1. Chair's Foreword

It is my pleasure to present the 2016-2017 annual report of Blackpool Safeguarding Children Board. This is a document that we are required to publish and one in which I hope to set out the achievements and challenges that we face as we work together to keep the children of Blackpool safe.

As you read through the pages of this report you will gain an insight into the work of the Board, how we hold each to account, review and learn from our activity and invest in our partnership with the ultimate aim of improving the lives of children in Blackpool. There is no doubt that there is much to celebrate in what we have done and I would particularly draw your attention to the multi-agency response to child sexual exploitation, emerging early help provision through Better Start and Head Start and our work with our schools. There is, equally, no room for complacency and it is acknowledged that we would have wanted to have made more progress in respect of our early help workstream, while our ability to base our actions on the robust analysis of data has been hindered by the late appointment of a Board analyst. Equally, a number of our more recent audits have identified similar aspects of practice that require improvement and we will seek to address this with a degree of urgency as we move forward.

I continue to be impressed at the significant commitment of the managers and practitioners of our partner agencies to the children of Blackpool and the work of Blackpool Safeguarding Children Board. This is all the more significant at the time of considerable financial constraints and increasing demand for all our services. I am happy to report that this has not just allowed us to meet our statutory requirements in terms of membership, but to secure full engagement with all our subgroups from throughout the partnership.

Children should be at the centre of everything that we do as a Board. I am therefore pleased to highlight the development of our Pupil Voice group who, through their school councils, have been able to survey the views of a significant proportion of our secondary age population. Their views, on occasion, make for uncomfortable reading, but we owe it to them to act on them.

The year has been marked by an extraordinary number of changes of staffing in a number of our partner agencies and I would like to take this opportunity to acknowledge the contribution of a number of our longer standing Board members who left during the reporting period. These have included the Blackpool Clinical Commissioning Group Chief Nurse Helen Williams, who also chaired our Performance Management and Evaluation Group; Sharon Cooper, who worked in a number of roles across Children's Services and chaired our Multi-agency Audit Group and Shadow Board and Mike Leaf who chaired our Child Death Overview Panel. Blackpool Council Children's Services has undergone a considerable number of changes during the reporting period, including the departure of the Director of Children's Services, Delyth Curtis, and her deputy, Amanda Hatton both of whom played a crucial role in shaping our ongoing work. Amongst a number of new members I am pleased to welcome our new Director of Children's Services, Diane Booth, and look forward to working with her.

The work of Blackpool Safeguarding Board places significant demands on all of those who attend our meetings and work to deliver our business plan. I would therefore like to thank all members of the Strategic Board and our subgroups, together with our small business unit which is responsible for the ongoing success of our training programme and the orderly running of the Board.

Finally, I would like to thank all practitioners, volunteers and Blackpool residents who make a contribution to keeping children safe in Blackpool. Without you, the successes that we report here would not have happened. For our part, we will continue to work to provide you with the best possible system to keep our children safe.

Executive Summary

This is the statutory annual report of Blackpool Safeguarding Children Board in which we are required to review our work during 2016-17 and to make an assessment as to the effectiveness of the services that have a statutory duty to keep children safe in Blackpool.

The report begins with an overview of **Who we are and what we do** which covers the statutory framework under which we operate, our governance and financial arrangement and how we plan our business. Challenging each other to improve is central to our practice and examples of when challenge has resulted in change are given.

An understanding of **Blackpool: the place and its population** is central to the effectiveness of our work. Demographically we continue to be characterised by a stable child population, primarily of white British origin. Blackpool, as a whole, continues to experience long standing high levels of deprivation and nearly a third of our children will grow up in poverty. Our work to listen to the views of our children is becoming more established and while they report generally feeling safe, they are most worried by bullying and online safety.

An analysis of **Safeguarding in Blackpool: need, demand, pressure and performance** reveals that we continue to see high and increasing numbers of children at every stage of the safeguarding system, well in excess of national and statistical neighbour comparators. While our system performance remains good, the increasing strain throughout the system is noted and will continue to be a key driver to our work.

Having considered the system as a whole, the report continues to consider **How we are doing as a partnership** in respect of some key priority areas. Evidence of robust multi-agency working to address child sexual exploitation and children missing from home or care is presented, together with evidence from audits to support this judgement. However, the need for more rapid progress in respect of data collection is acknowledged. Early help remains a priority for the Board and is one in which we have made less progress than we would have expected during the reporting period. However, we are able to report some evidence of effective early help provision, together with more recent movement in terms of our thresholds and assessment documentation, together with a review of the MASH. A significant proportion of Board time has been occupied by neglect and domestic abuse during the reporting period and this has resulted in the roll out of the suite of neglect

evaluation tools, together with a number of initiatives to plug gaps in domestic abuse provision, for example in our work with perpetrators.

Our workforce remains central to work to safeguard children in Blackpool and we have continued to seek their views and engage with them through our shadow board and programme of schools' twilight meetings. The contributions of both have been particularly welcome as we have sought to develop our thresholds documentation. We continue to provide high quality multi-agency safeguarding training, to 1,640 practitioners in the reporting period, delivered by a pool of trainers drawn from our partner agencies.

The **Learning and Improvement Framework** is central to the work of the Board and serves to collate all our review and audit activity. During the review period we have published one serious case review and completed two unpublished multi-agency learning reviews. Work to deliver action plans from these and other reviews remains ongoing and resulted in a successful marketing campaign around alcohol use and safe care of children over the Christmas period. We continue to hold agencies to account and challenge their safeguarding practices through our Section 11 audit programme and regular review of published inspection reports. Lines of enquiry this year have included supervisory practices in our partner agencies.

A number of **Challenges for 2017-18** are noted, the foremost of which is how we respond, as a partnership, to the operational demands placed on us by the increasing number of children and families who need our help. This will require a more nuanced understanding of the reasons for the demand through developing our dataset and the development of innovative ways of working with children and families. These, and other challenges, are central to our newly development business plan for 2017-19.

1. Who we are and what we do

1.1 What is the LSCB?

The Local Safeguarding Children Board (LSCB) is a multi-agency body whose role is to oversee, co-ordinate, challenge and scrutinise the work of all professionals and organisations in Blackpool to protect children in the town from abuse and neglect, and to help all children grow up safe, happy, and with the maximum opportunity to realise their potential. It is a statutory body, established under the Children Act 2004. Under the Act every local authority in England is required to establish an LSCB with two primary purposes:

- To co-ordinate what is done by each person or body represented on the Board to safeguard and promote the welfare of children in the local authority area; and
- To ensure the effectiveness of what is done by each person or body for these purposes.

The Local Safeguarding Children Board Regulations 2006 and Working Together to Safeguard Children (2015), which is statutory government guidance, further expand the role and responsibilities of LSCBs. In particular Working Together says that LSCBs should, as a minimum:

- Assess the effectiveness of the help being provided to children and families, including early help.
- Assess whether LSCB partners are fulfilling their statutory functions.
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

However, Working Together also makes clear that "LSCBs do not commission or deliver front line services though they may provide training. While LSCB do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding".

Every LSCB is required to publish an Annual Report. The purpose of the Annual Report, as set out in Working Together, is to "provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the actions being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period". The report should include information on the LSCB's assessment of the effectiveness of Board partners' response to child sexual exploitation (CSE), and appropriate data on children missing from care, and how the LSCB is addressing the issue.

In December 2015, the Government commissioned Alan Wood to undertake a review of the effectiveness of LSCBs. His report was submitted to the Government in March 2016. One of the main recommendations of the review was that the statutory requirement to establish an LSCB should be abolished, and replaced with a new obligation on local authorities, the police and health partners to agree local multi-agency arrangements for the protection of children which should be co-ordinated, subject to evaluation, include arrangements for independent scrutiny, and engage with children. The Government accepted, in principle, all the recommendations which have been included in the

Children and Social Work Act 2017. However, there is now likely to be a transitional period before the new provisions have effect.

1.2 Who are we?

Blackpool Safeguarding Children Board (BSCB) is made up of a number of partner agencies (full membership is detailed in Appendix 1), all of whom have a statutory responsibility to safeguard and promote the welfare of children and are committed to the effective operation of BSCB.

A number of our partner have a statutory responsibility to sit on BSCB (for example, the local authority, police, health bodies and probation), while others have been invited to join due to the significance of their work in Blackpool (for example Blackpool Coastal Housing and the NSPCC). BSCB was compliant with statutory requirements in respect of partner agency membership throughout the reporting period.

BSCB is led by an Independent Chair who is able provide an external perspective by which impartial challenge can be brought to any member agency. Our current Chair, David Sanders, was appointed to the role November 2014. He promotes the work of BSCB through regular attendance at other strategic boards and through meetings with senior managers in partner agencies, schools, and other bodies that have a duty to safeguard and promote the welfare of children.

It is a statutory requirement that LSCB should take reasonable steps to appoint two lay members to make links with community groups, support stronger public engagement and improve local understanding of safeguarding children. Lay members act as independent voices within the Board to question decision making and to hold agencies to account. Throughout the reporting period BSCB had only one lay member in post and following a lengthy advertising campaign a second lay member was appointed shortly after the year end.

1.3 How do we work?

The work of BSCB is driven by the Strategic Board, which throughout 2016-17 met on a bi-monthly basis. Strategic Board members are senior managers from partner agencies who are able to make decisions on behalf of their agency and ensure that their agency abides by the decisions of the Board.

The delivery of specific elements of the BSCB Business Plan and other statutory functions are delegated to a number of subgroups, some of which are held on a joint basis with Blackpool Safeguarding Adults Board (BSAB) or with Lancashire and Blackburn with Darwen LSCBs. Subgroups are chaired by Strategic Board members with the necessary expertise to tackle the area in question, while members are drawn from the agencies considered necessary for the subgroup to meet its objectives. All subgroup chairs are members of the Business Management Group (BMG) which co-ordinates their work and monitors business plan delivery.

Strategic Board and subgroup members are expected to attend a minimum of 80% of meetings in person and, when they are unable to do so, to send an appropriately briefed named deputy. During

the reporting period the majority of Strategic Board members did not meet the required threshold for attendance. In the event of protracted concerns in respect of an individual's or agency's engagement the Independent Chair will challenge the organisation concerned. This has been effective in securing better attendance from a number of agencies during the reporting period, although it is acknowledged that further improvement is required in this respect.

1.4 Governance

David Sanders is formally accountable to Blackpool Council's Chief Executive, Neil Jack, for the effective functioning of BSCB. In turn, political oversight of the work of BSCB is provided by Cllr Graham Cain who sits as a participating observer on the BSCB Strategic Board.

BSCB is part of the broader local partnership architecture which promotes the health and wellbeing of all Blackpool residents. As well as BSCB, this includes the Health and Wellbeing Board (HWBB), Community Safety Partnership (CSP) and Blackpool Safeguarding Adults Board (of which David Sanders is also Independent Chair). There is understandably a degree of overlap between the work of these boards and the chairs have had regular meetings to rationalise and co-ordinate their work. This has resulted in the amalgamation of work done by BSCB and the CSP to tackle CSE and domestic abuse and joint programmes of work that are about to start to tackle transitions and financial abuse. During 2017-18 BSCB and BSAB will start to meet on the same day, with a joint session in which items of mutual interest can be tabled, thereby preventing the Boards from separately discussing the same content.

The Independent Chair also regularly meets with his counterparts from Blackburn with Darwen and Lancashire LSCBs to ensure that a co-ordinated response is taken to issues that extend beyond Blackpool. This assists our partner agencies, the majority of whom operate on a wider geographical

footprint. Formal arrangements are in place for the development of joint multi-agency policies and procedures, while a pan-Lancashire Child Death Overview Panel has been in place since 2011.

1.5 Financial arrangements

Funding for BSCB continues to be provided by a core group of partner agencies, with some income from training activity. Increases in contribution from some partners are gratefully acknowledged, at a time of financial constraint. It is therefore disappointing to note that the National Probation Service considerably reduced its contribution without national or local consultation. The contribution of other resources 'in kind' by the wider partnership is likewise acknowledged and consists of time taken by staff to attend meetings, participation in our pool of trainers and the use of buildings.

Income and Expenditure Summary

Income		Expenditure	
Blackpool Council	102,140	Staff costs	122,619
Blackpool CCG	51,867	Independent Chair	24,985
Lancashire Constabulary	30,368	Training	26,404
Blackpool Coastal Housing	5,000	Board support costs	6,040
Cumbria and Lancashire CRC	2,565	Serious Case Reviews	10,024
National Probation Service	1,710		
CAFCASS	550		
Training income	3,530		
	197,730		190,072

Board staffing costs remain the largest area of expenditure, although the intended longer term staffing structure only came into being in the final month of the reporting period, hence the small underspend this year (agency administrator costs reduced what would have been a greater underspend). Ongoing training costs have been reduced through the development of a pool of trainers from partner agencies, although a one-off cost was incurred for the neglect evaluation tool training and licence (see Chapter 5, below). Income received for non-attendance at training has been primarily used to fund conferences in Human Trafficking and Modern-Day Slavery and (after the year-end) Infant Mortality and Female Genital Mutilation (FGM). Serious case review costs have been within budget this year, but are expected to significantly increase in 2017-18. BSCB has agreed its contributions from partner agencies for the next two financial years and will use its accumulated underspend from previous years to fund the agreed staffing structure and projected serious case review costs that would otherwise take it over-budget.

1.6 The LSCB Team

The work of BSCB is supported by a small business unit, which has been merged with that of BSAB to provide additional resilience. The current structure was agreed during the reporting period and all staff were in post shortly prior to the year end. The BSCB element of the team consists of:

- A Business Development Manager
- 0.8 Full-time equivalent (FTE) Training co-ordinators
- 0.95 FTE Democratic Governance Advisors to support meetings

- 0.5 FTE Analyst
- 0.5 FTE Training administrator

1.7 Business Planning

This report covers the final year of a two year business plan that was agreed by the Strategic Board in March 2015. This plan was split into six priority areas which included the four safeguarding themes of child sexual exploitation, early help, neglect and the toxic trio, together with the completion of outstanding elements of the BSCB Improvement Plan (drawn up in response to the 2012 and 2014 Ofsted inspections) and organisational development areas. The business plan was always intended to be a fluid document and some actions have been completed in a way other than originally envisaged, while other areas of work, for example domestic abuse, have assumed greater significance than expected.

Progress against the business plan was reviewed at every BMG meeting, with slippages identified and corrective actions agreed. At the final review in March 2017, of the 88 discrete actions 81 were agreed to have been completed, although it is accepted that a number of these, most notably in respect of the neglect assessment tools, were significantly delayed. Of the remaining seven, one (appointment of a lay member) has since been completed, while the outstanding six have been carried forward on to our next business plan. Five of these actions relate to the development and use of datasets and were not completed due to the lengthy time taken to recruit a Board analyst. While this has now been rectified, the Board's limited use of data is evident throughout this report and is a priority for the next year.

A new business plan for 2017-19 was agreed toward the end of the reporting period and is outlined in Chapter 9, below.

1.8 Challenge and change

A main role of the Board is to challenge the partnership or single-agencies to make improvements to safeguarding arrangements where risks are identified. Having done so the Board will support partners to co-ordinate solutions to remove or reduce those risks. The following are examples of the Board fulfilling this function in 2017-18.

A number of reviews and audits identified that missing from home return home interviews were either not being completed or completed in a timely fashion and risks were not being identified. In response Blackpool Council Children's Services introduced a new return home interview template that included specific reference to child sexual exploitation and monitoring of all interviews by a service manager, while BSCB included the completion rate within its dataset. Subsequent audits have demonstrated better use of intelligence from interviews, however the completion rate remains lower than we would expect and will continue to be scrutinised.

The Board challenged Public Health to consider the impact of its changes to the school nursing and health visiting services on their ability to safeguard vulnerable children.

The BSCB Strategic Board received a number of presentations on proposed changes to health visiting and school nursing services, while our Independent Chair also met with the Director of Public Health to seek assurance that the changes would not compromise the ability of the services to safeguard children. These meetings have provided us with the confidence that safeguarding provision will either remain unaltered, or in the case of the new health visiting model be strengthened. The Principal Social Worker has subsequently met with all health providers to review how the broader health sector engages with safeguarding processes. The re-iterated expectation that all meetings will be attended by the best placed health professional will form part of a broader Multi-Agency Safeguarding Standards document that will be produced later this year.

The Board reviewed the compliance of its Sudden Unexpected Deaths in Childhood (SUDC) rapid response process with Working Together requirements.
The review identified that the majority of deaths occurred outside the service's operational hours, as a result of which they did not receive the required multi-agency response. The commissioners were subsequently challenged and expanded provision will be implemented later this year.

The Board raised concerns about inappropriate use of register codes, the use of part-time timetables and the lack of alternative curriculum provision within Blackpool.
The schools' safeguarding advisor has subsequently worked with schools in Blackpool to ensure that legislation is correctly applied and that children are appropriately safeguarded when reduced timetables are used. A number of different projects are currently working to develop alternative curriculum opportunities for children who cannot manage in mainstream schooling.

2. Blackpool – the place, its population and what our children tell us

2.1 Demographics

Blackpool is a seaside town in the north-west of England. Its population of 139,500 people living within an area of just under 13.5 square miles renders it one of the most densely populated areas outside London, although its population is projected to decline slightly in forthcoming years. Transience is a significant feature of the town, with 8,000 people estimated to move in and out of the town annually.

There are approximately 28,685 children aged under 18 resident in Blackpool, making up 20.6% of the population. Overall, the 65+ age group is the most over-represented in Blackpool and is expected to further increase in the forthcoming decade. Children and young people from ethnic minority groups form 10.0% of the school age population, compared with 30.0% nationally. Life expectancy for children born between 2013 and 2015 is estimated to be 74.3 and 79.4 for boys and girls respectively, compared with 79.5 and 83.1 nationally.

Blackpool experiences considerable levels of deprivation which have increased in recent years. The English Indices of Multiple Deprivation 2015 record that 38.3% of smaller areas within Blackpool are within the most deprived 10% nationwide, while 20.2% are within the most deprived 1%. In contrast, none are in the most affluent 20%. The impact of this level of deprivation is such that 27.4% of children live in out of work benefit claimant households and 32.1% of the overall child population lives in poverty (in a household with an income of less than 60% of the median), compared to 20.1% nationally.

Outcomes for children reflect those associated with higher levels of deprivation. For example, attainment at Key Stage 4 is lower than average, while levels of teenage pregnancy and hospital admissions for substance misuse, alcohol misuse and self-harm are amongst the highest in the country. 6.5% of 16-18 year olds are not in education, employment or training. More positively, levels of family homelessness are amongst the lowest in the country.

Within Blackpool there were 2,120 children in need as of 31st March 2017 (2016: 1,916), equating to 739.1 per 10,000 of the population (2016: 665.0). This is considerably in excess of both the national average of 337.7 and that of our statistical neighbours of 466.4 (2016 figures). Put in different terms, in Blackpool, in every class of 30 children, two will have a social worker.

2.2 What our children tell us

The views and experiences of children in Blackpool should be central to the planning and delivery of the work of BSCB. It was acknowledged in our last annual report that this was an under-developed area of our work, although plans to remedy this were outlined. During the reporting period our Pupil Voice group has met on four occasions and has had representation from every secondary school, one further education provider, one special school and one primary school throughout the year. Members are drawn from school councils and have been asked to seek the views of their wider school populations. More recent meetings have been chaired by members of the group who have been encouraged to set the agenda.

Feedback from this group would suggest that children generally feel safe within their home and school environments, but feel less so in the online environment and in public areas of the town. In terms of online safety there was strong evidence of an understanding of the risks that they may encounter and the means by which these can be checked. All reported having received online safety advice in school and a survey of games and applications used produced very similar results to those expected. The single greatest area of concern, raised by children from all schools, was bullying, which was heightened by the fact that social media means that the issue cannot be 'left at school'. While members were aware of how their schools tried to deal with the issue, it was clear that they felt more needed to be done.

The group also provided a strong message regarding their experience of Blackpool as a town. Members consistently reported feeling unsafe on public transport, which many would not use alone, and in the town centre environment, often as a consequence of other groups of (usually older) children. They cited a lack of activities for children resident in the town and of longer term opportunities, expressing a belief that the town needed to focus on its residents and not tourists. While much of this is outside the remit of BSCB, it is a strong message and we owe it to our children to report it.

BSCB also seeks to ensure that the views of individual children are heard when they come into contact with agencies that work to safeguard them. Every audit and review that we undertake includes questions about whether the views of children were recorded (or appropriate observations made of non-verbal children) and acted on. It is evident that there has been a steady improvement in the recording of the views and wishes of children during the last year which is welcome. This has been supported through processes in which children are asked to complete participation packs before child protection conferences and in which older children are given the opportunity to chair review meetings. A number of our partner agencies routinely canvass the views of children to inform service developments, for example Blackpool Teaching Hospitals (BTH) have used surveys of patients to develop staff training and children now chair half the meetings of the Corporate Parenting Panel.

3. Safeguarding in Blackpool: need, demand, pressure and performance

The vast majority of children in Blackpool will grow up to be happy and healthy and make a successful transition from education into employment. These children will only ever come into contact with universally provided health and education services. For those who do require further intervention to keep them safe or to promote their welfare, services in Blackpool, during the reporting period were provided in accordance with the BSCB "Thresholds for Intervention" document. A guiding principle to working with children and families who do need extra help is that the minimum level of intervention necessary should be provided at the earliest possible stage.

BSCB seeks to monitor activity at each stage of the safeguarding system to assure itself that interventions are effective and that children are kept safe. The overall picture is one of significantly higher number of children in the system, at every stage, than would be expected in comparison with national averages and our statistical neighbours (a comparator group of local authorities with a similar demographic). While this has been the case in Blackpool for some years, it is of concern that there has been a sustained increase in the numbers of children in the system throughout the reporting period, which has continued following the year end.

The Front Door acts as the single point of access for all contacts to Children's Services. In 2016/17 the Front Door received 12,519 contacts (2016: 10,115). A contact, in this context, can range from a urgent request for safeguarding action to pieces of information that require sharing, but no further action. The combination of all contacts in this category renders the analysis of conversion rates into referrals difficult, as some are clearly not intended to prompt further action, and means that conclusions cannot easily be drawn from the breakdowns of contacts by agency. That said, the overall conversion rate has remained stable at around 28-29% for five years to date. There were consequently 3,520 (2016: 2,944) referrals to Children's Social Care, of which 1,978 (2016: 1,382) proceeded to section 47 Enquiry.

This sharp increase in contacts, referrals and section 47 enquiries was similarly reflected in the overall numbers of children in need of 2,120 (2016: 1,916). However, a further breakdown of this category identifies increases in those assessed as requiring intervention under section 17 of the Children Act 1989 to 1,226 (2016: 1,085) and being looked after to 525 (2016: 469), but a more stable number of children subject to child protection plans at 369 (2016: 362). That the number of children subject to a child protection plan should remain stable in a system that has otherwise seen significant increases in activity does appear somewhat paradoxical at first. However, this may reflect changes agreed by BSCB to expedite the ending of child protection plans when a child becomes looked after or a review conference is inquorate. These were agreed in November 2016 and it is notable that the numbers of children subject to a child protection plan had increased from 362 in March 2016 to a high of 433 in November and then back to 369 by the year end.

The rate of children at each stage of the safeguarding system also remains well in excess of those recorded nationally and amongst our statistical neighbours (Blackpool figures at 31st March 2017, England and Statistical neighbours at 31s March 2016):

Rate per 10,000 child population of	Blackpool	England	Statistical Neighbours
Referrals	1,227.1	532.2	572.3
Section 47 enquiries	689.6	147.5	194.9
Child in Need (all)	739.1	337.7	466.4
Child Protection Plan	127.6	43.1	60.4
Looked After Child	183.0	60.0	90.9

Throughout the safeguarding system there are two to three times the rate of children in Blackpool than are seen nationally. Increased safeguarding activity is associated with higher levels of deprivation so figures in excess of the national average are to be expected, however Blackpool continues to experience rates well in excess of its statistical neighbours. This places a significant strain on all agencies, even without the more recent increases noted above, and is something that BSCB has yet to definitively understand. Our understanding of the situation is significantly hindered by the lack of data collection in respect of children receiving early help, which is discussed in Chapter 5, below. Until this data becomes available it is difficult to reach any conclusions regarding the numbers of children requiring statutory intervention. Potential reasons include an absence of effective early help provision, a risk averse approach amongst practitioners, or it may be indicative of a high level of need in the town that is being effectively identified. Notwithstanding this gap in data, BSCB does continue to try to understand and respond to the increasing levels of need for statutory intervention. An extra-ordinary Strategic Board meeting in November 2016 received reports from health, education and Police representatives, all of whom reported increasing workloads, both directly and indirectly linked to safeguarding. A number of actions were agreed that have informed our work in respect of early help, reported in Chapter 5 below, and our new business plan. Developing our understanding of the demands placed on our safeguarding system will remain a priority for BSCB.

There is less data available on the demands of child protection work in partner agencies other than children's social care, although the increase in activity noted above engages all partners in a multi-agency response. Equally, other agencies have reported increases in activity related to activities linked to safeguarding, for example Lancashire Constabulary have reported an increase in the number of people taken into their custody suite with mental health problems and CAFCASS have reported 21% increase in their public law workload in Blackpool which outstrips their overall national and regional increases. More generally we also know that, as in previous years, children and young adults are significantly more likely to be admitted to hospital as a consequence of substance misuse, mental health conditions or self-harm (although the most recent data available in this respect relates to 2015-16). The latter is something that BSCB has sought to understand and challenge partners to address in recent years. We have identified that our local acute hospital has a policy of always admitting children in these circumstances that is not mirrored nationally, which would partially account for the disparity. More recently, specialist mental health staff have provided an out of hours service within accident and emergency in order to signpost children who have self-harmed to appropriate community based services and to reduce admissions. This was the subject of a multi-agency audit in the summer of 2016 which identified good evidence of multi-agency working and outcomes for the children involved, together with a reduction in the number of admissions. The longer term impact of this project remains to be evaluated.

Rate of hospital admissions per 100,000 population	Blackpool 2015/16	Blackpool 2014/15	England 2015/16
As a result of self-harm (10-24 year olds)	1,444.7	1,388.4	430.5
Due to substance misuse (15-24 year olds)	345.3	278.2	95.4
Due to mental health conditions (0-17 year olds)	149.9	104.1	85.9

Characteristics of children subject to child protection plans

BSCB routinely monitors the category of abuse that child protection plans are made in respect of, in order to ensure that its activity meets the needs and experiences of the children of Blackpool. Viewed over the longer term there are some clear fluctuations in the registered categories of abuse (note that children can be registered under more than one category of abuse so the overall total for the year will exceed 100%):

Initial category of abuse for children subject to a child protection plan in the year ended	2012/13	2013/14	2014/15	2015/16	2016/17
Neglect	52.2%	51.9%	53.4%	44.4%	51.2%
Physical	19.6%	18.7%	35.5%	26.8%	25.5%
Sexual	15.1%	21.6%	17.3%	21.9%	11.9%
Emotional	53.1%	50.6%	58.9%	67.9%	71.8%

While the number of plans made in respect of neglect, physical and sexual abuse have fluctuated over this period there is a clear increasing trend in respect of the number of plans for emotional abuse. An audit reported in our last annual report suggested that 82% of plans in this respect included an element of domestic abuse and it would be expected that the Board's increased focus in this issue, outlined in Chapter 5 below, will establish a consistent and effective response in this respect. National comparisons in this respect are not altogether helpful due to Blackpool's practice of allowing registration under more than one category of abuse, which is not followed by the majority of local authorities. Blackpool therefore records a proportion of plans in respect of each category well in excess of national figures, however this is to be expected with 52.8 % of plans being made under multiple categories of abuse, compared to just 5.6% nationally.

We can say with a greater degree of certainty that the age range of children subject to child protection plans in Blackpool coincides with that expected nationally, as indicated below. The Child BW serious case review, discussed more fully in Chapter 7 below, did highlight some issues in respect of the effectiveness of work with unborn children. A broader audit and further relevant serious case reviews in respect of unborn children were either planned or underway at the year end. These will be reported in our next annual report and should provide a degree of assurance in respect of work with this group of children.

Age of children subject to child protection plan at year end	Blackpool 2016/17	Blackpool 2015/16	England 2015/16
Unborn	1.1%	1.9%	2.0%
Under 1 year	8.4%	11.2%	10.1%
1 – 4 years	24.4%	22.7%	27.3%
5 – 9 years	29.3%	32.3%	29.4%
10 – 15 years	32.5%	28.2%	27.4%
16 – 17 years	4.3%	3.6%	3.7%

A failure to consistently record the ethnicity of children subject to a child protection plan precludes an analysis as to whether this breakdown is consistent with that of the overall Blackpool child population. Recording practices in this respect have declined in recent years and must be improved. This is challenge that should be taken on board by both those agencies that make referrals and by Children's Social Care. Despite minor fluctuations, the split by gender of children subject to child protection plans continues to be around 50:50, in line with national trends.

Performance

Against a backdrop of high, and increasing, activity within the safeguarding system it is encouraging to report that the performance of the system, as measured against a set of standards set out in national guidance and comparative data has remained strong.

	Blackpool 2016-17	Blackpool 2015-16	England 2015-16	Statistical Neighbours 2015-16
Child and Family Assessments completed within 45 days	74.2%	80.1%	83.4%	73.4%
Initial child protection conferences held within 15 days of strategy meeting	97.5%	93.2%	76.7%	82.2%

A number of data indicators also cast light on the effectiveness of child protection processes. During the reporting period 34.0% of child protection plans ended within three months of their inception (2016: 25.1%), compared to 20.0% nationally. While it will be entirely appropriate for some children to be on a plan for a short period, the disparity with national data suggests the need for further analysis as to whether children are being inappropriately made subject to plans that are subsequently quickly closed. At the opposite end of the scale, 1.1% of plans ending in the year had been in place for over two years (2016: 6.9%), compared to 3.8% nationally which would suggest that plans are either having their intended effect, or being escalated appropriately. There remains a slightly higher percentage of repeat referrals (those received within 12 months of a previous referral) at 26.5 % (2016: 26.7%) than is seen nationally (22.3%).

4. How we are doing as a partnership

4.1 Child Sexual Exploitation

The need for a robust partnership response to child sexual exploitation (CSE) was recognised locally a number of years ago and has been driven by a number of high profile cases both locally and nationally. While Blackpool was consequently at the forefront of developing a multi-agency response to CSE, BSCB is keen to ensure that our response is effective and informed by recent national and local developments.

What we know about CSE in Blackpool

While there are a number of types of CSE known nationally, in Blackpool the predominant model is of a white male offending alone and after a process of grooming a single victim, who is also most likely to be white. The most likely offence location is the offender's place of residence, although some public areas are also reported to be hotspots for CSE and are monitored accordingly. There remains no evidence of gang or taxi related offending. The majority of victims are girls, although Blackpool has a significantly higher number of boys recorded as victims or considered to be at risk of CSE than is the case nationally or regionally. This is viewed as positive evidence that practitioners have the confidence to identify and report boys who are CSE victims. The predominant age of victims is between 13 and 15, although there is a trend for increasingly younger children being identified as at risk of CSE. Perpetrators tend to be less than five years older than their victim, although some are much older.

The key feature of CSE, as recognised in the new statutory definition published toward the end of the reporting period, is the imbalance of power between victim and perpetrator that is used to coerce, manipulate or deceive a child into sexual activity. Victims of CSE will frequently be gifted drugs or alcohol as a means of developing dependence on the perpetrator for supply and of lowering inhibitions. Social media is likely to have featured as both an initial and ongoing means of contact and may include the exchange of, or threats involving, indecent images. There is a strong correlation between being a victim of CSE and episodes of missing from home, a disrupted education and of self-harm. There is an over-representation of children in the care of the local authority amongst those considered as being at a high risk of CSE in Blackpool, which fits with the national picture.

During the reporting period 431 Police Protecting Vulnerable People (PVP) referrals with a CSE element were made to the Multi-Agency Safeguarding Hub (MASH) (2015/2016: 290). Further work is needed to understand this apparent increase, which is not similarly reflected in the Awaken caseload and may therefore represent the reporting of historical abuse or issues with the use of the CSE flag. The increase might also be viewed as evidence of improved recognition of CSE and intervention, as opposed to an increase in the actual levels of offending. This position is supported by audits of CSE cases in 2014 and 2016 that demonstrated better early identification of CSE in more recent practice.

What have we done about CSE?

Our response to CSE is delivered within a framework provided by a pan-Lancashire strategy and a local operational action plan, both of which were refreshed during the reporting period. Both provided for a response structured into seven areas:

Overall **Leadership** is provided by the BSCB strategic board, while a co-ordinated pan-Lancashire approach is maintained through the pan-Lancashire Strategic CSE Group which is chaired by the three pan-Lancashire LSCB Independent Chairs on a rotating basis. The delivery of the local action plan is managed by the CSE subgroup, which provides reports to every Business Management Group meeting and exception reports to the Strategic Board. The remit of these groups, and their respective action plans, has been expanded to include missing from home and trafficking during the reporting period, in recognition of their links to CSE. Political leadership is provided by elected members, all of whom received updated CSE briefings during the reporting period.

Action is taken to **Prevent** CSE through developing public awareness of the issue and their confidence to report concerns. Awareness raising amongst the general public is centred on the annual CSE awareness week in November and national CSE awareness day in March, in which Lancashire Constabulary's successful "The more you know, the more you see" branding continues to be used. The annual CSE conference held during awareness week was staged in Blackpool this year, and attended by over 200 professionals. A concerted effort has been made to improve awareness of CSE amongst children during the reporting period. BSCB now makes age appropriate materials available for children from year five upwards to all schools and further education providers in Blackpool. Materials for parents have also been provided. A PSHE package has been funded in all Blackpool secondary schools during the 2016/2017 academic year, ensuring that all year 9 pupils receive a CSE awareness lesson. Our last annual report noted the start of a programme to provide safeguarding (including CSE training) to all taxi drivers. All of Blackpool's approximate 1,200 existing taxi drivers have now completed this training, barring a handful that are not expected to renew their licence. Completion of the training is now a prerequisite of being issued with a new licence and part of the renewal process for existing licences. BSCB has subsequently focussed on providing safeguarding awareness raising for licensed premises (including hotels, guest houses, pubs and amusement arcades), the leisure industry and tourist attractions. During the reporting period we have held two days of multiple briefings to which all licensed hotels and guest houses, together with other businesses have been invited and a third event was provided for pubs that are part of the Pubwatch scheme. Over 200 people attended these events. Finally, BSCB intends to raise awareness amongst specific groups of the population, work has started in respect of the LGBT community and will be expanded to other groups where CSE is either more prevalent than expected, or is thought to be under-reported.

Work to **Protect** children at risk of CSE is led by the Awaken team, which has been in place for over ten years. Awaken is a multi-agency team with health, police, education and social care staff members. Each child open to Awaken will be provided with one key-worker, who will be the person judged most likely to be able to effectively work with them. Audit activity undertaken by BSCB in the reporting period has suggested that CSE has not always been identified at the earliest possible

opportunity. BSCB has consequently developed a risk indicators guide and screening tool, which are available to all professionals on our website and should promote early identification of vulnerability and intervention (at the time of writing both are under review to ensure that recent research findings are incorporated). This complements the spotting the signs tool that is used within health settings. During the reporting period BSCB sought assurance from practitioners and commissioners that appropriate therapeutic services were available to victims of CSE. We are satisfied that this is the case and have produced a directory of services that has been made available to staff and publically through the Family Information Service. All children who receive a service from Awaken are asked for feedback on their experiences both at the closure of any criminal investigation and at the point they exit Awaken provision. Collated feedback is subsequently used to inform future service provision and to develop our understanding of CSE in Blackpool.

A multi-agency approach to share information and co-ordinate intervention underpins work to **Pursue** offenders. This is co-ordinated through fortnightly Multi-Agency Child Sexual Exploitation (MACSE) meetings. They are attended by a wider range of agencies than those permanently situated in Awaken, including probation providers which allows the sharing of information about perpetrators. Meetings discuss children considered to be vulnerable to CSE, known or suspected perpetrators and premises or locations of concern, allowing for information to be shared and action plans developed. During the reporting period the documentation used in MACSE meetings has been reviewed against other national models. The multi-agency partnership in Blackpool has developed an approach by which it seeks to disrupt perpetrators of CSE at the earliest possible stage to minimise the harm that a child suffers and to prevent offences from occurring.

To support this approach the Community Safety Partnership has expanded its use of Community Protection Warnings (CPW). These are issued, after liaison with the Police and Children's Services, to adults who have given cause for concern and can require them to stop specified activities or behaviours which are assessed as contributing to an ongoing CSE risk. A failure to comply can lead to the issuing of a Community Protection Notice (CPN), the breach of which could ultimately lead to prosecution. During the reporting period 105 CPW were issued, but only 9 CPN and there were no resulting prosecutions. This demonstrates an 86% success rate for CPW and 100% for CPN. Blackpool's innovative use of this approach has recently been recognised as good practice within a Home Office national bulletin. This approach is now being developed to make use of other civil injunction means to disrupt party houses and other venues where children may be at increased risk of CSE.

The complex nature of CSE demands an effective **Partnership** response, which is well embedded in Blackpool, in both the co-located Awaken team and broader MACSE meetings. The CSE subgroup ensures that agencies engage at all levels and has enabled the development of attendance at MACSE meetings. During the year a pilot has started to provide one Blackpool secondary school with a link to the Awaken team, with a view to enabling them to manage CSE, and specifically sexting incidents, more effectively and at an earlier stage, thereby preventing the need for later referral to specialist services.

BSCB uses **Intelligence and Performance monitoring** to judge the effectiveness of its response to CSE. During the reporting period it has received a Lancashire Constabulary Western Division

intelligence assessment of CSE activity and a North West Problem Profile, both of which conformed to our existing understanding of CSE locally. A new Joint Strategic Needs Assessment chapter on CSE was written during the year that drew on the understanding of CSE that we have developed in Blackpool in recent years and is now available publically. We have made less progress than we hoped in respect of the development of a specific CSE dataset. We reported in our last annual report that we had agreed a framework for this, however agencies were unable to supply a number of the indicators. The appointment of a Board analyst has allowed more progress to be made following the year end and a revised framework has now been agreed and will be reported in our next annual report.

During the reporting period we have undertaken two audits of cases held by Awaken. The former reviewed three cases in which there had been CSE concerns for a number of years and suggested that there had been a number of missed opportunities to identify vulnerabilities and intervene prior to Awaken involvement. The fact that the children were reported as missing from home or care was not identified as a risk factor for CSE, while there was no systematic consideration of siblings being at risk. The second audit considered five children where CSE concerns had been identified more recently (mid 2016) and provided a more positive overall picture. CSE was appropriately identified, including through missing from home return home interviews and there was evidence that siblings and peer associations were considered. The findings of the two audits suggest that the multi-agency system is currently able to identify and intervene to address CSE, but that has not always been the case, as a consequence of which we may continue to work with children where earlier opportunities to identify vulnerabilities were missed. Both audits supported a strong correlation between CSE and self-harm, as did a separate Multi-Agency Audit Group audit of children who had self-harmed.

Over recent years **Learning and Development** activity in respect of CSE has been an area of significant focus for BSCB. As was reported in our last annual report, the majority of our partner agencies have made CSE awareness training mandatory for all staff and we continue to seek assurance in respect of the numbers who complete training through our Section 11 audit programme. Having delivered a significant number of CSE training packages in recent years through the BSCB training programme, demand has tapered during the last eighteen months which would suggest that the vast majority of staff who need to attend this more in-depth training have done so. The full-day 'CSE, trafficking and missing from home' course is now run three times a year, in common with the majority of our training offer, and was attended by 64 professionals during the reporting period. It was recognised that professional awareness of human trafficking and modern day slavery are lower and a conference was subsequently held in March 2017, with the support of the Blackpool Teaching Hospitals CSE and Human Trafficking Analyst and in conjunction with our colleagues in Lancashire Safeguarding Children Board. Presentations were provided by a range of nationally recognised speakers to approximately 280 attendees.

What we will do next

- As a matter of priority develop a standard CSE dataset which will be routinely monitored by the CSE subgroup and reported to our strategic board
- Continue public awareness raising, based on intelligence in respect of venues for offending and with groups in which CSE is under- or over-reported

- Respond to increasingly reported concerns about sexting by providing guidance to schools about how to deal with incidents
- Offer online safety assemblies to all schools through the Awaken education worker
- Develop briefings on specific aspects of CSE to be delivered during CSE awareness week in November 2017
- Work to secure funding to deliver Chelsea's Choice, or a similar production, within all Blackpool secondary schools
- In conjunction with pan-Lancashire colleagues, revise the Standard Operating Protocol in light of the new statutory definition of CSE (implemented in March 2017) and changes in practice
- Consider the outcomes of the pilot for working more closely with a secondary school with a view to ensuring that agencies intervene at an early stage to prevent children from being harmed

4.2 Children missing from home or care

Children who are missing from home or care (MFH) are vulnerable at that time, quite simply because those who are responsible for their care are unable to ensure that they are safe. The correlation between MFH and CSE has been noted above, while episodes of MFH have been a feature of recent serious case reviews and multi-agency learning reviews involving older children. As corporate parents Blackpool Council are particularly concerned to address the over-representation of the already vulnerable group of children in its care amongst those who go missing (although this may, in part, reflect a greater willingness on the part of residential homes and foster carers, over parents, to report children as missing).

During the reporting period MFH has been incorporated within the same local and pan-Lancashire governance structure as CSE, and is the subject of a shared action plan. This allows a more closely co-ordinated strategic and operational response, the importance of which is emphasised by the close links between CSE and MFH.

The multi-agency response to MFH in Blackpool is provided in accordance with a pan-Lancashire protocol that was agreed in 2014. The nature of the response is predicated on an initial risk grading made by Lancashire Constabulary. An internal review of their practice in this respect has indicated that appropriate decisions are being made in this respect. The priority in responding to any child who goes missing is ensuring their immediate safety. Once they have returned home this is confirmed by a Police safe and well check, which should be followed by a return home interview within 72 hours. It is the responsibility of the local authority to ensure that the return home interview is provided, in which it will seek to try to understand why the child went missing and what can be done to seek to prevent them individually, and children more generally, from going missing again. A standard template is used for interviews that includes a specific question about CSE. For children who are already known to the local authority the interview will be undertaken by the professional deemed most able to effectively engage with the child (although is balanced with a need for neutrality). Other children will be seen by a member of the Duty and Assessment team. It would be expected than any looked after child who was at risk of going missing had a specific

element of their care plan to address this and that this would be reviewed by their Independent Reviewing Officer.

The Police and Blackpool Council both have missing from home co-ordinators in place who are responsible for co-ordinating their agency's operational responses to children who are reported as missing. The local authority co-ordinator is responsible for logging and collating information obtained from return home interviews which allows themes to be identified and action taken accordingly. The multi-agency response to children reported as missing has been developed during the reporting period by the introduction of the sharing of all MFH notifications (that would previously have only been shared between the police and local authority) through the MASH. Monthly MFH panel meetings are attended by professionals from throughout the partnership to review and develop action plans for high risk children, including Blackpool and out of area looked after children who are resident in Blackpool. Links are in place with missing from education processes, including those who are electively home educated.

BSCB receives data in respect of children missing from home and looked after children missing from care. The overall number of missing from home or care episodes amongst all children increased from 1,126 in 2015/16 to 1,547. During the reporting period the number of individual children missing from home on both one or more occasion and three or more occasions in any given quarter fluctuated, but continued to show a reducing trend that has been evident since 2013-14. There tends to be an even split between boys and girls, although the most common age of boys going missing is 13-14, whereas girls tend to be in the 15-17 age range. Conversely, there is an upward trend in the number of looked after children missing from care during the same period and in the last quarter 10% were reported missing on one or more occasion and 4.6% on three or more occasions. Included within this figure are six children who have been reported missing on 30 or more occasions during the last year. This data is presented as a proportion of all looked after children, given that it is overwhelmingly older children who are reported as missing, the proportion of older looked after children who go missing will be much higher than this figure suggests.

BSCB has raised concerns in respect of the quality and completion rate of return home interviews in its last two annual reports. During this reporting period we have seen evidence of the effective use of interviews in our CSE audit, noted above. The relevant service manager has also reviewed all interviews completed over a given period and was satisfied that those completed within the Duty and Assessment team were of a consistently good standard, although acknowledged the need to replicate this consistency amongst those completed by other teams. This exercise has also allowed the ongoing development of the interview template. In March 2016 only 28.1% of interviews were recorded as having been completed within the required 72 hours. It was accepted, at this point, that there were issues with the quality of data, most significantly in that one interview can legitimately cover more than one missing episode, while a 100% completion rate will never be possible as some children will always decline to participate and on other occasions it may not be possible to have access to the child. However, it is concerning to report that data from March 2017 would suggest that only 32.4% of interviews have been completed as required. It therefore remains a priority for BSCB to seek assurance that return home interviews are being completed as required. Assurance will also be sought in respect of whether police safe and well checks are completed as data in this respect is currently not collected.

A small number of children are logged as being 'absent', rather than missing from home by the Police (there are approximately 90 episodes per quarter). This is a nationally accepted practice, used when a child is not where they are expected or required to be. Recent College of Policing guidance has recommended the removal of this category and the introduction of one of missing with no apparent risk. This would ensure a full multi-agency response, including return home interview on all occasions on which a child is missing. BSCB supports this proposal and awaits Lancashire Constabulary's formal response. In the meantime all children logged as absent are reviewed by the missing from co-ordinator to identify any risks or trends.

What we will do next

- Continue to challenge agencies to account for the completion of safe and well checks and return home interviews
- Seek to understand and address the increasing number of looked after children going missing from care
- Revise the MFH Protocol once changed practice in respect of the absent category is agreed

4.3 Early Help

The provision of early help to children and families is a key means by which longer term harm to children can be forestalled and the demand for higher tier services can be reduced. The need for effective early help provision in Blackpool is emphasised by the high number of children who require protection, as outlined in Chapter 4 above. BSCB consequently needs to assure itself that early help is available to all children and families with emerging needs and that only those in genuine and urgent need of safeguarding are referred and worked with at a higher level.

Early Help was one of the key safeguarding themes within BSCB's 2015-17 Business Plan and the need for significant progress in this respect has been rehearsed in our last two Annual Reports. Issues in this respect were identified by Ofsted in their 2014 inspection of Children's Services and summarised by a Blackpool Council commissioned review in 2015, which noted:

- a lack of clarity in respect of partnership responsibilities for the provision of early help at strategic and operational levels
- the provision of early help is not sufficiently co-ordinated to enable an understanding of the scale of provision or its effectiveness
- partner agencies do not consistently monitor the numbers of children receiving early help
- the continuous assessment tool is used solely to make referrals, rather than to provide ongoing assessment
- the duty and assessment team do not consistently provide feedback on referrals which contributes to an overall lack of clarity about thresholds

Our Business Plan and last Annual Report highlighted a number of areas in which progress was required during this reporting period and it would be fair to say that issues which we expected to have resolved remained outstanding at the year end. More significant progress has been in the first few months of the ensuing year and this will be alluded to herein before being fully reported next year. Work in this respect is led by our Early Help subgroup, the chairing of which was assumed by

our Independent Chair in March 2017, in recognition of the need to drive this agenda forward and provide independent challenge to partner agencies. Multi-agency early help provision should flow from an agreed partnership strategy, owned by the Board. It is therefore disappointing to note that a strategy had not been agreed by the year end.

Considerable concerns have been voiced about the effectiveness of the thresholds document and associated Getting It Right (GIR) documentation. The latter had been launched in late 2013 as a single form which was to be used to assess children and families who are in need of early help and to refer them to Children's Services, if subsequently necessary. Repeated reviews, audits and anecdotal feedback suggested that the form was solely used for referrals to higher tier services and not to assess and co-ordinate early help provision. Feedback from professionals cited the length and complexity of the form as the primary barrier to its use as a continuous assessment.

Our Early Help subgroup was consequently determined to provide a shorter dedicated early help assessment form, together with a discrete referral form for Children's Services and a refreshed thresholds document. We agreed to develop a thresholds document that went beyond solely defining levels of need to one that emphasised the need for early help provision and encouraged multi-agency conversations to determine the right intervention. This approach is predicated on a resource being available within the Children's Services 'Front Door' to provide advice about where a child sits within the Continuum of Need and the early help provision that would be appropriate, thereby empowering practitioners to intervene, rather than simply referring to higher tier services. The revised document will also seek to encourage agencies to adopt the common language of Resilient Therapies. This underpins the Head Start project (see below) and is an asset based approach that focuses on the strengths of a child and family. The revised document consequently includes a focus on the strengths of the child and family, in addition to example risk indicators. This overall change in emphasis provides for a focus on the outcomes of intervention for a child, as opposed to the processes by which this will be achieved. Finally, a revised thresholds document will allow for the inclusion of emerging risk factors that were not included in the 2013 version, for example radicalisation and female genital mutilation, and learning from reviews undertaken in the intervening period.

The new thresholds document and forms were piloted in six schools in early 2017 and while feedback was generally positive, BSCB did not approve the changed documentation until May 2017. This extended period allowed for further work to align our thresholds with those of Lancashire and Blackburn with Darwen, which was undertaken at the request of a number of partner agencies whose geographical footprints extend beyond Blackpool. With a roll out projected over the summer period, it is incumbent on BSCB to ensure that the documentation is used as widely as intended, to prevent a repeat of the issues previously noted with the GIR process. To this end the means of incorporating it within schools' safeguarding software are being explored, while commissioners of Health Visiting services have been requested to include its use within contracts.

Our Early Help subgroup has received feedback from partner agencies and undertaken an audit of cases that have progressed to Initial Child Protection Conference to identify if appropriate early help services were available and delivered. These activities would suggest that early help provision is available and we have subsequently promoted the Family Information Service website as a resource

for professionals for information in this respect. There is, however no central collation of data in respect of either the completion of GIR assessments, or children open at Levels 2 or 3 of the current thresholds of need document (these levels broadly equate to single- and multi-agency early help provision, respectively). This lack of data is a significant gap in our understanding of need in Blackpool and needs to be resolved to enable us to begin to understand our demand for higher tier services.

While more systematic approaches are being explored, BSCB has requested that all partner agencies provide feedback as to the number of children that they are working with at Levels 2 and 3. The success of this approach has been limited although returns have been provided by the local authority Families in Need (FIN) team and Children's Centres, Blackpool Teaching Hospitals community based services and approximately a quarter of schools. From returns received it is apparent that up to 1,000 children are receiving early help from the local authority and Blackpool Teaching Hospitals at any given time. Returns from schools are harder to interpret. In any given month the returns received from a variable number of schools would suggest in the region of 150-250 children receiving early help, however methods of assessment and recording clearly vary considerably, with some schools reporting up to 20% of their roll in receipt of early help, while others report only a handful of children. This exercise does demonstrate the urgent need for a more systematic means of data collection and a common understanding of what constitutes early help, which must be resolved by the partnership.

Our Early Help subgroup has also challenged the partnership to provide better co-ordinated early help provision, thereby reducing the likely demand on higher tier services. This has resulted in a pilot in two Children's Centres in which they are re-modelled to provide a service for 0-19 year olds and act as multi-agency hubs, allowing more effective co-ordination of service provision. This approach mirrors that of the Vulnerable Adolescent Hub which will be launched during 2017 and will bring together Blackpool Council and other partner agencies who work with vulnerable older children and young adults to provide their services under one roof with a shared aim of ensuring that they have secure accommodation, a route to fulfilling employment and positive relationships with family and friends. Key to this approach is ensuring that the right services are available, at the right time and from the person that the child is best placed to work with. The case for change was born from a recognition that vulnerable older children and young adults were typically open or known to five or more individual local authority services which creates duplication and causes confusion for the child. By allowing the child to work with the one person with whom they feel most comfortable, but to access other services in the same building they should have a better chance of achieving the desired changes.

Blackpool has also received significant Big Lottery funding for two multi-agency projects that provide early help to children and families in Blackpool:

Better Start is a multi-agency project, led by the NSPCC, with £45 million funding over a ten year period, which aims to improve the life chances of children aged 0-4. The project seeks to provide two outcomes of a healthy gestation and birth and improved school readiness. A number of evidence based programmes are being rolled out with the aim of providing universal and targeted interventions to provide early help at the point of need and prevent escalation to higher tier

services. During the reporting period two general parenting skills courses, Baby Steps and Video Interactive Guidance were available, with the former being offered to all prospective parents in Blackpool from April 2017. Parents under Pressure, Safe Care and Survivor Mums programmes are also available for parents with a history of substance misuse, families where there are concerns about neglect and mums who have been victims of abuse, respectively. The impact of all Better Start programmes will be academically evaluated, the outcomes of which will be reported in future annual reports.

Head Start is a multi-agency project, led by Blackpool Council, which received £10 million funding during the reporting period to provide a five year programme to increase resilience in 10-16 year olds in order to prevent future mental ill health. It is an asset based approach, which uses a universal language of resilience and has a strong focus on the participation of children in its design and delivery. The project has a universal whole-town offer, together with targeted elements aimed at pupils transitioning from primary to secondary school, children who self-harm and looked after children. Example interventions include use of a resilient therapies approach to build resilience in children, walk and talk counselling, mentoring and more specific interventions for the target groups. While the project is funded for five years, it aims to achieve system changes that will significantly outlive its tenure. BSCBs use of the language of resilience within its thresholds document is an example of how this approach can be embedded more widely and permanently.

What we will do next

- Agree a comprehensive Early Help strategy to ensure the consistent and quantifiable provision of early help by all agencies who work with children and families in Blackpool
- Implement the revised thresholds document and associated assessment and referral forms that were agreed subsequent to the year end and hold agencies to account for their use
- Audit the use of the new processes to evaluate their effectiveness
- Ensure that a robust means for collating data as to the number of early help assessments completed and/ or children receiving early help

4.4 Access to higher tier services

During the reporting period there were two means by which children could be referred to higher tier services: the Children's Services 'Front Door' and the Multi-Agency Safeguarding Hub (MASH). The former handles multi-agency referrals for both Children's Social Care and the Families in Need team, the demands on this resource have been outlined in Chapter 4, above. In contrast, the MASH handles Police PVP referrals only (although, in practice, some referrals may effectively be from other agencies, but entered on a PVP). Blackpool has its own MASH, however the process is replicated across the three LSCB areas in which Lancashire Constabulary operates. The response received depends on the initial risk grading. Where a child is considered to be at high risk the PVP is passed to the 'Front Door'. Other PVP are shared with partner agencies to build a multi-agency chronology that ensures that the child (and/ or adults involved) are referred to the most appropriate service to meet their needs. The original aspiration had been to start to accept referrals from all agencies, however the volume of work that it currently handles is such that it does not have the capacity to make this change.

BSCB, in conjunction with its pan-Lancashire counterparts, consequently challenged Lancashire Constabulary to fully review the working of the MASH with a view to it becoming a genuine multi-agency referral and triage process. The findings of the subsequent multi-agency review were reported to BSCB at the end of the reporting period. These indicated that Blackpool accounted for 17% of 37,000 pan-Lancashire referrals of which 15% were effective (in other words, the referral was appropriate and the MASH process resulted in a tangible outcome), 55% were preventable (the referral either duplicated an earlier one, or the incident should have received an alternative response) and 30% were the result of systems failure (the referral was appropriate but the result of previous failed intervention). Once a referral was in the system there were 96 administrative steps identified prior to an outcome, of which only 20 were considered to add value. This obviously results in considerable delays and contributed to the overall conclusion that the MASH system requires fundamental change.

What we will do next

- Provide strategic oversight to the re-design of the MASH with the ultimate aim of developing a genuinely multi-agency process that becomes the one front door for all referrals to Children's Services
- Work with Lancashire Constabulary to facilitate their move from risk gradings to the levels of need and intervention that will be common to all three pan-Lancashire LSCB.

4.5 Neglect

Neglect has been a long standing priority of BSCB, identified in audits, reviews and a higher than expected number of child protection plans being made in this respect. As of 31st March 2017 of the 369 children subject to a child protection plan 58.5% of children had a current category of neglect (2016: 49.0%; 2015: 61.2%). Interestingly, only 51.2% of plans had an initial category of neglect which suggests that social workers will often identify neglect after they start working with a child, raising the prospect that neglect is often missed at an earlier stage. The Child BW SCR, outlined in Chapter 7 below, adds extra impetus to our work in this respect.

The Neglect Strategy was agreed in November 2016, a primary objective of which is the implementation of a shared neglect assessment tool to enable professionals to consistently assess neglect across agencies and over time. It was reported in our last annual report that, with the support of the NSPCC, we had adopted a bespoke suite of neglect assessment tools. This provides a number of tools ranging from a basic neglect screening tool (the thriving families checklist) to the in-depth Graded Care Profile 2 (GCP2), together with a number of tools designed to assess specific areas of need e.g. parental anxiety and alcohol use. Professionals are able to use tool most suited to the child and family being assessed, although a protocol determines what is required once safeguarding intervention becomes necessary. At the beginning of the reporting period we were piloting the use of the tools and, having agreed that a full roll out was desirable, subsequently trained a multi-agency cohort of trainers and progressed to full implementation. Trainers provide briefings within their own agencies for use of the more basic tools, while those who will use the full suite of tools are required to attend one or two days of training offered as part of the Board training programme, which allows them to be licensed to use GCP2. Delivery of the BSCB training programme began in November 2016 and it is disappointing to report that of the 125 places

available prior to the end of the reporting period only 79 were taken (although two whole day events primarily aimed at social workers were planned for May 2017, will have over 90 attendees). Having agreed to implement the suite of tools it is imperative that partner agencies attend the training and use the tools in practice. This will, in part, be supported by the new thresholds document and assessment forms that include specific prompts for the use of the tools.

The Joint Targeted Area Inspection (JTAI) programme in mid- to late-2017 will have a focus on the multi-agency response to older children who are neglected. As part of its preparation for a potential inspection BSCB undertook a Multi-Agency Audit Group audit of children subject to child protection plans on the grounds of neglect. This audit again identified the need for consistent assessment of neglect between agencies and over time, thereby emphasising the need for the successful roll out of the neglect evaluation tools. That said, there was evidence that neglect was identified and referrals made at an appropriate stage. Once implemented child protection plans were not, however seen to be effective. There was evidence of drift and where plans were failing this has not been recognised and corrected. Children's services consequently implemented a programme of training for social workers in neglect and the audit has provided the impetus for BSCB to develop a "Safeguarding Standards" document to promote greater compliance with safeguarding processes. The Child BW Serious Case Review, covered in Chapter 7 below, has likewise prompted activity to improve our multi-agency response to children who are neglected.

What we will do next

- Ensure that sufficient multi-agency professionals are trained in the suite of neglect assessment tools to enable their consistent and widespread use
- Embed the use of the neglect assessment tools within early help and safeguarding processes to promote their use
- After an appropriate period, evaluate the use and effectiveness of the neglect assessment tools

4.6 Domestic abuse

Domestic abuse, as part of the toxic trio, was part of the BSCB 2015-17 Business Plan and added focus was provided to the issue by the prospect of a JTAI inspection in this respect during the reporting period. The multi-agency response to domestic abuse cuts across the agendas of a number of strategic boards, as a result of which BSCB agreed to the creation of the Domestic Abuse and Interpersonal Violence Partnership Board (DAIV PB) which, while not formally part of the BSCB governance structure, would report to the Business Management Group (BMG).

The need for a robust partnership approach to domestic abuse is emphasised by its prevalence in Blackpool. While work is undergoing to improve data provision, the number of cases being heard at Multi-Agency Risk Assessment Conferences (MARAC) serves as a useful indicator:

Blackpool MARAC	2016/17	2015/16
Cases heard	523	442
Repeats (within 12 months)	153	84
Number of individual children in households	558	509

Cases heard at MARAC are those where a police officer attending an incident assesses it as high risk, or those referred on the professional judgement of practitioners in other agencies. Consequently, a degree of caution has to be used in interpreting this data, although the 8% increase in cases does give some cause for concern when placed against the national 5% rise. That said, the proportion of repeat cases has risen from 19% to 29% and, if stripped out, leaves a more static number of new cases. The 523 cases heard in the reporting period represents a rate of approximately 93 per 10,000 adult female population, compared to the most recently available national average of 34 (year ended 30th September 2016). However a degree of caution should be exercised with this comparator as it may reflect working practices associated with MARAC, as opposed to solely the prevalence of domestic abuse. The absence of a specific domestic abuse category renders capturing data in this respect from Children's Services systems difficult, however an audit reported in our last annual report, concluded that 82% of the children subject to child protection plans for emotional abuse had been exposed to domestic abuse, although this may not have been the primary reason for the current intervention.

The DAIV PB has agreed a Domestic Abuse Strategy 2016-20 which has an aim of ensuring that all victims receive the right support at the right time, which is effective and adopts a whole family approach. This will be achieved through four objectives of prevention, provision for victims, working in partnership and providing interventions for perpetrators. A multi-agency action plan was in development at the year end, the delivery of which will be monitored by BMG.

A range of work against the strategic objectives is already underway and includes seeking White Ribbon accreditation in order to make a public statement of the partnership's determination to end male violence against women. A successful bid has been made for Home Office funding to both provide additional interventions to children and families who are current victims of domestic abuse and to develop PSHE and other work to break generational cycles of violence. The latter work will be linked to Head Start. A second successful bid has been made for funding to provide specialist accommodation for complex need victims including those with children, for whom there is no current refuge provision. Additional interventions are being offered for victims, including Blackpool Council providing funding for Independent Domestic Violence Advocate (IDVA) support for all victims of domestic abuse incidents that the police assess as being standard risk (services for higher risk victims having been provided for some time) and the Police and Crime Commissioner funding an IDVA to provide support to staff and patients at Blackpool Teaching Hospitals. Finally, Step Up is a partnership between Blackpool Council and the Centre for Early Child Development to provide early intervention to children and families with emerging domestic abuse concerns, but who do not meet the threshold for children's services intervention.

The fact that domestic abuse cannot simply be addressed by removing the perpetrator from the relationship has long been recognised in Blackpool and is re-affirmed by our new strategy. Ongoing funding for the voluntary Inner Strength programme for perpetrators has been provided and during the reporting period 20 men completed the programme. Cumbria and Lancashire CRC now deliver the Building Better Relationships programme (which can only be delivered as part of a court order, following conviction) in Blackpool, rather than requiring participants to travel to Preston, which should improve completion rates. As a result of a number of reviews and audits that highlight the

ineffectiveness of written agreements in which adults agree to end relationships, Children's Services have now ended their use.

A Multi-Agency Audit Group audit of children subject to child protection plans where the primary concern is domestic abuse provided broadly positive findings. It identified that risk was identified and referrals made in a timely manner and in accordance with thresholds, although strategy meetings were identified as an area in which improvement was needed. When subject to child protection plans there was evidence of planning, delivery of interventions and that progress was measured. Engagement with perpetrators was more variable and there was learning specific to one case in relation to linking with adult mental health services.

BSCB offers a full day Domestic Abuse and Referral Pathways course which was attended by 86 professionals during the reporting period, while domestic abuse is covered by many of our other training courses including our Hidden Harm (toxic trio) course which 105 professionals attended.

What we will do next

- Agree and hold agencies to account for the delivery of a multi-agency action plan
- Develop our data suite to help us understand the scale of the issue and success or otherwise of interventions
- Evaluate the effectiveness of our strategy and action plan in reducing the harm caused to children by domestic violence

4.7 Private fostering

A private fostering arrangement is one in which a child under 16 (or 18, if disabled) is looked after, or planned to be looked after, for over 28 days by someone other than a close relative. Any such arrangement should be notified to the local authority, in order for them to be satisfied that the child is safeguarded and their welfare promoted.

From a starting position of 5 private fostering arrangements that were in place in April 2016, 10 commenced and 7 ended during the year, leaving a total 8 in place at the end of March 2017. The majority of private fostering arrangements are of older children, sometimes from abroad, who move to take up educational opportunities.

The number of reported private fostering arrangements in Blackpool during the last five years has remained low and fairly static, which mirrors the position in the wider region. BSCB continues to promote the reporting of private fostering arrangements through its inclusion in the thresholds document, agreed after the year end, and in a number of our training courses. Research undertaken by Ofsted suggests that raising the awareness of practitioners is more effective than public awareness raising campaigns in increasing the reporting of private fostering arrangements. Interestingly, the lack of a public awareness raising campaign during the reporting period had no apparent impact on the number of reported arrangements, in comparison to 2015-16 when an awareness raising campaign was delivered.

4.8 Radicalisation

Radicalisation is the process by which people come to support extremism and terrorism and, in some cases, to participate in terrorism. In this context extremism is defined as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs" (HM Government Prevent Strategy 2011) and may include, but is not restricted to, Islamist, far right, animal rights and support for Irish terrorist groups. Many BSCB partner agencies are subject to statutory duties, within the Prevent Duty Guidance (2015) to address radicalisation. Indications of radicalisation in children should prompt a safeguarding response, in addition to which they may be referred to the pan-Lancashire Channel Panel that will co-ordinate a multi-agency response to emerging extremist views. The Channel Panel is currently part of a pilot in which responsibility for its running has been transferred to Blackburn with Darwen Council from Lancashire Constabulary.

Overall responsibility for counter-terrorism in Blackpool rests with the Community Safety Partnership and is delivered through the Prevent Partnership Board, however BSCB retains responsibility for ensuring that children are safeguarded from radicalisation and receives regular updates in this respect. Work is co-ordinated through an action plan that has been agreed during the reporting period.

Having provided briefings for a significant number of professionals during 2015-16, this is now being consolidated through the more in-depth Workshop to Raise Awareness of Prevent (WRAP) course that has been delivered to 69 professionals during the reporting period through the BSCB training programme, while assurances have been received through our Section 11 audit process in respect of WRAP training provided by our partner agencies internally. A workshop was also provided as part of the Schools' Twilight programme to develop participants' ability to identify indicators of far-right extremism.

4.9 Online safeguarding

Keeping children safe online presents new challenges to agencies and individual practitioners and was highlighted by our Pupil Voice group as an environment in which they feel less safe. Increasing responsibilities are also being placed on schools in this respect, with the 2016 revisions to Keeping Children Safe in Education including a specific online safety annexe and increased responsibilities being placed on governors. BSCB is part of an established pan-Lancashire response which is led by our Online Safeguarding subgroup. During the reporting period a refreshed strategy and action plan were agreed with objectives of safer management, safer access, safer learning and safer standards.

A key function of the group remains the raising of awareness and provision of advice and support to partner agencies to keep children safe in a rapidly evolving online environment. During the reporting period a dedicated Online Safeguarding website resource was launched which provides resources and information about new areas of concern. This is complemented by the established Prevent4schools website which, while developed for the Lancashire audience, continues to receive a significant number of visitors both locally and nationally. The group continues to review and respond

to emerging trends and threats, while needs are identified through a survey undertaken annually following the e-Safety Live training event.

5. Our workforce

BSCB is committed to ensuring that the children's workforce is properly equipped to safeguard and promote the welfare of children by understanding their experiences and needs as frontline practitioners and by ensuring that they are able to access high quality training that enables them to make a difference to the lives of children in Blackpool.

5.1 Listening to practitioners

BSCB has a well-established Shadow Board of frontline practitioners drawn from partner agencies, which is chaired by the Blackpool Council Head of Safeguarding. It meets a few days after the Strategic Board and will consider a broadly similar agenda. The purpose of the group is twofold: firstly, it can offer a practitioner perspective to discussions and decisions made at Strategic Board which will be fed back to subsequent meetings and secondly, it offers a further means by which information can be disseminated amongst frontline practitioners. Shadow Board members are therefore asked to agree with their Strategic Board member how they will each disseminate information within their agency.

During the reporting period the Shadow Board has contributed to the development of the CSE action plan, the resolving professional disagreements process and the revision of the thresholds document and associated forms. They have additionally re-affirmed findings of audits and reviews that identified that attendance at strategy and core group meetings is becoming increasingly problematic, which helps the Board triangulate information. In contrast, they have challenged concerns voiced by the Strategic Board in respect of the effectiveness of agencies in identifying Young Carers.

5.2 Working with schools

Schools play a critical role in overall activity to keep children safe. Their contact with a child and their family, over a sustained period of time, allows the school to develop the knowledge and ability to readily identify when a child is at risk of harm and to intervene to address this. From a position in late 2014 in which BSCB did not have any schools representation on its Strategic Board we have worked in a sustained way to improve our engagement with schools at all levels.

At the end of the reporting period we had representation on our Strategic Board from two primary schools, one secondary school, one special school and the Pupil Referral Unit, together with the Schools' Safeguarding Advisor, who is employed by Blackpool Council with funding provided by all schools to improve their safeguarding practice. Schools are represented on all our subgroups and we have continued to develop our programme of half-termly Schools' Twilight meetings, which have been attended by up to 50 head teachers, designated safeguarding leads and governors. During the reporting period these have included input on child sexual exploitation, female genital mutilation, our neglect evaluation tools, mental health and emotional wellbeing, far right extremism and recently completed serious case reviews. We have additionally provided overviews of new guidance, including Keeping Children Safe in Education. We have launched a dedicated schools' resource on

our website, which includes a range of template policies and safeguarding guidance, developed at the request of schools and in response to audit and review findings.

BSCB also has a broader role in holding schools to account for their safeguarding processes and requests annual Section 175 audits (self-evaluations) from all our schools, which are complemented by audits that the Schools' Safeguarding Advisor offers. During the reporting period we received full responses from 33 out of 44 schools and partial responses from another four. Scrutiny of the audits has resulted in feedback being provided to individual schools and has informed the content of Schools' Twilight meetings, for example to include advice around use of Disclosure and Barring Service checks, the Single Central Record and expectations of governors. In view of the poor rate of return our Independent Chair has written to all schools prior to this year's audit outlining expectations of schools in relation to LSCB in Working Together (2015). At the suggestion of schools we have changed the timing of the audit, but will additionally request data from each school as to safeguarding activity in the preceding year.

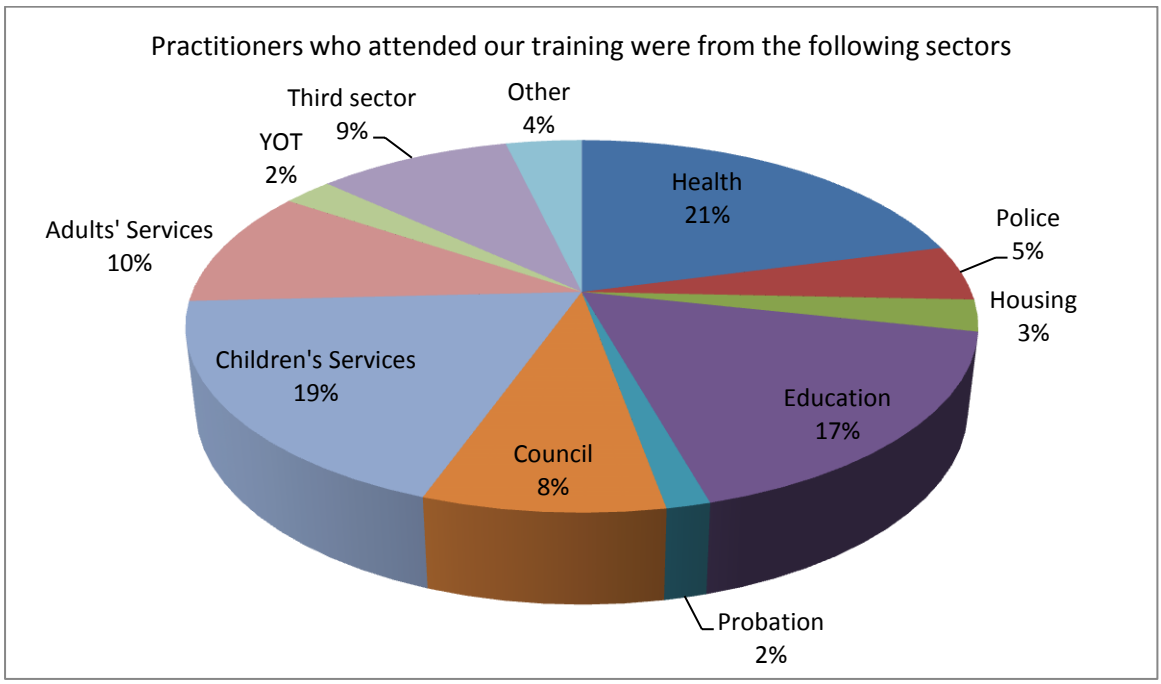
During the reporting period the BSCB Strategic Board has had a considerable focus on exclusions, the use of part-time timetables and the availability of alternative curricula for children who cannot manage in mainstream schooling. With links into Blackpool School Improvement Board and its predecessor, Blackpool Challenge Board, the Board is able to provide advice, guidance and appropriate information to help inform and guide school best practice in relation to inclusion and support in schools and to challenge schools if practice is below expected standards. Streams of work were underway at the year end to develop alternative curriculum options and support for safeguarding processes in schools, which will be reported in our next annual report.

5.3 Training and Development

Working Together requires LSCB to monitor and evaluate the effectiveness of training. Like most other Boards, BSCB also chooses to deliver its own training as a means of ensuring the availability of good quality, multi-agency training. Our approach to training and development is set out in our Training Strategy 2016-19 and underpinned by our operating framework, both of which were agreed in the reporting period. BSCB delivers a shared training programme with BSAB which enables us to provide courses that cover the full safeguarding spectrum to the adults' and children's workforces, while also maintaining a number of child specific courses.

During 2016-17 we delivered training to 1,648 practitioners (this omits attendance at courses with solely safeguarding adults content). This represents an 18.6% increase on attendance in 2015-16, with the primary increase in attendance coming from Blackpool Council employees, most notably from Children's Social Care. Having challenged Children's Social Care in this respect for a number of years, this is a welcome response. This increase demand has allowed us to run additional courses in some topics and has been sustained over the initial months of the new business year. BSCB training is made freely available, although a charge is levied in respect of participants who fail to attend without prior notification. Paradoxically, an increase in overall attendance (and therefore bookings) increases of income in this respect, which is re-invested to fund external trainers and conferences. The non-attendance rate runs at around 8%, with Blackpool Council and the third sector attendees significantly over this average. Of greater concern is that 22% participants cancel prior to the day of

training, this carries an additional administrative workload for the Board and wastes spaces that we are not always able to fill at short notice.



Courses are delivered by practitioners and trainers drawn from across the partnership, together with the Boards' training co-ordinators. The latter resource has been increased from one to 1.6 full time equivalent for 2017-18 which should allow us to meet the increased demand and develop courses to meet emerging needs. A small number of courses continue to be externally sourced, at a cost, where we do not possess the expertise to deliver the training ourselves. The training programme itself is continually reviewed in light of changing practice expectations and learning from reviews, for example, leading to an increased focus on disguised compliance. New courses have been introduced during the reporting period for Designated Safeguarding Leads in educational settings and in safeguarding children with additional needs, with courses in child sexual abuse and harmful sexual behaviour in development at the year end.

Participants in courses continue to provide on the day evaluation with following comments having been received in the course of the reporting period:

"Excellent training, very informative and current. I've learnt a lot"

"Different teaching techniques, 'interactive', kept me interested and concentrating. For someone like me who has little attention span in a classroom that has kept me engaged throughout, brilliant thanks"

"Great credit to our area with the excellent knowledge. Gives me hope we will improve this area and its families, with the range of knowledge and support there is"

While a participants' on the day experience of a training course is a valid measure of its success, our Training Subgroup has worked to understand the longer term impact of training on professional practice and ultimately on the lives of children in Blackpool. A half-day development meeting on the topic led to the agreement of an evaluation process in which attendees would be contacted a number of weeks after a course to ascertain changes made as a result of attendance. Our initial findings from this have been that our training does improve confidence and knowledge of subjects, but we have identified less evidence of direct changes to practice. It is recognised that our work in this respect is at an early stage and we will use our increased training co-ordinator resource to develop this area.

BSCB also seeks to evaluate the training needs of the multi-agency workforce and the effectiveness of single agency safeguarding training. Section 11 audit returns (see Chapter 7 below) are scrutinised for assurance in respect of the proportion of staff in each organisation receiving safeguarding training, while a specific exercise was undertaken in respect of CSE training early in the reporting period and Prevent training immediately prior to the year end. All agencies could provide evidence of the percentage of staff who had received safeguarding training appropriate to their level (which had not been the case the previous year) and all either met the guidelines for their sector or had plans to remedy a reported shortfall. Having obtained this assurance, a review of training materials used by agencies for internal safeguarding training courses was undertaken. This identified evidence that agencies were covering the expected range of topics, but did suggest the need for a common Blackpool 'message' to be delivered to staff to both ensure standards of practice and understanding of local systems. BSCB will therefore develop a set of slides for incorporation into single-agency safeguarding training that will be made available in the forthcoming year.

5.4 Policies and Procedures

Clear and comprehensive policies are the foundation of effective multi-agency work to safeguard children. BSCB, in conjunction with its pan-Lancashire colleagues, provides a comprehensive suite of safeguarding policies and procedures that are available to all practitioners online. The website host provides data in respect of the use of the site (during the five month period from September 2016 to January 2017 17,000 individual users visited the site) and all audits and reviews consider whether practice has been in accordance with agreed multi-agency policy.

During the reporting period policies have been updated to reflect changing national guidance (for example, the new CSE definition), learning from SCR (the pre-birth protocol) and to provide further clarity and consistency (injuries to non-mobile infants). On occasion more fundamental changes are required which has been the case with the Concerns Resolution Protocol. A number of reviews and audits had identified situations in which practitioners should have escalated concerns about decision making in other agencies and had failed to do so. Feedback from practitioners directly involved and from our own Shadow Board suggested that they were not aware of the existing protocol. This has subsequently been revised as the Resolving Professional Disagreements Protocol and includes a means of monitoring its use. The revised policy was launched after the end of the reporting period, consequently its use will be reported on in our next annual report.

5.5 How we deal with allegations against staff

In January 2017 following a review of the Safeguarding and Quality Review Service within Children's Services the Local Authority Designated Officer (LADO) role was joined with the Adult Services Designated Adult Safeguarding Manager (DASM) role. Both of these statutory functions are now overseen and delivered by one officer of the Local Authority. There is a high degree of equivalence between these two duties and guidance in both the Working Together refresh 2015 and the Care and Support Guidance (2016) to the Care Act talk to the same essential criteria for consideration of a referral to a Designated individual. Moreover both sets of guidance state; *there should be clear policies in line with those from the LSCB/SAB for dealing with allegations against people who work with children, in either a paid or unpaid capacity.*

Blackpool Council has chosen to title this new integrated role the Designated Safeguarding Manager (Allegations) for Children and Adults at Risk. Colloquially the post is still referred to as the LADO.

There are presently two sets of guidance for the these two functions, although it is intended to integrate the guidance and procedures documents in accordance with an agreed framework ratified by both Boards and in a way that continues the pan-Lancashire approach.

The Designated Safeguarding Manager (DSM) continues to operationalise the BSCB Procedure for Managing Allegations Against Persons Who Work with Children. These procedures were last reviewed in January 2014 and the post holder will be requesting in October 2017 from BSCB a structured review of these procedures takes place in order to achieve the efficiency set out above.

6. Learning and Improvement Framework

Blackpool Safeguarding Children Board is a learning organisation. It therefore seeks to review the work of agencies, both individually and as a partnership, to safeguard and promote the welfare of children. Learning and actions taken as a result of reviews and audits is collated in the Learning and Improvement Framework which allows for the identification of themes and trends that can be utilised to inform further activity.

The approach enables BSCB to investigate, better understand and respond to the safeguarding environment in Blackpool. For example, the audit programme in 2016-17 has included audits in respect of the children of substance misusing parents and children who self-harm that have arisen as a consequence of learning from serious case reviews and data analysis, respectively. The enhanced understanding of the issue that we obtain allows us to disseminate effective practice and take corrective action where issues become apparent.

BSCB promotes good practice through the publication of serious case reviews on its website, the findings of which also inform our wider training programme. We have recognised that we need to do more to promulgate good practice and have published dedicated practitioner briefings in respect of our two most recently completed serious case reviews. This is an area of work that BSCB needs to develop during the forthcoming year.

6.1 Serious case reviews/ Multi-agency learning reviews

LSCB are required to undertake a Serious Case Review (SCR) when abuse or neglect is known or suspected and either a child dies, or is seriously harmed and there is cause for concern as to the way that professionals have worked together to safeguard the child. SCR should establish what happened and why and whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. LSCB are required to publish SCR and their response to the findings.

BSCB, through the case review subgroup, has managed an unprecedented number of SCR since 2013 and while the majority of the reporting period was relatively quieter, the year ended with a significant influx of referrals. During the reporting period BSCB completed the one SCR and two multi-agency learning reviews (MALR) that were in progress at the start of the year. Following challenge from the National Panel our Independent Chair reversed his decision not to undertake an SCR in respect of one referral received during the previous reporting period and this review, which has proved somewhat complex, remains ongoing at the year end. During the reporting period we have considered two referrals, one of which was accepted to meet the criteria for an SCR, which was started shortly after the year end. As of 31st March 2017 a further five referrals were awaiting consideration.

This year BSCB published one SCR:

Child BW

What happened?

Child BW, together with two elder half-siblings, was subject to a child protection plan on the grounds of neglect prior to birth and throughout the three months before their death from natural causes. There had been considerable agency involvement with the family during the sixteen months that they resided in Blackpool, prior to BW's death, with significant concerns noted in respect of the care of the children and the home environment (partially as a consequence of poor quality accommodation, as opposed to the actions of the family). Interventions escalated from early help provided by the half-siblings' school through to a child protection plan and the consideration of legal proceedings to take the children into care. There were periods of engagement and progress, but this was not sustained and there were also times when agencies struggled to contact and engage with the children's mother.

What did it tell us?

The report concluded that the death of Child BW, from natural causes, could not have been predicted or prevented, but that the children's circumstances could have been acted on, and potentially improved, more quickly. There was evidence of a lack of assessment and understanding of parenting capacity and ability to change, which resulted in prolonged inadequate parenting of the children. All professionals should have challenged the mother more consistently and effectively, using prescribed thresholds for neglect, while working to detailed and specific outcomes for the children. More positively, inter-agency communications were noted to be good with the involvement of adult facing agencies particularly noted.

The report made seven recommendations which included embedding the use of standard neglect assessment tools, auditing the recording of outcomes on child protection plans and the management of unborn babies who require safeguarding, updating the multi-agency pre-birth protocol, reviewing the use of the safer sleep assessment tool and updating elements of our training programme to cover issues identified.

What have we done?

Work to roll out and embed the use of a suite of neglect assessment tools had already begun prior to the completion of this report, and is outlined in Chapter 5 above. The report has therefore been used to promote this training and illustrate the need for consistent assessments of neglect by all agencies. The Pre-birth Protocol has been revised in light of this review and an audit of unborn babies subject to child protection plans is scheduled for the summer period, while the training recommendations have been included within relevant courses. Improved recording of outcomes within child protection plans is included as an item within a wider Children's Services improvement plan.

Other reviews and action plans

It was noted in our 2015-16 Annual Report that BSCB, immediately prior to the year end, had taken the decision not to publish the Child BU SCR. This decision was subsequently supported by the

National Panel, although a practitioner briefing summarising the main learning points has been published on our website. An action plan was also delivered in respect of this review, together with two unpublished MALR that were also completed during the year.

Our Case Review subgroup has worked to deliver these action plans together with outstanding items from SCR noted in previous annual reports. These have included the delivery of a marketing campaign in respect of alcohol use and the safe care of children over Christmas that achieved a degree of local prominence and media coverage as a result of posters displayed throughout the town and a Facebook page with a reach of over 85,000 users. We have launched a new Resolving Professional Disagreements Process to encourage agencies to challenge each other's decision making and have developed guidance for schools on the transfer of safeguarding information. References to harmful sexual behaviour, substance misuse and neglect have also been introduced or expanded within our revised thresholds document, the development of which is covered in Chapter 5, above. As a result of reviews our provider of the health visiting service has promoted the need to include fathers in assessments, Lancashire Constabulary are in the process of reviewing how they manage child witnesses and Children's Services have reviewed the use of Section 20 agreements.

It would be fair to say that the completion of a high number of SCR in a short period provides a significant challenge to partner agencies in terms of implementing required actions and it is disappointing to note that a number of actions, specifically in respect of the re-launch of our early help assessment and the roll out of neglect evaluation tools have been delayed beyond their originally envisaged timeframes, although progress in respect of these findings is now becoming evident. In contrast, actions around strategy meetings remain stalled. Issues around attendance and recording of meetings have been evident in reviews for over two years to date and remain present in more recent audits. It is essential that these actions are now addressed with a degree of urgency.

What have our recent SCR told us as a whole?

At the end of the reporting period BSCB had completed seven SCR over a four year period which, taken together, provides a significant amount of learning about safeguarding in Blackpool. That said, the circumstances of the individual reviews are somewhat disparate, as a consequence of which there has been limited commonality in findings, other than in broadest possible sense. The most commonly repeated positive finding is that information sharing and communications between agencies in Blackpool is good, this is in contrast to overviews of SCR nationally and therefore worth emphasising. Other repeated findings have included the need to engage with and include dads in assessments, difficulties associated with transfers between local authority areas, the need for rigorous assessments, accurate recording and the triangulation of information and for children to be stepped down to lower tier services in a safe and planned way. The aggregated finding from our SCR are included in our rolling programme of SCR workshops for practitioners which have been attended by 131 practitioners during the reporting period.

6.2 Child Death Overview Panel and Sudden Unexpected Deaths in Childhood Rapid Response

The Child Death Overview Panel (CDOP) is a subgroup of the three pan-Lancashire LSCB and undertakes the Boards' statutory functions in relation to child deaths.

By its very nature the death of a child is very distressing for parents, siblings, carers and professionals involved with the family. CDOP carries out a systematic review of all child deaths to help understand why children die and reduce the risk of future deaths in similar circumstances. By identifying modifiable factors, the panel can recommend measures to help improve child safety and prevent future deaths. Broader findings can be used to inform strategic planning and the commissioning of services. By sharing the findings throughout Lancashire there is a greater ability to identify themes and trends.

Within Blackpool there were 14 child deaths during the reporting period and CDOP reviewed 11 (a CDOP review occurs after all other legal and review processes are exhausted, as a result of which the number of reviews will always differ from the number of deaths).

Of the 11 deaths reviewed:

- 6 (55%) were deemed to have modifiable factors (circumstances that, if changed, would reduce the risk of future child deaths)
- 6 (55%) were expected (predictable 24 hours prior to death)
- 9 (82%) were aged under one year
- 8 (73%) were recorded as perinatal/ neonatal events
- 11 (100%) were male

During the reporting period findings from reviews of individual or groups of cases have resulted in briefings being provided to medical professionals, public awareness raising of sources of support available for children when they receive exam results and requests being made to service providers and coroners about specific ways of working.

The weakness of data derived from CDOP is that the number of deaths considered (even pan-Lancashire only 97 were considered in year) is statistically insignificant. Consequently, while the review of an individual case may cast a light on risk factors or service provision, extreme caution has to be utilised in the drawing of general conclusions. An example of this would be the fact that all Blackpool deaths reviewed this year were male, whereas longer term local and national data would indicate only a very slightly higher number of male deaths. Nevertheless, all areas within England are required to have a CDOP process and it is possible to aggregate learning from a wider area. A review of CDOP findings from the Cheshire, Merseyside, Greater Manchester and Lancashire areas in 2014-15 was completed during the reporting period. This provides a population base of approximately 1.3 million children and identified that:

- More than half of the deaths reviewed occurred in children under the age of one
- While 25% of north west children live in the most deprived quintile (nationally), 65% of deaths are of children in this quintile
- Key modifiable factors are parental smoking, barriers/ delays to healthcare, parental drug or alcohol use and co-sleeping
- The majority of deaths are classified as either perinatal/ neonatal events (35%) or chromosomal, genetic and congenital abnormalities (25%)

This wider approach has been used to develop a regional action plan to reduce infant mortality, the local elements of which are monitored by BSCB.

Safer Sleep campaign

CDOP has a well-established safer sleep campaign that has previously been recognised by NICE as an example of effective practice. There nevertheless continues to be an ongoing number of deaths that fall within the sudden unexpected deaths of infants category or in which sleeping arrangements were considered to be a factor. More locally, two recent SCR (Child BV and Child BW) have both involved the deaths of children in unsuitable sleeping environments. In these cases, both families confirmed that they received safer sleep advice which they were able to recall. CDOP consequently commissioned a review of deaths within this category between 2013 and 2015, which examined 22 cases. Many of the findings coincided with national research into this subject, for example in respect of deprivation and slightly more boys dying than girls. Of the six modifiable factors targeted by the safer sleep campaign two or more were present in 21 of the cases, which would suggest that the campaign remains relevant. However, of the 22 cases there was only evidence of the safer sleep material being discussed in 14. It has therefore been agreed that the safer sleep campaign will continue to be funded and providers continue to commit to ensuring that its messages are provided to prospective and new parents. In order to address concerns from the Blackpool SCR and other pan-Lancashire child death reviews that safer sleep advice is being provided but not followed, a home safety assessment tool that includes sleeping arrangements has also been developed. It is acknowledged that more work is required to promote its use by all agencies that visit families with babies.

Sudden Unexpected Deaths in Childhood (SUDC)

Working Together requires that LSCBs ensure that a multi-agency rapid response process is in place to review the circumstances of any unexpected death of a child. Multi-agency colleagues work together to share information to ensure a thorough investigation (of whatever type is required), that the bereavement needs of the family are met and that lessons are learned from the death, where possible. The pan-Lancashire SUDC service is led by two dedicated nurses (outside office hours initial co-ordination is provided by Lancashire Constabulary), in conjunction with a range of multi-agency partners, including children's services, acute hospital trusts and North West Ambulance Service.

An external review of the SUDC service was undertaken, during the reporting period, by a Public Health registrar. The aim of the review was to assess conformance with Working Together and the strengths and weaknesses of the current model. The review concluded that the nurse led response within working hours generally ran smoothly and was in broad conformity with the expectations of Working Together, however the out of hours response, which disproportionately relied on the on-call acute paediatrician was not of a sufficient quality. The quality of initial response was assessed as being critical due to the influence that it has on the ensuing process. While the demand on the service in terms of the timing of deaths fluctuates, as many as two thirds in a given period can occur outside office hours and therefore receive a lower standard response. The conclusions of the have been endorsed by the three pan-Lancashire LSCB and currently being reviewed by the CCG responsible for the commissioning of the service.

A more full analysis of the work of CDOP can be found in its annual report that is available on the BSCB website.

6.3 Audit activity

When a specific issue is identified by a review or data analysis and it is agreed that further information is needed to fully understand its implications, BSCB will undertake an audit of practice to inform its next steps.

The Multi-Agency Audit Group (MAAG) has completed four audits during the reporting period which have assessed the safeguarding of children of substance misusing parents, children who self-harm, children living in households with domestic abuse and children subject to child protection plans for neglect. Additionally, two audits of multi-agency work with children at risk of CSE were carried out by the CSE subgroup. MAAG activity during the second half of the year was dominated by the need to ensure that the BSCB partnership was able to meet the expectations of a Joint Targeted Area Inspection, which would expect the partnership to be able to provide an evaluation of multi-agency work in five to seven cases within five working days. We are now confident that we have the processes in place to enable this, however this focus has delayed projected audits into unborn babies subject to child protection plans and child sexual abuse. In order to secure more consistent audit results and to measure progress on a series of issues over time, for example core group meetings, recording of the views of children, we have adopted a standard audit tool that is adapted for each particular topic. We additionally aim to focus our audits the outcomes of practice for the children involved.

The findings of our individual audits and implications for particular areas of practice have been noted throughout this report, however the year's audits have also cast light on a number of issues that have been present irrespective of the focus of the audit (similar issues have also emerged in an SCR underway at the year-end). A number of these can be grouped under a heading of compliance in that there has been evidence that attendance at and recording of strategy meetings and core groups is not as expected and that expected actions on child protection plans are simply not completed. Risk tends to be recognised but is not always acted on. The combined effect of these issues is a tendency for cases to drift, which was particularly evident in the neglect audit. During audits we have struggled to identify the outcomes of interventions and this is a challenge for partner agencies to demonstrate that their interventions have an impact on the children and families that they work with. More positively, we have identified improved recording of the voice of the child in agency records during the course of the year. These combined audit findings clearly present a challenge to the partnership and to each agency individually. In order to promote compliance with expected standards as a partnership BSCB will develop a safeguarding standards document which will serve as a guide to practitioners and a means by which agencies can be held to account and challenged for their actions.

The Performance Management and Evaluation Group (PMEG) also undertake deep dive audits into services provided by individual agencies in which managers are invited to provide an overview of their work and how they meet their safeguarding responsibilities. During the reporting period we

have undertaken audits into the Child and Adolescent Self-Harm Enhanced Response service (CASHER), North West Ambulance Service (NWAS), the Youth Offending Team and Blackpool Teaching Hospitals' work to reduce still births and maternal deaths. Some audits (CASHER and NWAS) serve to provide assurance that issues identified are being appropriately addressed and, in the case of CASHER, has allowed BSCB to help publicise this issue with schools. Others can lead to action, for example BSCB sought a response from the Director of Children's Services to issues raised around the housing of 16-17 year old young offenders. During an earlier deep dive audit of adult substance misuse services PMEG identified significant issues in terms of the transfer of safeguarding (and other treatment) information on a transfer of provider. Commissioners subsequently provided assurances as to how future transfers would be managed and this will be tested later this year in a repeat audit following a further transfer of provider.

6.4 Section 11 audits

Section 11(4) of the Children Act 2004 requires every LSCB partner to have arrangements in place to ensure that "their functions are discharged having regard to the need to safeguard and promote the welfare of children". LSCB partners are therefore asked to complete annual Section 11 audits to self-evaluate their compliance with this duty, these are subsequently scrutinised by PMEG and partners are held to account for the completion of any required improvements.

During the reporting period returns were received from all expected agencies, although Blackpool Council will again be challenged in 2017 to provide an audit for the entire Council's activities, as opposed to just Children's Services. The audit is split into nine sections against which each agency is asked to rate itself. There has been an increasing trend for agencies to rate themselves as 'green', or fully compliant, which continued this year. While noting some inconsistencies in ratings, for example in terms of the percentage of staff required to be trained at any given level, between agencies, PMEG was happy to accept the self-evaluations as evidence of improving compliance with Section 11 duties.

Scrutiny activities vary year to year and on this occasion agencies were asked to provide further evidence in respect of staff supervision, which had been highlighted as an issue in recent SCR and was assessed to be a weaker overall area in the self-evaluations. All agencies were able to provide evidence of supervision policies (although some did not make explicit reference to safeguarding) and could evidence supervision taking place on individual cases. Some were able to provide evidence of staff surveys in which practitioners confirmed that they received supervision and whether they found it useful. However, none could provide systematic data in respect of supervision either in terms of the proportion of staff receiving supervision in accordance with policy expectations or the proportion of cases in which the responsible staff member had received supervision.

Every Section 11 audit process provides a mix of actions which agencies are asked to remedy immediately, others which will be reviewed in the following year's returns and one that lead to further scrutiny. On this occasion we accepted that required numbers of staff were receiving single-agency safeguarding training, but asked the training subgroup to review the quality of this, the outcomes of which are noted in Chapter 6 above.

As a consequence of the majority of our partner agencies having a wider geographical footprint than just Blackpool, Section 11 audits are requested in conjunction with our pan-Lancashire colleagues. During the reporting period we held a 'Challenge Event', together with our colleagues in Lancashire LSCB, for the National Probation Service in which their audit return was subject to further scrutiny. This provided a means by which they could raise issues with partnership working, most notably in terms of attendance at MAPPA meetings, and be challenged as to their own safeguarding practices.

6.5 Dataset

Working Together requires that the Local Authority and partner agencies provide the LSCB with data and performance information to allow it to assess the effectiveness of services to safeguard and promote the welfare of children.

BSCB has adopted a dataset based on a model developed by Greater Manchester LSCBs that is used more widely across the region. The dataset contains a suite of indicators that is structured around the overall child population, children with specific vulnerabilities, those at each stage of the safeguarding system and the children's workforce. The dataset is produced on a quarterly basis and monitored by the Performance Management and Evaluation Group, with the full report being submitted to the strategic Board on a six monthly basis.

In addition to enabling us to understand and assess the effectiveness of safeguarding activity in Blackpool, as summarised in Chapter 4 above, we are able to identify and challenge agencies about specific subjects. An ongoing area of inquiry has been the placing of Looked after Children within Blackpool by other local authorities. As a result of this challenge data collection has been reviewed and tightened (resulting in a drop in the number of children reported) and we have identified that there are no unexpected concerns in respect of which local authorities are placing children in Blackpool. We have also gained the additional context of understanding that Blackpool places more looked after children outside the local authority area than other authorities place within, although this is partially explained by many of our foster carers living just beyond the Blackpool boundary.

BSCB has not made the progress that it would have wanted in terms of obtaining data and meaningful analysis. This has already been noted in terms of CSE and Early Help data, while the more in depth Part B of the Greater Manchester dataset has yet to be started. It was noted in our last annual report that the partnership had agreed funding for a half-time analyst post, however he only took up post in February 2017. It is therefore anticipated that our next annual report will evidence greater progress in this respect.

6.6 Inspections of our partner agencies

The majority of BSCB partner agencies are subject to inspection regimes and as part of its remit to ensure that safeguarding provision is effective, BSCB will review reports where concerns are raised in respect of safeguarding practices. As a result of this scrutiny BSCB may request an update as to changes made as a result of the inspection or may offer to provide more in-depth support to enable an agency to improve its practice.

During the reporting period we have reviewed inspection reports in respect of the Grange Park Health Centre, in which significant safety concerns were noted, but which has been assessed as having made the required improvements and received a 'good' grading on re-inspection. We have also received reports in respect of North West Ambulance Service, Lancashire Care NHS Foundation Trust and the Lancashire Constabulary custody suites, all of which noted improvements required in terms of safeguarding and in respect of which monitoring was ongoing at the year end. More positively, one of the two schools noted to have received inadequate inspections in our last annual report, South Shore Academy, has come out of special measures, while Highfield Humanities College has re-opened as an academy. While overall school inspection reports in Blackpool continue to demonstrate room for improvement, it is notable that in the last year there have been no specific criticisms of safeguarding practices in inspection reports.

7. Conclusions

On coming to the end of a report of this nature, it is important to step back from the detail and focus on the overall purpose of an LSCB annual report. It is to "provide a rigorous and transparent assessment of the performance and effectiveness of local services… [to] identify areas of weakness, the causes of those weaknesses and the action being taken to address them". This report has sought to meet those requirements.

The report demonstrates that agencies in Blackpool continue to identify and respond to significant numbers of children who require safeguarding and that, by and large, risk factors are appropriately identified and responded to. There continues to be a trend of increasing numbers of children, well in excess of national comparators, at all stages of the safeguarding system and our understanding of this, not least in terms of data in respect of early help provision needs to improve. Potential strains in the system are becoming evident in the findings of multi-agency audits in which compliance with processes and achievement of positive outcomes is not what we would expect. At the time of writing Children's Services are developing a single-agency plan to address this issue, while BSCB will develop a set of expectations for all partner agencies.

There continues to be evidence of a strong partnership response to CSE, underpinned by a refreshed strategy and action plan agreed during the reporting period, and an evolving response to children missing from home. Both are supported by multi-agency meeting processes in which information is shared and risks responded to. Considerable focus on domestic abuse has resulted in the development of new services to plug identified gaps in provision, with a comprehensive action plan in development at the year end. Work to provide practitioners with the means to consistently identify and assess neglect has resulted in the roll out of a standard suite of assessment tools, although more work is required to embed this in practice. We are less able to draw conclusions about the effectiveness of early help provision, due to the lack of robust data in this respect, while work to implement a revised thresholds document that will promote the provision of multi-agency early help has been delayed beyond anticipated timeframes.

It can be concluded that BSCB meets its own statutory requirements in terms of membership and has been able to assure itself that its members are, by and large, compliant with their Section 11 and Section 175 duties. Audit and review work has continued to shed light on the effectiveness of safeguarding systems in Blackpool, however delivering change as a result of this activity remains a challenge. It has been acknowledged throughout this report that our use of data is not where we would want it to be and is a critical area for improvement in the forthcoming year.

The development of the Pupil Voice group raises an interesting challenge for the Board. While we are clear about our priorities, these by and large concern the improvement of services for the 5% of children at the highest risk of harm. These are not the same things that concern the general child population of Blackpool, which tend to be more practical issues of safety around roads, on public transport and in the town centre. There is some convergence, for example around online safeguarding, but it is clear that that the issues that occupy BSCB are not the everyday concerns of the majority of the child population. This tension clearly cannot be eradicated, however it is a challenge that BSCB should consider during the forthcoming year.

8. Afterword

8.1 Challenges for 2017-18

The work of BSCB constantly evolves as new issues emerge, or existing one assume greater importance. This may be the result of us realising that we have insufficient information on an issue due to the findings of audits and reviews, or as a result of changing national priorities. During the reporting period we have identified a need to improve our understanding of work to identify and support young carers and to be assured that children with disabilities are safeguarded. The changing inspection regime has also necessitated our increasing focus on domestic abuse, neglect and intra-familial sexual abuse.

Our partner agencies continue to report that their greatest operational strain is the number of children who require intervention in Blackpool. While some are able to respond by increasing resources in specific teams, for example Lancashire Constabulary have increased their Public Protection Unit staffing, this does require a longer term response which emphasises the importance of effective early help provision to prevent the need for crisis intervention. This challenge should also prompt different ways of thinking about safeguarding and it may be that an increased emphasis is placed on enabling a child to live safely in their family home, rather than accommodating them elsewhere.

The Children and Social Work Bill was enacted shortly after the conclusion of the reporting period and provides some welcome elements, for example the compulsory provision of PSHE lessons. Other elements like the extension of a statutory duty to care leaves to the age of 25 and the accreditation of social workers will require significant changes that will be worked through in forthcoming months. The Act also provides for the replacement of LSCB with local arrangements determined by local authority, health and police partners. Detail in this respect is scarce and it is the duty of BSCB, as currently constituted, to ensure that projected changes to strategic structures should not deflect from the need for effective operational responses in the meantime.

8.2 Business plan 2017-19

BSCB adopted a new two year business plan, formulated during a joint development day with BSAB colleagues, shortly before the year end. This is available on our website and seeks to address issues identified in the preceding report. It therefore has sections in respect of developing our understanding of safeguarding needs in Blackpool (primarily through dataset development), early help, children with specific needs (school age children, older children, children with disabilities, young carers and looked after children), addressing specific risk factors (CSE and MFH, neglect, domestic abuse and substance misuse) and BSCB's own organisational development.

9. Appendices

Strategic Board members at the time of publication

Name	Title	Agency
David Sanders	Independent Chair	
Jenny Briscoe	Lay Member	
Gillian Fennell	Lay Member	
Cllr Graham Cain	Elected Member	Blackpool Council
Diane Booth	Director of Children's Services	Blackpool Council
Dr Arif Rajpura	Director of Public Health	Blackpool Council
Tony Morrissey	Interim Head of Safeguarding and Principal Social Worker	Blackpool Council
Moya Foster	Senior Service Manager (Early Help)	Blackpool Council
Andrew Lowe	YOT Service Manager	Blackpool Council
Kate Barker	Lead Early Years Consultant	Blackpool Council
Paul Turner	Schools' Safeguarding Advisor	Blackpool Council
John Hawkin	Head of Leisure and Catering Services	Blackpool Council
Claire Grant	Divisional Commissioning Manager	Blackpool Council
Lesley Anderson-Hadley	Chief Nurse	Blackpool Clinical Commissioning Group
Cathie Turner	Designated Nurse	Blackpool Clinical Commissioning Group
Dr Sujata Singh	GP Representative	Blackpool Clinical Commissioning Group
Marie Thompson	Director of Nursing	Blackpool Teaching Hospitals NHS Foundation Trust
Hazel Gregory	Head of Safeguarding	Blackpool Teaching Hospitals NHS Foundation Trust
Dr Rob Wheatley	Designated Doctor	Blackpool Teaching Hospitals NHS Foundation Trust
Bridgett Welch	Associate Director of Nursing	Lancashire Care NHS Foundation Trust
Alison Cole	Deputy Director of Nursing	NHS England
David Rigby	Sector Manager	NW Ambulance Service
Elaine Allen	Headteacher	St John Vianney's RC Primary School
Cara Vaughan	Deputy Principal	Waterloo Primary Academy
Jane Bailey	Principal	South Shore Academy
Rosie Sycamore	Headteacher	Highfurlong Special School
Wendy Casson	Headteacher	Educational Diversity
Mark Fell	Director 14-19	Blackpool and the Fylde College
Nikki Evans	Superintendent	Lancashire Constabulary
John Donnellon	Chief Executive	Blackpool Coastal Housing
Jackie Couldridge	Service Manager	CAFCASS
Sonia Turner	Head of North West Lancashire	HM Prison and Probation Service
Louise Fisher	Deputy Director	Cumbria and Lancashire CRC

Amanda Quirke	Senior Service Manager	NSPCC
Jed Sullivan	Third Sector representative	

Glossary of acronyms

BMG	Business Management Group
BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
BTH	Blackpool Teaching Hospitals
CAFCASS	Children and Family Court Advisory and Support Service
CASHER	Child and Adolescent Self-Harm Enhanced Response service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CPN	Community Protection Notice
CPW	Community Protection Warning
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CSP	Community Safety Partnership
DAIV PB	Domestic Abuse and Interpersonal Violence Partnership Board
FGM	Female Genital Mutilation
FIN	Families In Need
GCP2	Graded Care Profile 2
GIR	Getting It Right
HWBB	Health and Wellbeing Board
JTAI	Joint Targeted Area Inspection
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAAG	Multi-Agency Audit Group
MACSE	Multi-Agency Child Sexual Exploitation
MALR	Multi-Agency Learning Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MFH	Missing From Home
NICE	National Institute for Clinical Excellence
NWAS	North West Ambulance Service
PMEG	Performance Management and Evaluation Group
PSHE	Personal, Social, Health and Economic (education)
PVP	Protecting Vulnerable People
SCR	Serious Case Review
SUDC	Sudden Unexpected Deaths in Childhood
WRAP	Workshop to Raise Awareness of Prevent
YOT	Youth Offending Team