residing at the housing project and have made significant progress during their stay.

The eldest daughter in particular has made significant changes. She has attended several courses including the 'Grow' course which was an eight week course provided by the housing project. She has attended all the sessions and the feedback was extremely positive. She also had some work experience at a riding stable which she particularly enjoyed. She has continued to work with her midwife and her drugs/alcohol worker; she no longer takes legal highs or smokes cannabis. She completed a piece of work looking at the effects of taking legal highs whilst pregnant and the effects on the unborn child. She now talks to other residents at the housing project about what she has learned. Following the birth of her baby there has been no concerns in relation to her being able to care for her baby.

Following a change of school, the younger daughter's attendance has improved. Mother has several health problems and suffers from depression. This sometimes impacts on her ability to take the younger daughter to school. On these occasions the eldest daughter has adopted the parenting role and whilst there are still some difficulties, there have been significant improvements.

There have been no incidents of anti-social behaviour whilst at the housing project and the project staff feel they will be ready to move on in the near future. Outreach support will be provided by the resettlement officer. All other agencies will remain involved following move-on.

The family have received a high level of support from all the agencies and will continue to require it when they move to their own accommodation. Without the support and the close partnership working by all agencies the outcomes may not have been as favourable for both the mother and the eldest daughter. Regular meetings, sharing of information and continued support have significantly improved the prospects for this family.

Examples of Multi-Agency Work and Outcomes

Familywise Case Study
Familywise have been working with a family since December 2015 as part of the Supporting Families programme. The family recently moved to Blackburn; the family has eight children, five dependent with two adult children also living in the family home.

The family had significant presenting concerns: both parents are illiterate; there is a history of domestic abuse, including significant violent abuse; alcohol misuse by both parents, but particularly father; mental health difficulties of both parents; a lack of service support being accessed by the family resulting in the family being socially isolated; low educational attainment, for all children, with one child permanently excluded due to behaviour issues in school and mother's decision to withdraw all the children from school and to home educate; concerns of neglect and poverty in the family; and difficult family to engage with statutory services as they are wary of outside agencies and services.

A referral was made by the Familywise service to the council's education service specialising in vulnerable families, and a joint visit was organised. Initially the mother was reluctant to engage but with co-operation between the two services the mother agreed to access the offered support.

Familywise worked closely with the education service to maintain engagement with the family, to share information about any concerns, and to maintain communication with other agencies involved such as health services. One of the children has been quite poorly and has required hospital treatment and it has been through a close working relationship between the services that they have been able to continue to support the family.

Examples of Multi-Agency Work and Outcomes

Nightsafe Case Study

A 16 year old young person has been residing in one of the supported accommodation units for just over seven months and in that period has made progress from leading a chaotic lifestyle to one where the young person is able to think about managing their life more independently and express feelings to workers.

Prior to moving into the accommodation, the young person had been living unsupervised for approximately three years in the father's house. His father had been staying at his girlfriend's for most of that time. The young person had very little contact with mother who had abandoned the young person several years before. The young person was allowed to drink alcohol and take substances from a very young age. The young person has had very little parenting with no boundaries or rules to abide to and has been left on their own to make choices and survive. This includes resorting to criminality. The young person was bullied at school for their appearance and unkempt look and so withdrew from attending school. Previous to living at the supported accommodation, the young person was not engaging with any services and in breach of youth court orders leading to being arrested almost daily.

The service has been working with the following services to ensure support for the young person is co-ordinated and delivered in a way that does not overwhelm them:

- Children's Services Social Worker
- Youth Justice Team to complete the supervision orders
- Mental health services to address emotional health needs
- Substance misuse services to reduce reliance on using legal highs to self-medicate.

The young person has not reoffended since being at the supported accommodation; has become a parent and has supervised access; is accessing parenting skills course; has a mentor in place; is accessing services like gyms to improve physical health; and enrolled to attend education twice a week. Use of legal highs to self-medicate and depression remain a concern with the young person, with support on budgeting being provided to address spending money more wisely.

Examples of Multi-Agency Work and Outcomes

Honour Based Abuse (HBA) Case Study
The Multi-Agency Safeguarding Hub (MASH) contacted Blackburn and Darwen District Without Abuse (BDDWA) service to participate in a strategy meeting where a young person was suspected to have subject to HBA. At the strategy meeting attended by children's services, police, education and health services, agencies suspected that there were some risk indicators that the person may also be at risk of abuse through forced marriage. The service provided advice and expert support from their specialist BME Independent Domestic Abuse Advisor (IDVA).

Siblings of the young person had outstanding health concerns that were addressed through universal health and education services. A Further Education college was also involved in ensuring the safety of one of the children whilst in education. The additional monitoring by universal services and involvement of the police prevented the need for agencies to seek specialist protection orders; advice from the BDDWA on risk signs and indicators assisted all agencies to share information to raise any new concerns.

Business Plan Priorities, 2015-16 – Progress

Priority Area	Actions	Lead Committee	Progress
Development of Policies & Procedures on: • Dangerous Pets • Use of social media for case work • Mobile working (hot-desking) • Prevent (radicalisation & terrorism) • E-Safety	Development of Pan-Lancs policies & procedures Involvement of parents, children and practitioners in the development of policies and procedures Communication of LSCB policies, procedures and services in the borough	March 2016	All updated policies of the LSCB on pets, use of social media, mobile working and Prevent were completed and are available through the LSCB website. Work is ongoing with Pan-Lancashire LSCBs to develop online safety tools and best practice. Guidance for schools, with links to best practice resources, has been updated during the year. The use of the new Safeguarding Snapshots allows the LSCB to disseminate information about new changes and key safeguarding topics in a way that is more accessible and user-friendly.
Child & Parent Voice in the shaping of services and LSCB priorities	Develop methodology for the LSCB to capture directly and indirectly the voice of children and parents in the setting of LSCB priorities Seek assurance that in the development and design of new services, child and parent voice is captured	June 2016	The Communications & Engagement Committee works with the Participation Steering Group, Healthwatch and the One Voice Group to capture the voice of children and parents. Section 11 auditing and Participation Steering Group Annual Report have provided the necessary assurances.
CSE & MFH	Implement a new LSCB committee to oversee the arrangements and services on CSE & MFH Seek assurance that services and arrangements keep children safe in the borough	August 2016 March 2016	The new Committee has been established and has incorporated work on Trafficking/Modern Slavery and E-Safeguarding. Regular reports at the Committee from the Engage Team, partner agencies, a CSE/MFH dataset, auditing activity and action plan monitoring allows the Committee to seek assurances and challenge agencies on the robustness and effectiveness of CSE, MFH, Trafficking and E-Safeguarding services and arrangements.

Priority Areas, 2016-17

Priority setting for the LSCB draws upon a variety of sources:

- Outstanding actions from previous year priorities – none remain outstanding, but continued focus required on priority 5 below
- Issues emerging from the analysis of LSCB monitoring activities – Priority 2 & 3 below
- Emerging national and local safeguarding issues - Priority 6 below
- The views and wishes of practitioners, LSCB committee members, Board members – Priorities 4 & 5 below
- The views and wishes of children and parents – Priorities 2 & 5 below.

From the sources above and discussion at the 2016 Development Day for Board members, the Board has agreed the following priorities for the 2016-17 year:

1. Avoiding duplication and prioritising key areas of business
2. Thresholds, custodians of risk
3. Educational settings and safeguarding
4. Skilling / investing in the advocacy role for frontline staff
5. Voice of service user and staff
6. Implementation of the Wood Review Recommendations (Children & Social Care Bill Provisions).

Business Plan 2016 - 17

Priority Area	Actions	Lead Committee/Partnership Group	Timescale
Avoid duplication and prioritise key areas of business	Quality Assurance & Performance Monitoring returns to identify areas of demand, reducing resources and duplicated services Partner agreements to be reached on areas of duplication and action agreed to improve efficiency/productivity	Quality Assurance Committee Board	March 2017 September 2016
Thresholds, custodians of risk	Partner and partnership agreements to be reached on any revisions to thresholds for early help, safeguarding and child protection services	Board	December 2016
Educational settings and safeguarding	Embed the work of the previous Safeguarding in Education Committee into the work plans of all committees Provide co-ordination assistance to the education and learning sector to improve safeguarding arrangements Monitor the effectiveness of safeguarding arrangements in the education and learning sector (how learning from the 2015-16 audit has improved arrangements)	All Committees All Committees Quality Assurance Committee	December 2016 March 2017 April 2017

Business Plan 2016 - 17

Priority Area	Actions	Lead Committee/Partnership Group	Timescale
Skilling/investing in the role for frontline staff including advocacy role	Monitor the completion rates within agencies of safeguarding training and courses deemed mandatory by the LSCB and sector expectations Agencies to enhance systems within their organisations that promote safeguarding knowledge and provide tools that assist practitioners to become authoritative (with empathy and compassion) safeguarding practitioners	Quality Assurance Committee & Workforce Development Committee Workforce Development Committee	March 2017 June 2017
Voice of service user and staff	Seek assurance that in the development and design of new services, child and parent voice is captured Seek assurances that in service provision the wishes and feelings of the child are regularly sought, captured and responded to	Communications & Engagement Committee	March 2017
Implementation of the Wood Review Recommendations	Participate in the consultations of: • New statutory instruments that will outline the functions of future Safeguarding Partnerships • Future thresholds for national and local child safeguarding practice reviews • Revisions to the Working Together guidance Implementation of the provisions from the Children and Social Care Bill Agree with partners the local safeguarding partnership arrangements	Board	January 2017 April 2017 February 2017