BLACKPOOL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2017–2018

BLACKPOOL SAFEGUARDING CHILDREN BOARD

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FOREWORD FROM THE INDEPENDENT CHAIR

I am pleased to present the Blackpool Safeguarding Children Board (BSCB) Annual Report for the reporting year 2017-18.

This has been a year of change for BSCB, starting with the retirement of the Independent Chair David Sanders at the end of October 2017 and my appointment to replace him with effect from 1st November. I would like to take this opportunity to thank David, on behalf of all BSCB partners, for his valuable contribution to the work of the Board.

In the latter half of the year a review of the subgroups was undertaken in order to rationalise the work and enable partner contributions to become more proportionate by reducing their time commitment. The subgroups were reduced from ten to four, without losing any of the key work undertaken.

Attendance has remained problematic for some BSCB partners, particularly in relation to the subgroups where the LSCB's strategic aims and work programme are progressed. I am hopeful that the reduction in subgroups and attendance demands on time will enable improved attendance to be reported in our next annual report.

2017-18 has been another year of progress for BSCB. All key priority areas have been advanced alongside all other areas of regular business. The BSCB has responded effectively to all new local and national challenges. Another successful training programme has been delivered and evaluated. The Board has responded appropriately to all serious incidents and lessons have been identified.

This report gives a clear reflection of the totality of the work undertaken by BSCB in the 2017-18 period and the multi-agency working to safeguard children is brought to life in the practice examples outlined in the report.

As we move into another challenging year and another year of great change for the Board, I would like to thank all colleagues for their contribution to another good year and their continued commitment to keeping children in Blackpool safe.

Nancy Palmer
Independent Chair
Blackpool Safeguarding Children Board

Executive summary

This is the statutory annual report of Blackpool Safeguarding Children Board (BSCB) in which we are required to review our work in 2017-18 and 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 arrangements and how we plan our business. This has been a year of change with a new Independent Chair coming into role and BSCB members agreeing to a new governance structure and business plan.

An understanding of **Blackpool: the place and its people** 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 that mean that nearly a third of our children will grow up in poverty. The population of Blackpool does however, enjoy good access to housing and services.

An understanding of **Safeguarding in Blackpool: need, demand, pressure and performance** gives some course for optimism in that the number of children in need of help and protection declined during the latter months of the reporting period. This has been due to a concerted effort by the Children's Improvement Board to understand and manage demand at each stage of the system. The need for ongoing effort in this respect is underscored by a rate of children, at each stage of the safeguarding system, considerably in excess of national and statistical neighbour comparators.

Having considered the system as a whole, the report continues to review **How we are doing as a partnership** in respect of some key priority areas. During the reporting period BSCB re-launched its thresholds document and agreed a pan-Lancashire continuum of need, which provide the framework for the partnership's response to children who require early help and protection. A significant number of practitioner briefings were delivered as part of the launch, with the processes now forming an integral part of our ongoing training programme. While we have reviewed the use of the new assessment and referral forms as part of an audit, the need for more robust data in respect of the number of children receiving early help is acknowledged. The partnership response to children at risk of child sexual exploitation and of going missing from home or care is reviewed, with a particular reference to awareness raising activity and our work to develop our understanding of the effectiveness of the partnership response and the experiences of children.

BSCB had agreed a neglect strategy prior to the start of the year and has continued to offer training in respect of neglect assessment tools. We have sought to measure the use of these during the year and continue to work to embed a consistent and robust approach to neglect. Finally, considerable progress is noted in the development of the partnership response to domestic abuse, including our being part of the first county to achieve white-ribbon accreditation to promote our work to end violence against women and girls.

We also highlight the work of our partner agencies on an individual basis in reviewing **Our partner's activities**. This includes new models of delivery from a Children's Centre, an enhanced health visiting offer and the ongoing development of the Better Start programme through which the Baby Steps programme is now offered to all new parents in Blackpool.

The **Learning and Improvement Framework** is central to the work of the Board as the means by which we collate all our review and audit work. While we have not published any new serious case reviews during the reporting period, we have made good progress to deliver actions from previous published reviews, including through improved practices in strategy meetings and child protection planning. Our audit programme has similarly driven changes to pre-birth child protection processes and resulted in the commissioning of intra-familial child sexual abuse training. Our training programme continues to be in high demand, with more practitioners trained this year than in any beforehand. This is supported by work to better understand the effectiveness of our training in making changes to practice and the lives of children in Blackpool.

Finally, we review **Participation** work in which we seek to understand the experiences of children growing up in Blackpool. Our Pupil Voice Group reached a natural conclusion at the start of the year, however this was not before the views of the children involved, including where they did and did not feel safe, were reported to the appropriate forums. We will seek to re-establish this area of work in forthcoming months and use this to complement the work of our Multi-Professional Discussion Forums in which we explore the experiences of frontline practitioners in Blackpool.

WHO WE ARE AND WHAT WE DO

What is an LSCB?

A 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 upper-tier 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, the Regulations set out the functions of LSCB as being:

- Developing policies and procedures for safeguarding and promoting the welfare of children in the area;
- Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
- Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- Participating in the planning of services for children in the area of the authority; and
- Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

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.

The Children and Social Work Act 2017 received Royal Assent in April 2017. The Act replaces LSCBs with Safeguarding Partnerships that are the joint responsibility of the local authority, clinical commissioning group and chief officer of police for the area. Following the publication of the revised version of Working Together to Safeguard Children in the summer of 2018, the safeguarding partners have been given until the 29th June 2019 to publish their plans for future multi-agency safeguarding arrangements, with an expectation that they will be implemented within three months of publication. Blackpool Safeguarding Children Board (BSCB) has actively engaged in consultations in respect of the new arrangements and has supported the safeguarding partners to begin to explore successor arrangements for Blackpool.

Who are we?

BSCB comprises of a range of partner agencies (full membership is detailed in appendix A), all of whom have a statutory responsibility to safeguard and promote the welfare of children in Blackpool. They are all committed to the effective operation of BSCB.

A number of our partner agencies have a statutory responsibility to sit on BSCB (for example the local authority, police, health organisations, probation and Cafcass), while others have been invited to do so due to the significance of their work in Blackpool (for example Blackpool Coastal Housing and NSPCC). While there were a number of in year changes in schools' representation on the Strategic Board, 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 to provide an external perspective, by which impartial challenge can be brought to any member agency. Our Chair of three years, David Sanders' term of office ended in October 2017 and the role was assumed by Nancy Palmer. Nancy has considerable experience of this role in other local authority areas and is currently also the Chair of Blackburn with Darwen LSCB. She promotes the work of BSCB through regular attendance at other strategic boards and through regular 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 hold agencies to account. Both BSCB lay members resigned during the reporting period and, given the forthcoming dissolution of the LSCB, a decision was taken not to recruit successors.

Relationships

Nancy Palmer is accountable to Blackpool Council's chief executive, Neil Jack, for the effective functioning of BSCB. In turn, political oversight 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 statutory bodies of the Health and Wellbeing Board, Community Safety Partnership and Blackpool Safeguarding Adults Board (BSAB), of which Nancy Palmer is also chair. In addition, Blackpool Council's multi-agency Children's Improvement Board drives the ongoing development of broader children's services. There is understandably a degree of overlap between the work (and membership) of these boards and their chairs have regular meetings to co-ordinate their work and to avoid duplication. BSCB and BSAB meet on the same day which means that a joint session of the two boards can consider items of mutual interest, when necessary.

The Independent Chair and business manager also regularly participate in meetings with their counterparts from Blackburn with Darwen and Lancashire to ensure that a co-ordinated response is taken to issues that extend beyond Blackpool. This assists our partner agencies, the majority of whom have a geographical footprint that extends beyond Blackpool. A pan-Lancashire Child Death Overview Panel (CDOP) has been in place since 2011, while formal arrangements are in place for the sharing of multi-agency policies and procedures, including, from 2017, a shared continuum of need.

Structure

The work of BSCB is driven by the Strategic Board, which met on a quarterly basis during 2017-18 (this represents a reduction from bi-monthly meetings during previous years). 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 subgroups, some of which are held on a joint basis with BSAB, or with Blackburn with Darwen and Lancashire 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.

Following the appointment of Nancy Palmer and a new Director of Children's Services, Diane Booth, BSCB took the opportunity to review its scope and functioning. It consequently reduced the number of subgroups from eleven to four (albeit with the Multi-Agency Audit Group becoming a subgroup of the Performance Management and Evaluation Group). This has allowed an increased focus on the core business of LSCBs and building its effectiveness in these roles. The work of disbanded subgroups had either reached a natural conclusion, was handed on to other strategic boards or continued within the new structure. The work of the subgroups is referenced throughout this report and a structure chart is included as Appendix B.

Business Planning

During the reporting period BSCB worked to a two year business plan which had been agreed in March 2017. The plan was split into five priority areas:

- Understanding safeguarding needs
- Early help and thresholds of need
- Safeguarding children with specific needs
- Addressing specific risk factors
- BSCB governance and statutory functions.

Progress against the business plan was reviewed at every BMG meeting, with slippages identified and corrective actions agreed. The business plan was always intended to be a dynamic document, with some areas of working being completed in a way that was not originally envisaged and with others assuming greater or lesser degrees of importance. At the end of the reporting period 75% of the original 81 actions due to be completed within the reporting period had been signed off. The bulk of actions not completed related to children with special educational needs and disabilities (SEND) and the delivery of early help.

As previously noted, BSCB took the opportunity to review its structure and the scope of its work during the autumn period. This resulted in a decision to develop a new business plan for 2018-19 (Appendix C) which focuses on the core LSCB functions of the co-ordination of work to safeguard children and holding partner agencies to account for the effectiveness of their work. This represents a stepping back from more operational concerns and has been made possible by a confidence in the Children's Improvement Board to progress work in relation to the front door and early help (see Chapter 4, below), coupled with a recognition that the SEND board can and will report any concerns in respect of safeguarding.

Attendance at Board Meetings

The acceptable minimum attendance rate for the named representative at board and subgroup meetings is 75%. The Independent Chair and subgroup chairs challenge attendance likely to fall below the acceptable rate throughout the year. The attendance of the named representative at Strategic Board and subgroups is recorded below; although on many occasions when the named representative was unable to attend a deputy did so. In order to focus on those statutorily required to attend and for the sake of brevity, agencies that solely attend subgroups have been omitted. The majority of agencies met the acceptable attendance threshold for Strategic Board, and while subgroup attendance was less satisfactory it is envisaged that the rationalisation in the number of subgroups will improve this position.

Agency	Board	BMG	PMEG	CSE	Training
Blackpool Council – Elected Member	100%	n/a	n/a	n/a	n/a
Blackpool Council – Director of Children's Services	75%	n/a	n/a	n/a	n/a
Blackpool Council – Children's Services (other representatives)	100%	100%	100%	100%	40%
Blackpool Council – Early Help	50%	n/a	n/a	n/a	n/a
Blackpool Council – Youth Offending Team	25%	n/a	n/a	n/a	n/a
Blackpool Council – Schools Improvement	100%	25%	20%	n/a	20%
Blackpool Council – Public Health	100%	50%	80%	75%	n/a
Blackpool Council – Leisure, Catering and Illuminations	75%	n/a	n/a	n/a	n/a
Lancashire Constabulary – Western Division	50%	75%	40%	25%	n/a
Lancashire Constabulary – HQ Public Protection Unit	25%	n/a	n/a	75%	60%
Blackpool CCG – Chief Nurse	50%	n/a	n/a	n/a	n/a
Blackpool CCG – Designated Nurse	100%	75%	80%	n/a	60%
Blackpool CCG – Designated Doctor	100%	50%	n/a	n/a	n/a
Blackpool Teaching Hospitals NHS Foundation Trust	75%	50%	40%	75%	60%
Lancashire Care NHS Foundation Trust	75%	n/a	20%	n/a	100%
NHS England	75%	n/a	n/a	n/a	n/a
Cumbria and Lancashire Community Rehabilitation Company	100%	n/a	n/a	75%	20%
HM Prison and Probation Service	75%	50%	n/a	75%	100%
Blackpool Coastal Housing	100%	n/a	60%	n/a	60%
Schools	50%	n/a	n/a	n/a	n/a
NSPCC	75%	n/a	n/a	n/a	n/a
Cafcass	75%	n/a	n/a	n/a	n/a

Budget

Funding for BSCB continues to be provided by a core group of partners, with some income generated through charging for non-attendance at training courses. Increases in contribution from Blackpool Council and Lancashire Constabulary are gratefully acknowledged at a time of financial constraint. The contribution of other resources 'in kind' by the wider partnership is likewise acknowledged and consists of time taken by staff to attend and chair meetings, participation in our pool of trainers and the use of buildings.

Income and Expenditure Summary

Income		Expenditure	
Blackpool Council	104,183	Staff costs	142,425
Blackpool CCG	51,867	Independent Chair	20,709
Lancashire Constabulary	30,975	Training	18,081
Blackpool Coastal Housing	5,000	Board support costs	12,157
Cumbria and Lancashire CRC	2,565	Serious Case Reviews	35,284
HM Prison and Probation Service	1,710		
CAFCASS	550		
Training income	4,049		
	200,899		228,656

Board staffing costs remain the greatest area of expenditure and have remained stable throughout the reporting period. The overspend noted above was anticipated in our last annual report and has primarily arisen due to the number of serious case reviews that we have been required to commission (see Chapter 6). This is also likely to be the case in 2018-19 and will be met out of reserves.

The LSCB team

The work of BSCB is supported by a small business unit, which is merged with that of BSAB to provide additional resilience. The staffing structure and personnel have remained the same throughout the reporting period. 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

BLACKPOOL: THE PLACE AND ITS PEOPLE

Blackpool is a seaside town in the north-west of England. Its population of 139,195 people, living within an area of just under 13.5 square miles, renders it one of the most densely populated areas outside London. Transience is a significant feature of the town, with 6% of the population estimated to have moved out of the area in 2016 and the equivalent of 5.5% having moved in. According to the 2011 census 8% of the population had also moved within the town during the past year.

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 is in the most affluent 20%. The impact of this is that 22% of children live in workless households and 32% in poverty (in a household with an income of less than 60% of the median), compared to 20.1% nationally. The one area within the Indices of Multiple Deprivation in which Blackpool ranks amongst the most favourable in England is Barriers to Housing and Services, and some of the wealth of service provision is reflected throughout this report.

There are approximately 28,605 children aged under 18 resident in Blackpool, making up 20.5% 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, while the child (and overall) population declines. Life expectancy for children born in Blackpool between 2014 and 2016 is estimated to be 74.2 and 79.5 for boys and girls respectively, compared with 79.5 and 83.1 nationally.

Within Blackpool there were 1,873 children in need as of 31st March 2018 (2017: 2,119), equating to 641 per 10,000 of the population (2017: 739). This is considerably in excess of both the national average of 330 and that our statistical neighbours of 512 (2017 figures). Put in different terms, in Blackpool, in every class of 30 children, two will have a social worker.

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 and adulthood. These children will only ever come into contact with universally provided health and education services. When it becomes apparent that extra intervention is needed to keep a child safe and promote their welfare, that decision is based on the pan-Lancashire Continuum of Need, which was introduced in September 2017 (see Chapter 4 below). 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 opportunity.

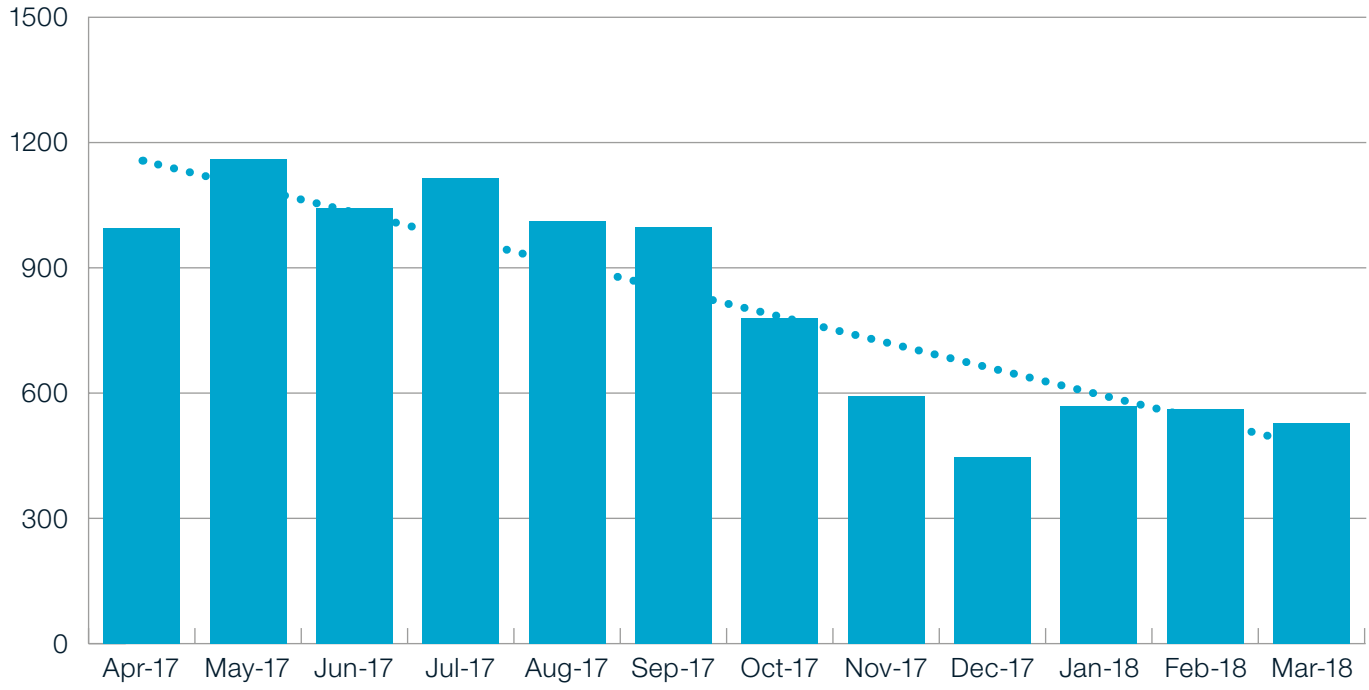
BSCB seeks to monitor activity at each stage of the safeguarding system to assure itself that interventions are effective and that children are kept safe. The overall picture is, and has been for some years, one of considerably more children in the system, at every stage, than would be expected in comparison to national averages and our statistical neighbours (a comparator group of local authorities with similar demographics).

The reporting period has seen a concerted effort led by Children's Services, and supported by the partnership, to change the systems and culture that have fostered the current position. This work has been predicated on the basis that while Blackpool's demographics are such that a higher rate of children might be expected within the safeguarding system than the national average, it is not unique and should not be conspicuously out of line with all other areas. Work has therefore focussed on developing a better understanding of the demand for services and how this can be safely reduced, while keep the best interests of children at heart. By the end of the reporting period there were clear signs of progress, however this is a piece of work that will take a longer period to produce stable and sustainable outcomes.

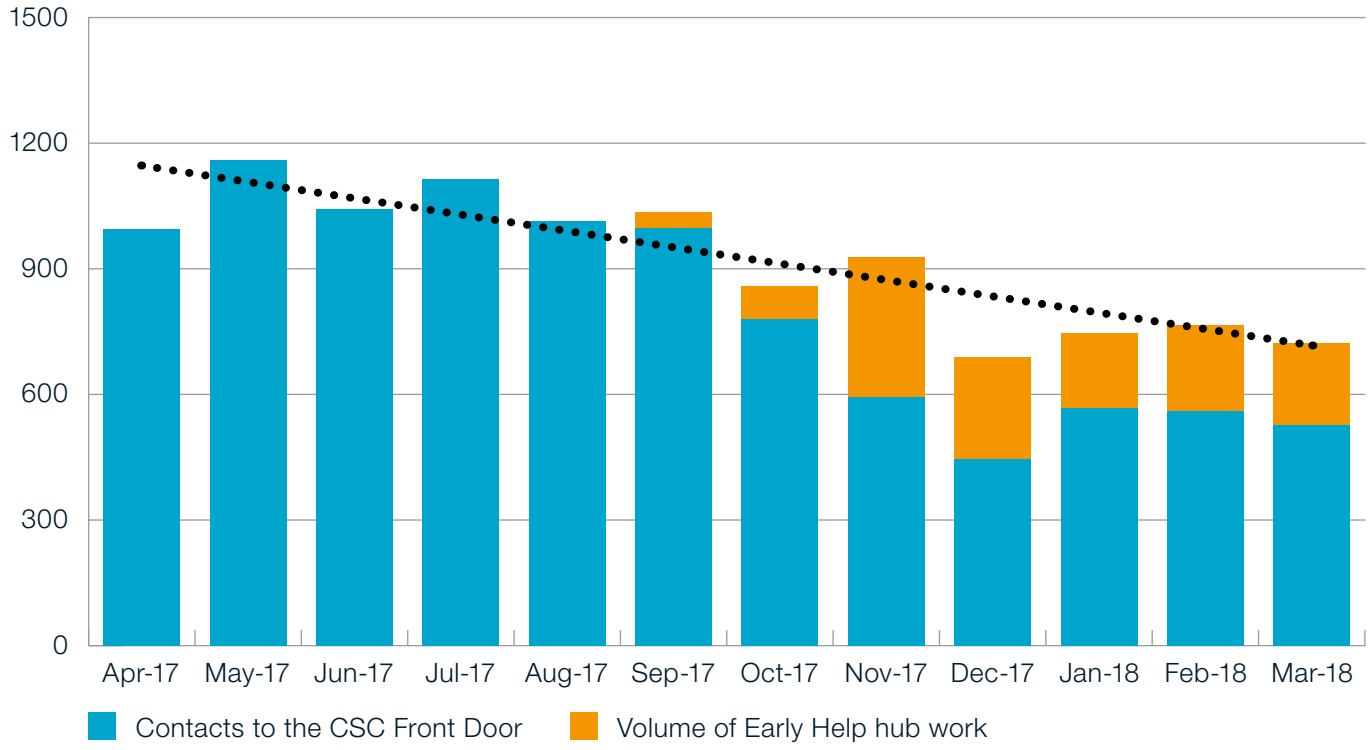
Early Help

Early Help is the level of provision between universal services and statutory intervention under the Children Act. It is expected to be provided by the best-placed professional already involved with the family, in partnership with whichever other agencies are needed to support the family to make the necessary changes. A lack of overall data in respect of early help provision remains a significant gap in our understanding of safeguarding need in Blackpool and consequently the effectiveness of the whole system. Without understanding the numbers of children in this part of the system, the conclusion that high demand for statutory services stems from ineffective early help provision cannot be discounted.

An early outcome of the work to manage and reduce demand was the creation of the Early Help Hub, which receives standard risk Police Protecting Vulnerable People (PVP) referrals and has more recently become a point of support and advice for all agencies delivering early help. Its creation has resulted in a reduction in the number of contacts to the Children's Services Front Door to 9,798 in 2017-18 from 12,519 in 2016-17 (2015-16: 10,115). The annual figure masks a more pronounced monthly reduction though:



However, when the volume of work received by the early help hub is included, it becomes evident that the reduction in the level of demand is more modest:



The introduction of the Early Help Hub has clearly reduced pressure on the Front Door and provided a means by which agencies can receive appropriate support to deliver early help. However, work remains to be done to change the culture of high demand for support. This requires a longer-term approach to empower both families and practitioners to make and sustain changes without the need for higher tier services.

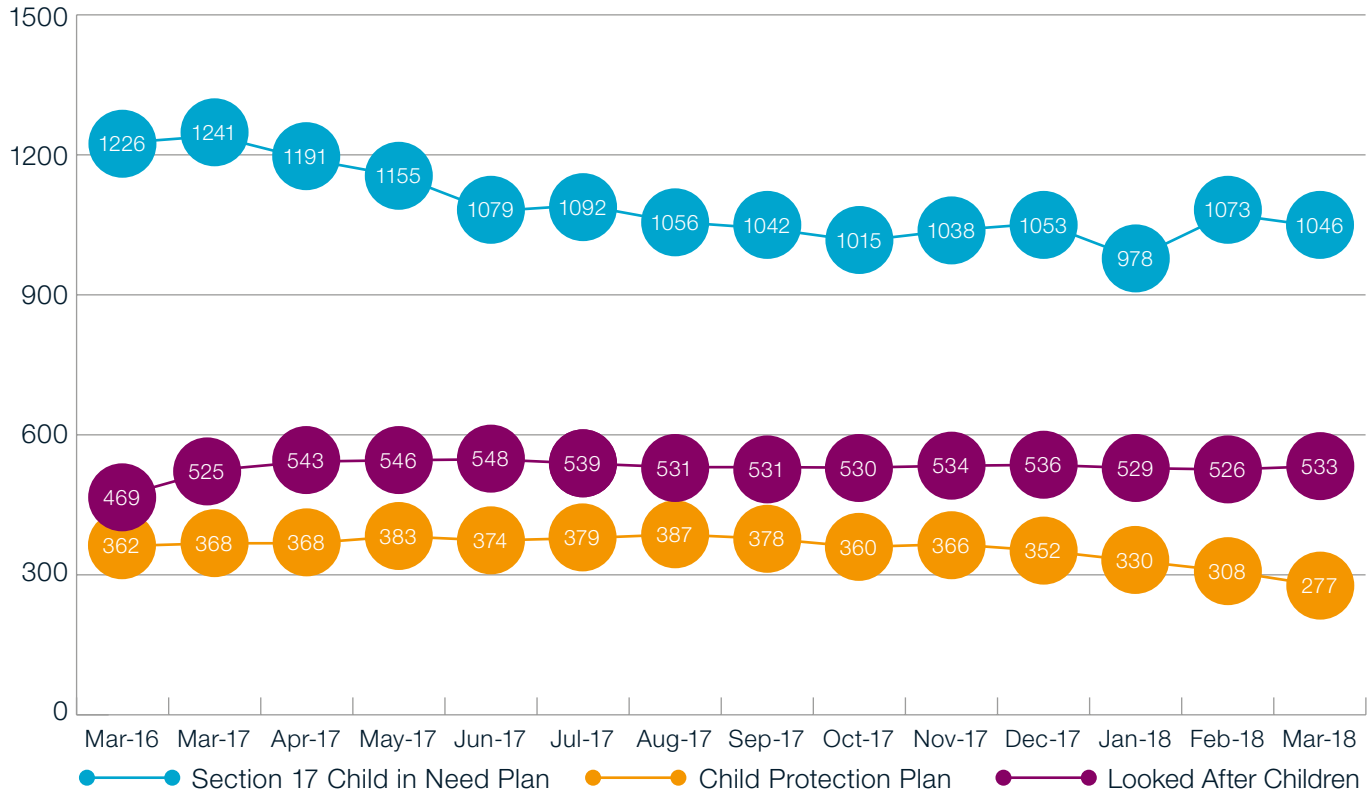
Referrals and assessments for statutory services

More effective triaging at the Front Door, and signposting to the Early Help Hub, has also resulted in a reduction in the number of referrals to 2,726 (2017: 3,347), which represents annual conversion rate from contacts of 27.8%. While the annual rate remains in line with the last five years, the monthly rate has steadily increased and averaged 38% in quarter 4. This indicates that contacts to the Front Door are increasingly meeting the threshold for a referral, which suggests that work is being more effectively triaged to the parts of the system where it should be and that partner agencies are making more effective threshold judgements. In turn, this frees up practitioners at the Front Door to concentrate on the work that needs their intervention. The rate of referral at 953 per 10,000 child population (2017: 1,167) does remain significantly higher than in England (548) and our statistical neighbours (618) though. The proportion of repeat referrals (within 12 months of a previous referral) remains unchanged at 24%, which is higher than national (21.9%) and statistical neighbour (16.6%) comparators. This is an area that requires further work to understand and address.

Further assurance in respect of the judgements of referring practitioners is provided by 83% of referrals resulting in a Child and Family Assessment (2017: 56%), although 35.5% were subsequently deemed not to be in need of further intervention which suggests that some assessments are being undertaken unnecessarily. When there are indicators that a child has been or is at risk of being significantly harmed the referral will trigger a section 47 enquiry. The rate of section 47 enquiries undertaken in Blackpool has consistently been the most disproportionately high indicator, at 690 in 2016-17 compared with 157 nationally and 226 in our statistical neighbours. A Children's Services internal audit of decision making and practices around section 47 enquiries has resulted in changes to practices, particularly in respect of enquiries on open cases and has resulted in a reduction in the number completed to 1,463 (2017: 1,978), which represents a rate of 511. The need for ongoing work in this respect is emphasised though by the conversion rate from section 47 enquiry to initial child protection conference (ICPC) of 33.7% (2017: 33.5%), set aside statistical neighbour (40.1%) and national (41.5%) comparators.

Children in Need

A concerted effort has also been made to safely reduce the number of Children in Need, which has been successful, insofar as the overall number has reduced from 2,119 on 31st March 2017 to 1,834 on 31st March 2018. This overall reduction hides the relative changes in those subject to section 17 Child in Need plans, Child Protection plans and Looked After Children:



[1] All comparator data in this report is for 2016-17

An initial reduction was therefore achieved in the number of children subject to a section 17 Child in Need plan, while Child Protection plans and Looked After Children peaked in May and June, respectively. A more recent reduction in the number of children subject to Child Protection plans has been achieved by reviewing thresholds, earlier escalation of plans that are not progressing and the introduction of the Risk Sensible model, which promotes a clearer focus on high risk indicators in decision making. However, this has resulted in more children being subject to section 17 Child in Need plans, which would be expected. There continues to be a disproportionately high, albeit reducing, proportion of child protection plans open for less than three months (22.2%, compared to 20.2% nationally) and children becoming subject to a child protection plan for a second or subsequent time (22.4%, compared to 18.7%) nationally). The former could be indicative of children being made subject to child protection plans unnecessarily, or that they are ending too early, while the latter suggests that some plans are ending at a too early stage for changes to have been embedded.

The number of Looked After Children has proved more difficult to reduce, although the number starting to be looked after has reduced to 212 during 2017-18 from 267 in 2016-17. This did not reduce the overall number though due to the number ceasing to be looked after also reducing from 215 to 208. It is anticipated that the number of Looked After Children will start to reduce though in forthcoming months though, with discharge plans having been put in place, and additional resources provided to the relevant teams, to secure permanent arrangements for appropriately identified children who are already in care or going through care proceedings.

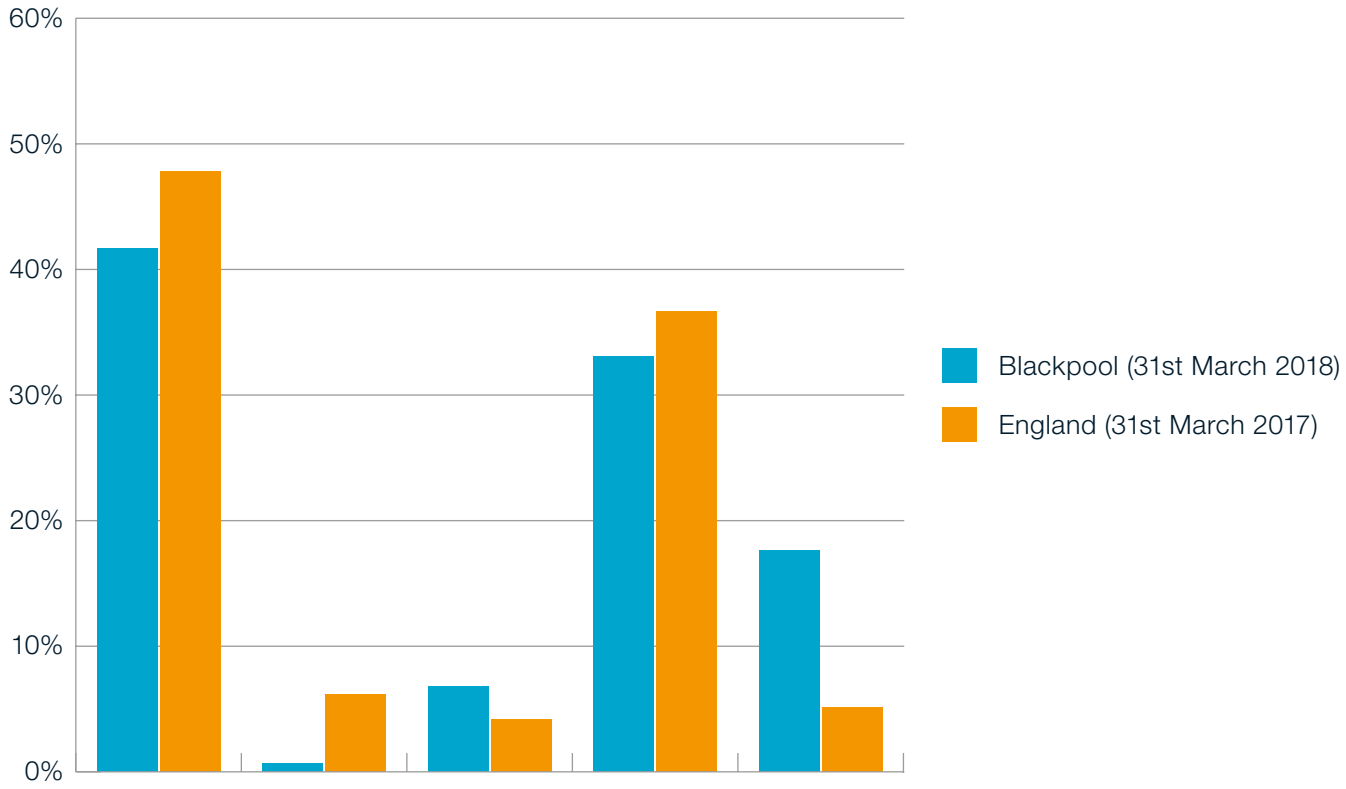
Further assurance that children receive interventions at the right level has been provided by a Children's Services audit of children subject to section 17 Child in Need plans, completed shortly after the end of the reporting period. This found that of the 343 children audited, 278 were at the right level, 6 should be stepped up and 59 stepped down to early help or universal provision (this judgement is based on current levels of need so does not reflect on the initial decision making).

After a number of years of increasing levels of demand and numbers of children in receipt of statutory services the above analysis does provide some cause for optimism. However, when set aside national and statistical neighbours (SN) the need for ongoing work in this respect remains evident.

Rate per 10,000 child population of	Blackpool (2018)	England (2017)	SN (2017)
Child in Need (all)	641	330	512
Child Protection Plan	97	43	67
Looked After Child	188	62	97

Characteristics of children subject to Child Protection plans

All child protection plans record one or more categories of abuse which, when viewed as a whole, enables an understanding of the risks that children face. The following graph provides a breakdown of the latest recorded category of abuse for children subject to a child protection plan on the 31st March 2018:



Blackpool had had a long-standing practice of routinely recording multiple categories of abuse, which was stopped during the reporting period. This has resulted in an in year reduction from 48.2% of plans having multiple categories to 17.6% and it is anticipated that this should eventually reduce to nearer the national average of 5.1%, at which point more meaningful comparisons will be possible of the prevalence of the types of abuse and neglect. This changing practice renders comparisons with earlier years in Blackpool invalid, although the long-standing dominance of plans for neglect and emotional abuse (which is reflected nationally) continues. An earlier BSCB audit of plans for emotional abuse suggested that the vast majority were due, at least in part, to domestic abuse and the prevalence of this as an issue has remained with domestic abuse flagged as an issue on 57.8% of child protection plans.

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 increase in unborn children and babies subject to plans potentially reflects work to improve practice in this respect as a consequence of recent serious case reviews and BSCB audits (see Chapter 6 below). There remains a slightly higher number of boys subject to child protection plans (53.6%), which is reflected nationally, although this has tended to fluctuate (in Blackpool) over the longer term. Our last annual report could not reach any conclusions as to whether the ethnicity of children subject to child protection plans in Blackpool reflected the local population due to poor recording. This has improved in the last year and it is now possible to say that the 93.5% of White British children subject to plans does reflect the local population.

Age of children subject to child protection plan at year end	Blackpool 2017/18	Blackpool 2016/17	England 2016/17
Unborn	2.9%	1.1%	2.2%
Under 1 year	11.2%	8.4%	9.7%
1 – 4 years	25.9%	24.4%	26.5%
5 – 9 years	26.3%	29.3%	29.6%
10 – 15 years	29.9%	32.5%	28.0%
16 – 17 years	4.0%	4.3%	3.9%

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 8 private fostering arrangements that were in place in April 2017, 11 commenced and 10 ended during the year, leaving 9 in place at the end of March 2017. The majority of private fostering arrangements are of older children staying with members of their wider family, with no dominant themes evident amongst the reasons for the arrangements.

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. 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. BSCB therefore continues to promote the reporting of private fostering arrangements through its inclusion in the thresholds document and in a number of our training courses. We have additionally discussed the topic in our schools' twilight meetings and started collecting private fostering data in our s175 audit programme (see Chapter 6 below). As the Ofsted research suggests, 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 last delivered.

Performance

Despite the number of children receiving statutory safeguarding interventions, indicators in respect of the performance of the system continue to compare favourably to those seen nationally and amongst our statistical neighbours. This is evident from the point of initial assessment, through to children leaving care and in the services delivered by our health partners.

	Blackpool 2017/18	England 2016/17	SN 2016/17
Child and Family Assessments completed within 45 working days	77.9%	82.9%	77.0%
ICPC held within 15 working days of the start of the s47 enquiry	93.6%	77.2%	79.3%
Proportion of children ceasing to be looked after who were adopted in the year	17.3%	14.0%	17.5%
Proportion of children ceasing to be looked after who were subject to Special Guardianship Order in the year	21.2%	11.3%	10.5%
Looked after children with a completed annual health assessment	93.7%	90.0%	n/a
Looked after children with a completed annual dental assessment	96.1%	84.1%	n/a

Other safeguarding indicators

There is less data available in respect of the demands of safeguarding work in other agencies, although the children, at each stage of the system noted above, do require a multi-agency response to ensure that they are safe. More generally, we know that children and young adults in Blackpool are more likely to be admitted to hospital as a consequence of alcohol and substance misuse, mental health conditions and self-harm, and that the rate in the latter three categories is the highest nationally (although the most recently available data relates to 2016-17). This area has been subject to long standing BSCB monitoring and challenge and while we do understand that admissions practices in our acute hospital trust have played a part, it does remain an area of concern. It is therefore encouraging to note reduced admissions in respect of self-harm which is, in part, due to the success of the Child and Adolescent Support and Help Emergency Response (CASHER).

Rate of hospital admissions per 100,000 population	Blackpool 2016/17	Blackpool 2015/16	England 2016/17
As a result of self-harm (10-24 year olds)	1,156.8	1,444.7	404.6
Due to mental health conditions (0-17 year olds)	188.8	149.9	81.5
Due to substance misuse (15-24 year olds)	339.0	345.3	89.8
Due to alcohol misuse (under 18 year olds)	74.3	n/a	34.2

HOW WE ARE DOING AS A PARTNERSHIP

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, more invasive, interventions can be reduced. The need for effective early help in Blackpool is emphasised by the high number of children who require protection, as outlined in Chapter 3, 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 need of statutory intervention are referred and worked with at a higher level.

Continuum of Need

Working Together requires LSCBs to publish a thresholds document that sets out the process for the assessment and delivery of early help, together with the criteria for statutory intervention. Work had been underway for a number of months at the beginning of the reporting period to develop and pilot an updated thresholds document, including a shared continuum of need (CON) with our pan-Lancashire colleagues. The adoption of a shared CON means that children will receive the same level of intervention to meet their needs irrespective of where they live, or move, within the wider Lancashire area. This simplification of matters for practitioners who work across local authority boundaries is further enhanced by the adoption of common information sharing guidance.

Keeping Children Safe in Blackpool

The revised thresholds document, Keeping Children Safe in Blackpool, was agreed by BSCB in May 2017 with an implementation date of 1st September. In addition to the pan-Lancashire CON, the document provides the process that multi-agency practitioners are required to use to deliver early help. Keeping Children Safe in Blackpool utilises the Resilient Therapy approach that underpins the Head Start programme. Practitioners are consequently expected to identify, and build on, positive resilient factors and to weigh these against needs and risks in making their decision as to where a child sits on the CON.

BSCB also responded to the overwhelming feedback from professionals that the existing Getting it Right (combined early help assessment and referral) form was overly long and complicated. We consequently developed separate and shorter Early Help Assessment (EHA), Early Help Meeting Record and Multi-Agency Referral Forms, which were introduced alongside Keeping Children Safe in Blackpool. The new documentation was predicated on the availability of support for multi-agency practitioners to deliver early help. This was initially provided through the Children's Services Front Door and has subsequently been transferred to the new Early Help Hub. Peer support for practitioners has also been provided through the development of the Early Help Support Network, which has initially been led by the local authority Families in Need team. The one meeting during the reporting period was attended by 45 practitioners from a wide range of agencies. They have agreed to meet on a quarterly basis to network, share good practice and discuss common challenges.

During the months preceding, and subsequent to, the launch of Keeping Children Safe in Blackpool, BSCB delivered briefings to 78 managers and 704 practitioners. This has been supported by Board members promoting its use within their own agencies and briefings that have been included within newsletters for General Practitioners and School Governors. The documentation is integral to all ongoing BSCB training and will be covered in a more detailed course, entitled The Blackpool Way, that will also cover Resilient Therapy and Risk Sensible and is due to be launched in autumn 2018.

In order to ascertain the effectiveness of the new approach an audit of EHA was completed by the BSCB Multi-Agency Audit Group in March 2018. This reviewed 25 EHAs that had been completed by a range of partner agencies, which did provide an initial positive indication that the forms were being widely used and early help delivered. Examples were identified of good quality EHA that provided holistic assessments of all children and family members and which drew on multi-agency information that flowed through into action plans. However, it was disappointing to note that only 7 were considered to be good, with 13 requiring improvement and 5 inadequate. Common areas of concern were the use of the form solely as a referral to statutory services and a seeming lack of understanding as to the nature of early help. The findings of this audit will form the basis of a practitioner briefing that will be published this summer while work will continue through the Early Help Support Network to support effective practice.

Early Help Data

BSCB's lack of understanding of the number of children and families in receipt of early help has already been noted in Chapter 3, above, and in earlier annual reports. Without this data BSCB cannot properly understand the flow of children through the safeguarding system or receive assurance that effective early help is being provided to children who are then stepped down to universal services, without the need for statutory intervention. BSCB has previously received information from the local authority, some schools and Blackpool Teaching Hospitals in this respect and incorporated a question in the section 175 audit of schools to capture the number of children that they provided early help to during the preceding academic year. This has indicated that up to 1,000 children are receiving early help from local authority or Blackpool Teaching Hospitals NHS Foundation Trust (BTHNHSFT) at any one time. Approximately two thirds of schools provided data, which indicated in that early help was provided to in the region of 2,000 children during the 2016-17 academic year. However, the variations between individual schools suggests a lack of consensus as to what constitutes early help, which is thought to stem from some schools recording solely behavioural interventions as early help. Sourcing data from individual agencies will also result in a considerable degree of double counting and there remains no systematic way to capture this data (either in terms of completed EHA or open cases), which remains a weakness. A web based version of the EHA remained in development at the year-end which, if successfully implemented, would provide a means of capturing EHA completion.

Early Help Strategy

Our last annual report noted that a partnership Early Help Strategy was in development. After carefully considering the scope and nature of its business plan (see Chapter 1.4 above), BSCB determined that it was not the best placed strategic body to develop and own this strategy. BSCB will consequently seek assurance that an appropriate strategy is in place and that its delivery is monitored.

What we will do next

- Continue to drive improvements in the use and quality of EHA through our training programme, publications and other appropriate means
- Challenge partners to develop the means to understand the scale and effectiveness of early help provision
- Seek assurance that an Early Help Strategy is in place and delivered against
- Work with pan-Lancashire colleagues to develop shared documentation wherever possible, including the launch of a shared referral form for statutory services.

Front Door

There are two means by which children can be referred to higher tier services in Blackpool: the Children's Services Front Door and the Multi-Agency Safeguarding Hub. The former handles multi-agency referrals to both Children's Social Care and the Families in Need team, while the latter receives Police Protecting Vulnerable Person Referrals only (although, in practice, some referrals may effectively be from other agencies, but entered on a PVP). Both teams benefit from co-located multi-agency practitioners, which enables the rapid sharing of information and joint responses. Blackpool has its own MASH, although the process is replicated in the two other LSCB areas in which Lancashire Constabulary operates. The response received depends on the initial risk grading, determined by the referring police officer. Where a child is considered to be at high risk the PVP is passed to the Front Door. Other PVPs are shared with partner agencies to build a multi-agency chronology to ensure that the child (and/ or adults involved) are referred to the most appropriate service to meet their needs. The number of PVPs received in Blackpool is significantly higher than elsewhere in Lancashire which has proved a long term challenge to the management of the MASH. As noted in Chapter 3, above, standard risk referrals are now passed directly to the newly constituted Early Help Hub, which has significantly reduced the volume of work received by the Front Door.

Blackpool Council Children's Services commissioned a peer review of the Front Door in February 2018. This review tracked approximately 50 cases, observed multi-agency meetings and met 40 multi-agency staff over a two day period. The review found that partners submitted well evidenced referrals, that there was good input from schools, good access to health and police information through the MASH, that social workers know their children well and that the Families in Need (FIN) team is a strength. Areas for improvement were more systematic in that the front door was judged to be fragmented with multiple point of entry and too many handover points where responsibility for a child was transferred to other practitioners or teams. This coincides with the findings of a longer term Police review of the MASH which has concluded that the process is overly bureaucratic and process-driven. At the time of writing a more extensive review of the journey of the child through Children's Services is underway, which will ultimately include a revised Front Door structure and process.

Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (HM Government 2017 Child sexual exploitation: definition and guide for practitioners)

Our response to CSE in Blackpool

Blackpool is a party to the pan-Lancashire CSE strategy and has a local operational action plan (the reporting period formed the second year of the 2016-18 plan). Oversight is provided by a pan-Lancashire strategic group and local operational subgroup, which regularly reports to the Strategic Board. Practitioners throughout Lancashire are expected to work in accordance with the Standard Operating Protocol that has been extensively reviewed during the reporting period.

The operational response to CSE in Blackpool is provided by the multi-agency Awaken team. At the year end this constituted 6 practitioners from Children's Social Care, 7 Police officers (representing an in year increase in capacity), 1.5 health practitioners and an education worker. Children will be key worked by the practitioner most able to effectively engage with them (although those requiring statutory social care intervention will always have a named social worker). Children who are considered to be at a high risk of harm are discussed at monthly Multi-Agency CSE (MACSE) meetings which are attended by the wider partnership and utilised to develop multi-agency risk management plans. MACSE meetings also review high risk perpetrators and premises or geographical areas in which children are known to be at particular risk.

What we know about CSE in Blackpool

The CSE subgroup monitors the volume of activity and nature of CSE in Blackpool. At the year-end there were 52 children open to Children's Social Care in Awaken (this is not a definitive number of children at risk of CSE as Awaken may also hold siblings of children who are at risk, and others at risk of CSE may be held by more appropriate teams to their needs, for example looked after children or children with disabilities) and 74 ongoing Police investigations. During the year there were 318 PVPs submitted in which CSE was recorded to be a factor, which is a reduction from the 431 recorded in 2016-17, but in line with longer term averages (note that PVPs may be in respect of one or more children and that CSE may not be the primary concern). Throughout the year there were typically between five and seven children graded as being at a high risk of harm and therefore discussed in MACSE meetings. The nature of CSE in Blackpool remains as noted in previous annual reports, in that there is no evidence of organised or group exploitation, grooming, trafficking or offending. The only established links are between victims and their mutual associations. Victims continue to primarily be aged between 13 and 15, with a greater number of girls than boys.

Summary of activity to address CSE in Blackpool

BSCB has an ongoing programme of awareness raising which centres on CSE Awareness Week each November. During this week there were two Lancashire wide conferences, one of which was specifically for schools. BSCB delivered two new training courses, Teen Dating and To See or Not To See (covering the impact of pornography on teenagers) and there was a range of public awareness raising activity. New leaflets for children, designed by children, were produced for the week, while a range of materials have been made available to support school practitioners working with children across the age ranges. Elected members for three wards also provided funding to deliver Chelsea's Choice and Crashing, which are awareness raising plays, to approximately 3,000 children in secondary schools in their wards. Additionally, Awaken team practitioners will provide assemblies to all year 6 pupils on online safety and to all secondary school pupils on sexting during the current academic year. During the reporting period we have made a significant effort to engage with parents and a member of Awaken staff, together with a representative from O2, has attended parents' evenings to raise awareness of CSE and online safeguarding.

BSCB continues to provide briefings to private businesses to improve staff recognition and increase the reporting of CSE. During the reporting period we have engaged with licensed premises through the local Pubwatch scheme and provided briefings to a significant number of staff at a local takeaway chain. The Blackpool Council licensing department additionally targets interventions at businesses who have given cause for concern. Having provided briefings for all existing taxi drivers in previous years, BSCB reviewed the means by which the activity could become a sustainable part of the licensing process. This was still in progress at the year end, however it is envisaged that CSE and wider safeguarding input will be included as part of the customer care course that all new drivers are required to complete prior to receiving their licence.

In addition to monitoring the work of the Awaken team, BSCB seeks wider assurance as to the availability of services to protect victims of CSE from harm and to facilitate their recovery from any harm that has been caused. During the reporting period a directory of therapeutic services for victims of CSE has been produced and incorporated within the Family Information Service (now called FYI Directory) website. The Office of the Police and Crime Commissioner (OPCC) for Lancashire has recognised the need for effective early help for children at risk of becoming victims of CSE and for younger children displaying signs of harmful sexual behaviour. It has therefore funded the pilot Enlighten project in Blackpool, which was launched in February 2018. This provides a key worker who can work with schools to support their delivery of assessments and interventions to children, together with bespoke therapeutic support which is delivered by Core Assets.

A range of measures, short of prosecution, are available to disrupt perpetrators. Blackpool has been at the forefront of developing the use of Community Protection Warnings and Notices which can be served on suspected perpetrators and require them to cease from specified behaviours. Any interventions of this nature are always co-ordinated with the Awaken team to ensure that they do not create unintended consequences for children involved. During the reporting period 26 Community Protection Warnings were issued which related to CSE. The fact that these largely achieve their intended consequence is evidenced by there only having been two Community Protection Notices issued, which follow a failure to comply with the requirements of a warning. Measures against individuals are also supported by others that can target premises, while the Police continue to issue section 2 abduction notices where this is considered to be appropriate.

During the reporting period BSCB has developed a CSE and Missing from Home dataset, which has enabled us to better understand the scale of need, however this does not allow us to understand the effectiveness of interventions or, most importantly, the outcomes for children. Exit questionnaires are in place for children whose case is closed to Awaken, however a review of the findings of these by the CSE subgroup, has suggested the need for a change in the questions asked as the findings were not considered to be consistent with more informal feedback received from the children. This has now been done and will be routinely reported to the CSE subgroup. CSE did not form part of BSCB's cycle of audits during the reporting period, however one serious case review was completed in respect of a child who had been the victim of CSE (and intra-familial sexual abuse). Given the vulnerability of the victim this was not published, however an action plan was completed and a practitioner briefing published (see Chapter 6 below).

What we will do next

- Incorporate child criminal exploitation (CCE) into our strategic and operational responses to CSE in recognition of the need for a consistent response to all forms of child exploitation
- Develop the means to better understand the outcomes of our work to address CSE
- Continue to deliver CSE Awareness week, with a focus on raising public awareness in 2018
- Undertake a multi-agency audit of responses to CSE and CCE

Missing children

Children missing from home, care or education are vulnerable at that time, quite simply because those responsible for their care are unable to ensure that they are safe. The correlation between missing children and CSE has been a feature of previously reported audits and case reviews, and was again a factor in the unpublished SCR, noted above. As corporate parents, Blackpool Council are particularly anxious 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).

The multi-agency response to children missing from home and care (MFH) has been incorporated within the local and pan-Lancashire structure for CSE and is therefore the subject of the same action plan. Operationally, children who are considered particularly vulnerable as a consequence of repeated MFH episodes are discussed at multi-agency MFH panels. Following the year end these were moved to be held immediately after MACSE meetings to promote attendance at both. Children who are missing from education are currently reviewed by the Blackpool Education Registration and Admissions (BERA) panel and further work is required to ensure that information is shared between these fora.

What we know about missing children in Blackpool

On average, during the reporting period 64 children who were not open to Children's Social Care were reported as missing from home each quarter (2017: 47), with the proportion of boys and girls fluctuating on a quarterly basis. The most common age likewise varies between 13 and 15. The numbers recorded as missing from home on three or more occasions each quarter averaged 4.5 (2017: 1.0). BSCB will continue to monitor this data to ascertain whether recent rises continue and what action might need to be taken as a consequence.

In contrast, the proportion of looked after children going missing from care on one or more occasion in a quarter had reduced from a peak of 10% to 6% at the year end, which is the lowest since June 2015. A similar reduction was seen in those reported missing on three or more occasions in a quarter from a peak of 5.5% to 2.4%, which is also the lowest rate since June 2015. Boys do tend to outnumber girls in this cohort and again the 13 to 15 age range is the most common. The reduction in missing episodes has been attributed to better work to engage with children who go missing to understand their concerns, review the suitability of placements and work with providers to improve their practices in the management and reporting of missing episodes. A very small cohort of children are reported missing from home on nine or more occasions during a quarter (an average of 4.5 per quarter in the reporting period (2017: 8.75)). They were all already open to Children's Social Care at the time which indicates that appropriate oversight was being provided to manage the risks that they face.

When a child who has been reported MFH returns to their place of residence they are expected to receive a safe and well check from a Police officer in order to identify if they have been harmed whilst missing (in residential homes this does not always apply). BSCB has raised the lack of any systematic means of evidencing that these checks are being undertaken, beyond reviewing on individual cases, with Lancashire Constabulary. In order to better understand the reasons why children go missing from home, whether they have been harmed while missing and what might stop them from going missing in the future, all children who go missing are also expected to be offered a return home interview (RHI) by an independent person within 72 hours of their return home. This is an area that BSCB has repeatedly raised in its annual reports and throughout its meeting cycles as being of unsatisfactory performance with only 28% completed in 2015-16 and 33% in 2016-17. This increased to 35.6% in 2017-18, however the rate during quarter 4 was 45% (a further 35.1% were completed outside the 72 hour timeframe throughout the year). BSCB has received further assurances that the ongoing review of Children's Services' structures will include a dedicated resource to support the completion of return home interviews, while another provider has been commissioned to complete those for looked after children placed outside Blackpool. It is essential that these changes do translate into improved performance to ensure that the needs of children who go missing are understood and responded to.

Our understanding of MFH has been strengthened by a Children's Services audit in this respect, completed shortly after the year end. The audit reviewed the cases of 42 children who had been reported as missing five or more times in the last quarter. In addition to reviewing practice this allowed for an analysis of the reasons stated by children for going missing, the most common of which were:

- Not wanting to be in care
- Not wanting to continue to live with their parents
- Wanting to spend time with family or friends when this has been prohibited
- Simply wanting to spend time with friends etc. in which context they did not regard themselves as being missing.

Social workers were assessed to be making good use of historical information and effectively assessing risk, however their use of multi-agency information was less effective and the quality of RHI was not consistently as good as it should have been. Challenges in completing timely RHI were noted to be getting children to engage in the process and responding to repeated missing episodes in quick succession.

During the forthcoming year the outcome of a Police systems review on MFH processes is expected. Preliminary findings have already indicated the need to better understand the reasons why children go missing, rather than just returning them to the place from which they have been missing, although the response to high risk missing children was seen to be effective. BSCB continues to await the Department for Education response to a College of Policing recommendation that the absent category should be scrapped to enable it to fully review its missing procedures.

What we will do next

- Continue to hold partners to account for the completion of Safe and Well check and Return Home Interviews
- Ensure that effective information sharing systems are in place to share intelligence about children who are MFH and those who are missing from education
- Seek assurance that reviews of Children's Services' structures and Police systems produce better outcomes for children who are reported MFH
- Revise pan-Lancashire policies and procedures and the MFH protocol once definitive advice in respect of the absent category is received.

Neglect

Neglect has been a longing standing area of focus for BSCB as a consequence of a succession of audits and reviews, including the Child BW SCR that was published shortly before the start of the reporting period (the Child BY SCR, which will be published during the autumn 2018, will likewise include learning in respect of neglect). The Blackpool Joint Strategic Needs Assessment (JSNA) was updated during the reporting period to include a chapter on neglect. Based on national research this estimates that almost 2,500 children (1 in 14 of the child population) in Blackpool are currently likely to be experiencing neglect, although this provides the caveat that other known factors present in Blackpool are such that this is likely to be an underestimate. As of the 31st March 2018, 48.2% of the 278 children subject to child protection plans had a current category of neglect, although a longer term analysis cannot be provided due to changes in the recording of categories, outlined in Chapter 3 above.

The multi-agency response to neglect in Blackpool is delivered in accordance with a three year BSCB strategy that was agreed in 2016. Oversight was provided by the Neglect subgroup, which evolved into a Joint Targeted Area Inspection (JTAI) preparation group and has since been disbanded, passing responsibility back to BMG. The following overview of activity to address neglect is based around the five strategic intentions.

BSCB works to ensure that the multi-agency workforce in Blackpool is properly equipped to identify and respond to neglect through the provision of training and materials. A bespoke suite of neglect assessment tools, including the Graded Care Profile 2 (GCP2) was developed, in conjunction with the NSPCC, and roll out started during the previous reporting year. The use of the tools is supported by a protocol that was launched in September 2017, alongside Keeping Children Safe in Blackpool, which requires the completion of a neglect screening tool for all referrals for statutory services on the grounds of neglect. It is likewise expected that children subject to a child protection plan for neglect will have a GCP2 completed. BSCB provided training in the use of the full suite of tools to 280 practitioners during the reporting period, including two large scale events for Children's Services and others geared specifically to managers, early years, health and substance misuse services. Resources (other than the licensed GCP2) are made freely available on the BSCB website. Training continues to be provided, albeit at a reduced frequency given that demand has now tapered off.

In order to assess the effectiveness of the suite of assessment tools, BSCB undertook a survey of the 280 practitioners who had been trained in the use of the tools in December 2017. We received 81 returns (29%) of whom 20 (25%) had used GCP2. The most common reason for not having done so, was that the need had not arisen, although this did have the consequence of a reported lack of confidence to use the tool, should the need arise. The tool had most commonly been used by Children's Social Care and schools and at an early help level. Feedback provided suggested that families had engaged well in the process and that the use of the tool had informed decisions taken to step cases up and down. The following examples of the positive impact of the use of GCP2 were provided:

"Home environment and meeting the children's needs has improved, also parents' awareness of the impact on their children"

"Family can see the benefits and fully engage in the process as they have identified what needs to change".

This survey clearly presents BSCB with something of a challenge in that, where used, GCP2 is seen to be effective. However, the majority of people trained have not used the tool and will therefore become gradually less confident in doing so as time progresses. Further work is therefore needed to understand the experiences of practitioners and to embed the use of the assessment tools.

Once practitioners have identified and assessed neglect, BSCB needs to be confident that adequate interventions are available to address the underpinning factors. In addition to the statutory interventions provided under child protection plans there are a number of interventions available to all children and families in Blackpool. These include programmes delivered by Better Start, including Baby Steps and Safe Care. The revised Health Visiting offer provides additional interventions to promote school readiness, while Head Start works with older children to develop their resilience. Two of our adult facing organisations, HM Prison and Probation Service and Blackpool Coastal Housing, have provided specific training and resources to enable their staff to respond to neglect. Further details in respect of all these interventions are provided in Chapter 5, below.

BSCB seeks to ensure that it understands neglect in Blackpool. This has been done on a global scale through the JSNA chapter and routine data collection, noted above, and on a case by case basis through audit activity. An audit of five children subject to child protection plans was completed by the MAAG in September 2017, as a follow on to one completed in January 2017. This identified better multi-agency working and information sharing, including joint working between FIN and CSC, than had been evident in an earlier neglect audit. GCP2 was seen to be used, and used effectively, in one case, but would have been expected in more (although this was prior to the introduction of the protocol noted above). There was however, evidence of drift in two cases and limited evidence of improved outcomes as the result of interventions provided. CSC commissioned further neglect training (about the nature of neglect) as a consequence of this audit.

The final strand of the strategy, to challenge providers for the commissioning of appropriate levels of services to address neglect, has not been implemented due to the evidence, outlined above, that interventions are available to meet the needs of families where neglect is an issue.

What we will do next

- Conduct a further survey of practitioners to ascertain the levels of use of GCP2 and the wider suite of neglect assessment tools

Domestic Abuse

The prevalence of domestic abuse (DA) in Blackpool and its frequency as a safeguarding issue for children has rendered it an issue in which BSCB has taken a close interest for a number of years. The multi-agency response to DA cuts across the agendas of a number of strategic boards and, at the beginning of the reporting period, was overseen by the Domestic Abuse and Interpersonal Violence Partnership Board (DAIV). During the course of the year this board formally became a subgroup of BSCB and BSAB however, after further review, it was agreed that it was better sited within the Community Safety Partnership governance structure, with its more operational remit. Irrespective of the ultimate ownership of this group, BSCB will continue to seek assurance that appropriate priority is given to the safeguarding of children from DA. Work to address DA is delivered in accordance with a four year strategy agreed in 2016 and an action plan agreed in year.

What we know about domestic abuse in Blackpool

Our understanding of DA in Blackpool has been enhanced by the completion of a strategic needs assessment and dataset during the reporting period. The rate of reported DA incidents in Blackpool has exceeded that of the wider Lancashire area for a number of years. With 50% of Blackpool residents within the most deprived quintile of the national population, in which women and men are more likely to be victims of DA, higher than average rates can be expected. During the year both the number of calls to the Police and PVP referrals in respect of domestic abuse in Blackpool decreased on a quarter by quarter basis. However, the annual figures of 3,958 and 5,426 respectively represent the highest rate in Lancashire by some way. It is notable that a third of calls relate to incidents in just three (of 21) wards. Children are recorded as being present at the time of the incident in 2,628 PVP, or 48% of the total. This is below the Lancashire average of 56%, which may reflect Blackpool's older population or be reflective of variable police practice across the county. The Lancashire-wide percentage of successful DA prosecutions is stable at 79%. During the reporting period 44 people presented as homeless as a consequence of fleeing domestic abuse, which represents 6% of the total homeless presentations.

Cases heard at Multi-agency Risk Assessment Conferences (MARAC) are those where a Police officer attending an incident assesses it as high risk, or those referred in the professional judgement of practitioners in other agencies. MARAC meetings provide a forum for multi-agency risk assessment and planning. During the reporting year the Blackpool MARAC heard 604 cases (2017: 523; 2016: 442), of which 31% (2017: 29%; 2016 19%) were repeats (heard within the previous 12 months), and included 741 children within the households (2017: 558; 2016: 456). This represents 93 cases held per 10,000 adult female population, compared to a national average of 36.

Aspects of the foregoing data, such as the decrease in Police call outs and PVPs and the increase in MARAC cases, initially appear to be contradictory and BSCB will seek to better understand the underpinning factors to these in the forthcoming year. That said, a degree of caution must be applied to all this data due to the reliance on the judgements of practitioners in identifying an incident as being one of DA and grading it consistently. Likewise, there will be differing MARAC practices nationally.

Work to address domestic abuse in Blackpool

BSCB continues to seek assurance that appropriate interventions are commissioned for children who experience domestic abuse, together with adult victims and perpetrators, who will often be their parents or people with whom they live. The underpinning basis for DA provision in Blackpool is a whole family approach and one public sector offer, to avoid fragmentation and duplication in service delivery. Blackpool has a comprehensive DA offer, which is fully recorded within the JSNA, including the following interventions commissioned specifically for children or within the reporting period:

- A children's independent domestic violence advocate service, delivered by Empowerment, for 3-21 year olds providing individual support to explore feelings, safety planning, support networks, develop understanding of healthy relationships etc.
- Complex needs refuge pilot, funded by the Home Office, to provide wrap around support to DA victims with complex needs (including to their children), including refuge spaces, employment and healthy lifestyle advice. This is a 12 month pilot which will inform the provision of future services.
- Targeted work, linked to the national Violence Against Women and Girls strategy, with older children to break cycles of abuse, in which children who live with DA, grow up to be perpetrators of DA.
- Ongoing funding from Blackpool Council and the OPCC for the Inner Strength perpetrator programme has been agreed. This has now been delivered to groups of male and female perpetrators, who have volunteered to attend. External evaluation of the programme is now being sought.
- The Tavistock Foundation Parents as Partners programme is now being delivered. This provides intensive interventions to couples who want to remain in a relationship and their children.
- Blackpool was part of the bid which led to Lancashire becoming the first white ribbon accredited county. This is an ongoing campaign to raise awareness that violence and abuse is never acceptable. The campaign is supported by a wide range of local organisations and public awareness raising centred on 16 days of action in November, in which Blackpool Tower was lit up white.

What we will do next

- BSCB is assured that a wide range of interventions are available for children and others affected by DA. Partners will however, be held to account for the effectiveness and outcomes of these interventions.
- Complete a multi-agency audit and multi-professional discussion forum to better understand the experiences of children affected by DA and the perspective of frontline practitioners.

Managing allegations against staff

Working Together requires organisations and agencies working with children and families to have clear policies for dealing with allegations against people who work with children. Allegations are distinct from complaints or concerns and relate to situations in which a person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Upper tier local authorities are required to ensure that responses to allegations are co-ordinated with activity to safeguard involved children and to have in place a designated officer (colloquially known by their old title as a LADO) to be involved in the management and oversight of allegations.

Organisations are required to report allegations to the designated officer within one day of them being made. The designated officer, in turn, is expected to provide advice and guidance to employers and voluntary organisations as to how to deal effectively with allegations and ensure that appropriate links are made to related police investigations. Effective investigations would be thorough and fair, but also timely. In Blackpool, the role of the designated officer is combined with the equivalent role for allegations against practitioners who work with adults.

The BSCB Strategic Board receives and annual report from the designated officer in which trends in referrals are monitored and recommendations may be made to improve the identification and management of allegations. It is anticipated that revised multi-agency procedures will be adopted later in 2018. During this reporting year there were 68 recorded referrals to the designated officer. This compared with the figure of 74 reported last year represents a decrease in referral numbers of 8 %. As was the case last year this figure of 68 does not count cases that were carried over from the previous reporting year. It is the case that some referrals that enter the formal process can stay open for many months and this is often the case with lengthy criminal investigations that result in prosecution and trials at Crown Court.

Of the 68 referrals received 60 were progressed within the formal allegations process and resulted in at least one formal initial consideration or allegations meeting. This represents a conversion rate of 88.2% of all allegations appropriately referred to the designated officer. In comparison to last year's conversion rates of 74.4% this represents a significant increase upward of cases referred that meet the existing criteria for the allegations management process. This can be viewed as a positive in terms of it being evidence of reasoned discernment being applied to the individual circumstances on the part of the referring agency prior to submission of the referral.

In terms of employment role people are more likely to be referred (and an allegations meeting held) as employed in education than in any other sector. Nevertheless, the total is down from 13 to 12 such cases with the percentage overall remaining consistent with last year. These education referrals include teachers, teaching assistants, technicians and other support staff. Foster carers remain the second most prevalent with a total of 10 (14.7%) cases which is an increase of 2 from last year where 8 (10%) of all referrals concerned foster carers. Residential care workers are the next most prevalent group with 6 (8.8%) of referrals, an increase of 1 (1.4%) on last year but still considerably less than the year 2015 to 2016 where the figure was 65% higher. NHS referrals are hard to discern by job role but it is the case that referrals have included front line practitioners in Accident and Emergency and this has involved both doctors and nurses by job role. In total there were 5 (7.3%) of such referrals. Faith Group worker or volunteer status recorded no referrals. There has been a drop of 2 referrals (3.8%) in Early Years referrals. Other job or volunteer role account for 20 (29.5 %) of all referrals and this group of individuals includes the grass roots sports, Cadet and entertainment sectors. As a percentage of overall referrals this diverse group has increased from the 12 (16.2%) reported during the year 2016 to 2017.

OUR PARTNERS' ACTIVITIES

Children's Services

This has been a year of change for Children's Services, not least starting with the appointment of a new Director, Diane Booth, in April and further significant changes to the senior management team. The re-constituted Children's Improvement Board has sought to drive improvements to services on a multi-agency basis, reflecting the fact that all work within Children's Services involves multi-agency working to keep children safe and promote their welfare. As such, a number of the changes made, for example the development of the Early Help Hub, are covered elsewhere within this report.

The Blackpool Young People's Service (BYPS) was established in July 2017 to bring together youth offending, leaving care, substance misuse, sexual health and careers advice services to provide an integrated service for 10-25 year olds. Service delivery is on a multi-agency basis, with health, probation and police colleagues working alongside local authority practitioners. BYPS aims to reduce the need for young people to be open to multiple services and practitioners by assigning one key worker and providing services from one venue. By sharing expertise it is envisaged that problems will be more readily identified and addressed before they become entrenched. An early focus for the service has been the care leaver's offer which has been expanded to include interventions to improve readiness to work, financial maturity and ability to maintain a tenancy.

A new model of multi-agency service delivery has also been trialled in the Talbot and Brunswick Children's Centre, with a view to providing a series of community hubs throughout Blackpool. They will provide a broad range of services, moving beyond the pre-school age group and aligned with neighbourhood models being introduced by BCCG and Lancashire Constabulary. In practice this has resulted in services as diverse as birth registrations, DA perpetrator programmes and health appointments being delivered from Talbot and Brunswick Children's Centre, together with youth groups and leisure activities for all ages. By co-locating services they can provide peer-support for practitioners and enable children and families to more readily engage with other service provision. Given that the vast majority of children of a relevant age who are subject to child protection plans engage with children's centres this is a means by which these children can access services that they may otherwise be marginalised from.

Children's Services have introduced a new risk management operating model, Risk Sensible, which aligns to the pan-Lancashire footprint and allows agencies across Blackpool boundaries to work to the same operating model in respect to risk which provides a more consistent approach to children, young people and families. All staff in Children's Services will be trained in the use of this model to improve understanding and decision making in respect to the management of risk. It has also been rolled out on a multi-agency basis and forms part of the ongoing BSCB training programme.

An early Improvement Board priority was to develop an effective quality assurance framework to enable changes in practice to be based on a robust understanding of the needs of children and families in Blackpool and of the effectiveness, or otherwise, of current practice. This has resulted in an improved use of data and performance information, both at a strategic level in the Improvement Board and operationally by first line managers. An audit team has been established, with findings from this and all other learning activity being reviewed and incorporated within the training programme. As a result of the audit programme learning circles have been introduced for practitioners, together with reflective group supervision. A direct work tool resource pack has been developed and a care planning protocol introduced which ensures management oversight. Future plans include seeking the views of children as part of the audit process and live audits of practice.

Children's Services continue to listen to the views of children through the Just Uz group which brings together looked after children from the age of five upwards. A separate care leavers' group has been established during the reporting period, which has been influential in the ongoing development of the care leavers' offer and housing pathways, while they continue to be involved in the recruitment of staff, including the new director. Their input has resulted in increasing use of social media by social workers to maintain contact with children. Just Uz continues to provide social activities and peer support for its children and young people, with various specific groups, for example for older girls.

Health

The health economy in Blackpool is relatively uncomplicated with the majority of provision commissioned by Blackpool Clinical Commissioning Group (BCCG) and Blackpool Council's Public Health department, with more specialist services being commissioned by NHS England. Acute and community (for example health visiting and midwifery) services are provided by Blackpool Teaching Hospitals NHS Foundation Trust (BTHNHSFT), while Lancashire Care NHS Foundation Trust (LCFT) provide some adult mental health services, including in-patient treatment for 16 and 17 year olds. General Practitioners are all independent contractors and link into BSCB through BCCG.

Blackpool Clinical Commissioning Group

BCCG requires all its providers to complete an annual safeguarding self-assessment audit to demonstrate compliance with safeguarding standards. Where a provider is not fully compliant and action plan is put in place and monitored through quality meetings and site visits. This provides assurance that providers have appropriate safeguarding arrangements in place and where they can be improved that this is done.

Each GP Practice has an identified safeguarding lead who completes the annual self-assessment audit, while the CCG provides a safeguarding help line for GP practice staff to provide advice and support. A Deputy Designated Nurse was appointed shortly after the year end with a specific focus on Primary Care. A pilot has also been commissioned to improve two-way information sharing between GP Practices and MARAC.

BCCG commissions safeguarding resources for the wider health economy, with the contract used to provide health practitioners in MASH and Awaken.

BCCG has undertaken an internal supervision audit, which identified that all staff who work directly with children have access to regular peer group supervision, together with ad hoc supervision from the Head of Safeguarding. Deviations from best practice in the recording and frequency of supervision have been addressed. Compliance with safeguarding training has been reviewed and Prevent training made mandatory for all staff. All new starters complete safeguarding training within their first few weeks in post.

BCCG's Communications and Engagement strategy places the views and experiences of local residents at the centre of their work to improve local health outcomes. This includes seeking the views of children and other people who would not ordinarily engage with BCCG. A young people's mental health champions' panel contribute to work on mental health for young people, while joint work with Public Health is in progress to undertake a citizens' inquiry in each neighbourhood. These include children as part of the group and make recommendations as to how to improve health and wellbeing in the local area. To date these have resulted in changes to the GP's contract to stipulate the need for same-day appointments for children.

Given their integral role in successor arrangements for LSCB, BCCG's safeguarding priorities for the year ahead are the implementation of Safeguarding Partnerships and Child Death Review panels. Within the health economy BCCG aims to align safeguarding arrangements to the integrated care system and local integrated care partnership.

Public Health

This year has seen a unique opportunity for Blackpool Council's Public Health and Better Start partners to enhance the Health Visiting service offer, so that it makes a stronger contribution to improving the outcomes for children in Blackpool. From April 2018 families will be offered a service that aims to ensure a comprehensive universal offer that enables additional needs to be identified and addressed at an early stage; and interventions provided for families to address current or anticipated issues that will impact on positive outcomes for children.

It is envisaged that family engagement with this comprehensive service will increase, leading to improved outcomes for families. At the universal level the model consists of eight home visits to all families, six within the first year of life plus two additional health reviews, including a school readiness child health review. Additional contacts will be available for children where there are identified safeguarding needs.

The enhanced health visiting model was developed from consultation with a wide range of stakeholders as part of the Health Visitor review led by Public Health in partnership in 2016, with Better Start. The model was jointly developed by stakeholders representing the Better Start Partnership. The Centre for Early Child Development will lead on work to measure its impact by ensuring that the service can develop a systematic way in which data is routinely captured and analysed so that population needs can be better understood and quality of delivery assessed and improved.

Blackpool Teaching Hospitals NHS Foundation Trust

BTHNHSFT has introduced an increased flexibility into review health assessments for children looked after, which are now provided where and when the child wants. This allows medicals to be completed around other activities, for example during weekend leave for a young person in the army.

Specialist nurses embedded within the CSE teams develop a hand holding/ trusted relationship with children, for example, supporting them to attend consultant and specialist services. This work can be over significant periods of time, including through court processes.

The CASHER service (also see Chapter 3 above) offer out of hours support to children and young people referred from Accident and Emergency (A&E) and Paediatric wards, seeing an average of 23 children and young people a day throughout the reporting period. This service was a finalist in the 2017 Nursing Times awards.

BTHNHSFT also provide a weekly drop in at Talbot and Brunswick Family Hub, alongside a youth group. This provides an opportunity for children to receive emotional health and wellbeing support while engaging in fun and creative activities, with one to one support also being available. Importantly, this can act as an alternative point of contact to A&E for former CASHER users and those currently open to Child and Adolescent Mental Health Services (CAMHS) and Youtherapy. Weekend drop in clinics are also provided in the Women and Children's Unit for follow up and new self or GP referrals, while Youtherapy are the provider of a DA Integrative Therapist within the DA complex needs pilot, noted in Chapter 4 above. BTHNHSFT continues to provide an Independent Domestic Violence Advocate (IDVA) and Independent Sexual Violence Advocate (ISVA) to support victims of DA who access its services and for staff members who experience DA.

BTHNHSFT also supports safeguarding in primary care, with the internal safeguarding team now providing safeguarding advice and guidance to GP surgeries. Nine GP surgeries have also agreed to participate in a pilot in which the BTHNHSFT safeguarding team acts as a conduit for them to share information with MARAC.

BTHNHSFT seek the views of children on an individual basis when they are open to CSE, Youth Offending Team (YOT) and CLA practitioners and have recently undertaken a wider CLA survey. The incorporation of YOT into BYPS has allowed the YOT nurse to engage with wider service users to promote health and engage with young people.

During the forthcoming year, BTHNHSFT will renew their training needs analysis and training standards, following the publication of new intercollegiate guidance, and provide enhanced leadership and management development for the named nurses for safeguarding. The forthcoming incorporation of child criminal exploitation into the CSE response will also necessitate a review of the health role in Awaken.

Lancashire Care NHS Foundation Trust

LCFT predominantly provides services to adults in Blackpool, however the internal safeguarding team visit the Harbour (in patient mental health provision in Blackpool) on a weekly basis and provide support and guidance to all teams to ensure that safeguarding needs are met and that practitioners consider the needs of children in households and are aware of Blackpool processes.

Annual safeguarding priorities are determined with reference to LCFT's own three-year safeguarding vision and the business plans of the three pan-Lancashire LSCBs under which it operates. In year priorities include the implementation of the CP-IS system at urgent care sites, which ensures that health professionals can identify children open to CSC.

LCFT is also the provider for the Sudden and Unexpected Deaths in Children (SUDC) service, which is covered in more detail in Chapter 6, below.

During the reporting period safeguarding support has been provided to nursing professionals in section 136 suites following changes to the Mental Health Act, following the introduction of the Police and Crime Act 2017. LCFT has also strengthened domestic abuse routine enquiry within mental health services and integrated it into risk assessments. A revised pathway for Female Genital Mutilation has been devised and incorporated into pan-Lancashire policies and procedures, while LCFT has agreed that their practitioners will make voluntary 'Duty to Notify' human trafficking notifications.

Overall safeguarding activity across the organisation is increasing and demonstrated by increased information sharing, referrals, concerns and contacts to the safeguarding team, with a total of 3,113 recorded across the Trust.

Health Inspections

The Care Quality Commission (CQC) published their Review of health services for Children Looked-after and Safeguarding in Blackpool in late 2017. The inspection covered the work of BCCG, BTHNHSFT and LCFT and the subsequent action plan was developed by BCCG with the providers. The action plan has been scrutinised and will continue to be monitored by BSCB. It has resulted in the appointment of a Deputy Designated Nurse to work with primary care providers by BCCG. BTHNHSFT have strengthened health plans for CLA, provided a pro-forma for DA routine enquiry and put in place a new protocol for children who do wait for treatment in A&E. Other actions were addressed by existing work to re-design A&E to give nurses a full view of children in the area. Trigger cards have been provided to staff to help them identify children at risk, while a new recording system captures and ensures the availability of safeguarding information. Work has been undertaken with midwives to strengthen referrals to CSC and they have been provided with access to community health records. LCFT reviewed current cases in the services inspected to ensure safeguarding assessments were up to date and introduced a programme of dip sampling, auditing and targeted work to ensure continued compliance with areas raised. During the reporting period BSCB has also reviewed action plans implemented by LCFT and North West Ambulance Service in response to their CQC inspections and will review the BTHNHSFT inspection that was published shortly prior to the year end.

Schools

There are 32 primary, 6 secondary, 1 through (primary and secondary) and 3 special schools, together with a Pupil Referral Unit (PRU) and 2 further education providers in Blackpool. Their representation on the BSCB has been somewhat unstable during the reporting period however, at the time of publication, they were represented by the local authority Head of School Improvement, head teachers from secondary and special schools and the PRU along with a primary school deputy head teacher. BSCB has a long established programme of half-termly schools' twilight meetings that are typically attended by representatives from around thirty schools. During the reporting year these have included presentations on Keeping Children Safe in Blackpool, the Risk Sensible Model and DA provision, while schools are also given the opportunity to feedback and network with other agencies.

Schools typically spend longer with and know children better than any other agency. They are consequently a critical part of the multi-agency safeguarding system and often best placed to spot early signs of unmet needs and risks. In order to support this role, seven families of schools have been established to facilitate partnership working and effective safeguarding and pastoral work. Each school family has been provided with a named CSC service manager, and each school with a team manager, to promote collaborative approaches. This model will be supported by over £1 million of Opportunity Area funding which has been approved and will be used to employ practitioners to support early help and safeguarding provision within the clusters of schools.

While not always subject to statutory safeguarding interventions, children outside mainstream education are clearly vulnerable and, if nothing else, disproportionately represented amongst recent Blackpool serious case reviews. The number of children being excluded from Blackpool schools and educated in the PRU has been a long-standing concern of BSCB and subject to a degree of progress during the reporting period. The number of permanent exclusions has reduced from 48 to 35, while the number in the PRU has reduced from 330 to 290. There has been a reduction in the number of children moving to Blackpool who have directly entered the PRU, rather than mainstream schools, from 26 to 10. Progress in all of these areas has been supported by the employment of a local authority inclusion officer, with a brief to reduce exclusions and bullying and to promote inclusion.

During the reporting period 17 schools have been inspected by Ofsted, with 1 graded as outstanding, 14 as good and 2 requiring improvement to be good. Within these inspection reports there were no adverse comments in respect of safeguarding practice, while no schools are in special measures. Amongst Blackpool's early years settings (including nurseries and child-minders) 31.8% were graded as outstanding, 65.9% as good, 1.2% as requiring improvement to be good and 1.2% as inadequate at their most recent inspection.

Lancashire Constabulary

The direction of Lancashire Constabulary's safeguarding work during the reporting period has been significantly influenced by its National Child Protection inspection, which was undertaken in October 2017 and reported shortly prior to the year end and, to a lesser extent, its inspection on custody suites that had been published in late 2016. Both reports and their subsequent action plans are subject to ongoing scrutiny by BSCB.

As a consequence of the former report 87 child protection coaches have been appointed across the constabulary to advise immediate response teams. All officers will now be required to assess if children are present at every incident and, where they are, to speak to them and assess the home environment, to allow a judgement to be made as to where they sit on the CON. By recording what a child said at the time of an incident the wider partnership obtains a better picture of their needs in any subsequent safeguarding processes. This process is being supported through the auditing of ten cases each month, while every PVP is now reviewed and feedback provided to the completing officer, where necessary.

All officers have attended child protection briefings which promote the need to take immediate individual responsibility for actions to safeguard children and not rely on the submission of a PVP. While student officers in Blackpool are all seconded to the Family Protection Unit and Awaken to provide them with the opportunity to shadow staff members and to attend Child Protection conferences and MARAC. Briefings and more in-depth training is also being provided in respect of Adverse Childhood Experiences (ACE) to improve understanding of cycles of abuse and neglect.

Where children are not willing to engage following an incident, but where concerns are evident, the Police Early Action Team can follow up an incident and ensure that the right agencies are involved on a longer term basis.

HM Prison and Probation Service

HMPPS is the public sector provider of probation services and does not directly work with children, but does have contact with many adults who have parenting responsibilities or who offend against children. Safeguarding is at therefore at the forefront of practice, beginning at Court when details are collated about any children who have contact with defendants and multi-agency safeguarding information is requested. After sentence, the risk to children is continually assessed and monitored and any concerns discussed with partner agencies.

Work is delivered to support service users who have children to be the best parents they possibly can be and for children to be safe and thrive in their care. Service users are encouraged to work with child centred organisations who can offer interventions and early help to the whole family, while HMPPS delivers individual work to address the issues that hinder their parenting capacity.

HMPPS held a month of activities to highlight the 'National Probation Service Best Practice in Safeguarding Children guidance'. This included mandatory half-day briefings for all practitioners and managers, with a focus throughout the month on child criminal exploitation, neglect and sexual abuse to provide staff with information and toolkits to aid practice. A performance improvement tool was introduced to ensure child safeguarding referrals meet a quality threshold, thus supporting other agencies in their decision making.

As part of a divisional audit, a random selection of 97 cases from across Lancashire, including Blackpool, was reviewed. These consisted of child protection and child in need cases and were subject to peer on peer scrutiny. This exercise identified good practice but also areas for improvement. This led to a revision of the Delivery Plan for 2018/19 to incorporate the learning from the audit. This included inconsistent quality in case recording and flagging registration of child protection or child in need cases. An aide memoire for staff and has therefore been developed to improve the quality of case recording and the registration of cases.

Cumbria and Lancashire Community Rehabilitation Company

CLCRC is the private sector provider of probation services and therefore not a direct provider of services of children, however many of its service users are parents or carers, or have offended in a way that has the potential to cause harm to children. All assessments therefore consider risks to and contact with children and managerial oversight is expected on all cases where there is a risk to children. CLCRC also delivers interventions to its own and HMPPS service users including a court mandated DA perpetrator programme, which complements the voluntary programme, noted in Chapter 4 above.

Safeguarding quality assurance is provided by a routine programme of case audits that has a safeguarding element. A recent specific safeguarding audit has resulted in the introduction of practice development workshops to discuss live cases, professional practice workshops for targeted staff and a revised induction process. Home visits are now expected within four weeks of a safeguarding concern being identified. The Blackpool element of CLCRC has not been subject to inspection during the reporting period, although an HM Inspectorate of Probation report on CLCRC provision in Cumbria noted that its child safeguarding work (and overall provision) was good.

Cafcass

Cafcass is a national organisation which represents children in family court cases to ensure that their voice is heard. They provide services to Blackpool children from their Blackburn office, but will make referrals to and participate in safeguarding activity within Blackpool in accordance with local procedures. All practitioners routinely receive safeguarding supervision, while overall safeguarding practice is reviewed on a minimum of an annual basis.

Cafcass was inspected on a national basis in early 2018 and received an outstanding judgement, with strong safeguarding practice being highlighted.

NSPCC

NSPCC delivers evidence-based interventions as part of the broader Better Start programme to families who have a child aged between 0 and 4. The offer includes the universally available Baby Steps programme and other targeted interventions.

Baby Steps is offered to all prospective parents and focuses on building positive relationships between parents and their babies, as well as between the parents themselves. It is delivered by an NSPCC family engagement worker and a midwife or health visitor.

Video Interactive Guidance is a 10-12 week programme that provides parents with recorded footage of positive interactions that they have with their children with a view to developing confidence in their ability to parent successfully. Evidenced outcomes are a reduction in children's emotional and behavioural difficulties.

Parents under Pressure is an intensive parenting programme for parents who misuse substances. It has been shown to have a positive impact on child abuse potential and to improve parent-child interactions.

Safe Care is a programme offering support and training to encourage, inform and promote improved parenting. It is a 20 week programme and covers areas of child health and nutrition, home safety and organisation, and supervision and positive parent child interactions. The intervention is offered to parents where there are concerns in respect of neglect.

The Survivor Mums Companion is for any pregnant woman who has experienced trauma or abuse. It is a pyscho-education programme that aims to help women with a maltreatment history as they go through pregnancy, birth and becoming a parent. The programme gives information through provision of a workbook and teaches women new skills, as well as providing emotional support via regular telephone contact. Access is by self-referral with literature about the programme provided to all women when their pregnancy is confirmed. This programme has been delivered on a pilot basis to date, however it is anticipated that this will be scaled up following a current evaluation.

All of the above programmes will be subject to external evaluation, while individual cases are dip sampled locally and subject to audits by the NSPCC centrally, with findings fed back to staff locally. Internal findings, together with emerging lessons from SCRs have resulted in enhanced processes to capture information on referral, thereby allowing appropriate programmes to be offered.

Blackpool Coastal Housing

During the reporting period Blackpool Coastal Housing (BCH) has taken on young people's settings and work that other partners were no longer able to deliver, including the Clare Street homeless hostel and the programme for providing housing for children leaving care.

In recognition of the unique access that its own staff and contractors have to homes in Blackpool, BCH has provided training and developed flip books to help them recognise signs of abuse and neglect of children and adults. Part of this work has included the development of a tool to enable practitioners identify and assess hoarding which has been rolled out to the wider partnership and is available on the BSCB website. This work has resulted in an increase in the number of safeguarding alerts being received from contractors, which are followed up by BCH neighbourhood teams.

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 Child BW SCR identified that the multi-agency Pre-Birth Protocol had not been implemented as would have been expected. The Multi-Agency Audit Group subsequently undertook a wider scale audit of unborn children subject to child protection plans which, in turn, has resulted in revised practice guidance being issued. On other occasions learning activity can arise from an identified need to understand an area of practice more fully as a consequence of local or national priorities. This was the case with the multi-professional discussion forum and subsequent audit that we undertook in respect of intra-familial child sexual abuse and which has resulted in the commissioning of a new training offer.

BSCB promotes good practice through the publication of SCRs on its website, together with practitioner briefings. We offer practitioner workshops to promulgate learning from SCRs which, together with findings from our audit and review programme, is also incorporated within our wider training programme. Board members are likewise expected to promote learning within their own agencies. This is nevertheless an area of work which we recognise we could be more effective in and during forthcoming months we will start to publish regular newsletters and practitioners briefings covering the findings of our wider review activity.

Serious Case Reviews

LSCBs are required to undertake a serious case review 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 SCRs and their response to the findings.

BSCB continued to manage high levels of SCR activity, relative to its size, throughout the reporting period. By the end of the year we had commissioned 12 SCRs in the past five years, which equates to 8.4 per 100,000 child population annually, compared to a national average of 0.97 (based on SCRs commissioned between 2011 and 2014).

The Year in Numbers

SCRs underway at 1st April 2017	2
SCR Referrals received in year	10
SCRs commissioned	3
Multi-Agency Learning Panels agreed	1
Referrals resulting in no further action	6
SCRs completed in year	2
SCRs ongoing at 31st March 2018	3

The Multi-Agency Learning Panel (MALP) noted above is a means of quick review that BSCB has introduced. It involves a one-off meeting with practitioners involved in a case to discuss the strengths and weaknesses of multi-agency interventions (based on the chronology compiled for the referral consideration process), after which a brief report with recommendations is compiled. A further two MALPs were agreed toward the year end on cases that were not accepted as meeting the criteria for consideration for SCR, but where there was felt to be learning. All three MALPs are scheduled for summer of 2018.

Of the three ongoing SCRs at the year-end two, commissioned in March and April 2017 respectively, had been significantly delayed by criminal investigations, while the third was on track to be completed as expected. One of the two SCRs completed in year was published in April 2018 and will therefore be reported in our next annual report, together with the outcomes of actions resulting from the review.

Finally, the Child BX SCR was completed in year, however a decision was taken not to publish the report to protect the identity of the victim. BSCB nevertheless developed an action plan to implement changes as a result of the learning obtained within the review and published a practitioner briefing to disseminate learning from the review. The practitioner briefing highlighted the need to analyse what underlying issues risk-taking behaviour in teenagers was communicating, to ensure that what a child is saying properly informs assessments and subsequent plans, and to escalate concerns when a plan is not progressing.

Outcomes of Serious Case Reviews

It was noted in our last annual report that a significant number of actions remained underway from previous reviews, some of which had significantly exceeded their timeframe for implementation and were effectively stuck. The position at the end of this reporting period was more positive with the action plans from all completed reviews having been implemented. We are therefore in a position to report the following outcomes from recent review activity:

The quoracy, recording and effectiveness of **Strategy Meetings** had been highlighted in a number of reviews (and audit activity). Children's Services consequently undertook a more in depth audit of strategy meetings and section 47 enquiries that has resulted in changes in practices within the Front Door and the revision of recording templates used. This finding, coupled with ones from other review activity in respect of core group meetings, has resulted in BSCB publishing Multi-Agency Standards for Safeguarding which forms a reference guide for practitioners as to what is expected of them at each stage of the safeguarding process.

Three recent SCRs had identified a failure to complete **Early Help Assessments**, together with other shortcomings in respect of the thresholds and assessment documentation of the time. These findings influenced the development of the new documentation, outlined in Chapter 4.1, above, for example resulting in the inclusion of specific indicators around parental substance misuse and harmful sexual behaviour.

Return Home Interviews following missing episodes had been found to be ineffective, or simply not completed. The templates used by practitioners have subsequently been revised to include specific questions about CSE, while work is ongoing to improve completion rates with some more recent success (see Chapter 4.2 above).

Two SCRs identified that actions on **Child Protection Plans** were not effective in driving core group activity and therefore achieving change. These influenced a broader review by Children's Services of working practices that has resulted in the introduction of the Risk Sensible model. This requires practitioners to base plans on direct risk factors, resulting in fewer but more effective actions. BSCB has supported the multi-agency roll out of the model through the delivery of training and materials.

Following the publication of two SCRs in which parents did not follow safer sleep guidance, a **Home Safety Risk Assessment** has been developed to support practitioners to make enquiries as to where babies sleep in practice, together with a number of other home safety factors. A co-ordinated multi-agency timeline for the delivery of safer sleep materials and messages has also added routine enquiry as to where the baby will sleep into ante-natal appointments. Assurance has been received that these are used by health visitors and children's centres in Blackpool, which will be tested in a forthcoming audit.

A number of reviews had noted that the **Voice of the Child** either was not recorded, or that there was no evidence that it informed subsequent assessments or plans. Children's Services have subsequently introduced a requirement to record children's views verbatim and have introduced a programme of Learning Circles to develop practice in this respect.

Findings of reviews have also resulted in revised policies launched during the year in respect of Resolving Professional Disagreements and the commissioning of Harmful Sexual Behaviour training. BSCB equally learns from the process of conducting reviews and commissioned a workshop for staff members who complete chronologies for reviews to develop effective practice.

Child Death Overview Panel

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

By its very nature the death of a child is 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 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.

There were 11 deaths of children ordinarily resident in Blackpool during the reporting period (2017: 14). CDOP reviewed 11 deaths, with five completed within nine months of the death and the remainder taking one year or longer (a CDOP review occurs after all other legal and review processes are completed, so can be subject to lengthy delays).

Of the 11 deaths reviewed:

- 6 were male and 5 female
- 9 were aged under one year of which 8 were under four weeks old
- 7 were expected (predictable 24 hours prior to death)
- 5 were recorded as chromosomal, genetic and congenital anomalies, the most commonly recorded category (in 2016/17 it had been peri-natal/ neo-natal events)
- 2 were deemed to have modifiable factors (circumstances that, if changed, would reduce the risk of future child deaths), however there were no common themes in these

The weakness of data derived from CDOP is that the number of deaths considered (even pan-Lancashire only 128 were considered in year) is statistically insignificant. Consequently, while a 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. This can be overcome by larger scale analysis and thematic reviews. A recent analysis of ethnicity by category of death of 591 children pan-Lancashire reviewed between 2012 and 2017 identified a disproportionate overall number of deaths amongst the Asian Pakistani ethnic group compared to their proportion within the community. It likewise identified differences in the proportion of death in each category according to ethnic group, which can be used to inform future public health activity. Blackpool recorded a lower proportion of deaths in non-white ethnic groups than its overall population, although on this smaller scale again a degree of caution has to be exercised.

CDOP undertakes a range of awareness raising activities as a consequence of its findings. Its most prominent is the Safer Sleep campaign that has been recognised as effective practice by the National Institute for Health and Care Excellence (NICE) and continues to be delivered to all prospective parents by health professionals and children's centres. A safer sleep conference entitled "Making Every Contact Count" was delivered to 120 practitioners in May 2017, including drama based workshops and presentations from a coroner, police and the SUDC service. CDOP publishes an occasional newsletter which has covered learning from pan-Lancashire and national CDOPs and holds meetings with groups of professionals to improve engagement with the overall process, with a particular emphasis on GPs during the reporting period.

What we will do next

- Complete thematic reviews into deaths attributed to trauma and to infection, together with a review of recent deaths by suicide.
- Consider the findings of a recently completed audit of ACEs identified in reviews
- Build links to the local suicide reduction programme and the national review of deaths of children and adults with learning difficulties
- Ensure a smooth transition to new Child Death Review processes

Sudden Unexpected Deaths in Childhood

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 wherever possible. The pan-Lancashire SUDC service is provided by LCFT and during the reported period consisted of two dedicated nurses who work in conjunction with multi-agency partners, including children's services, acute hospital trusts, primary care providers, Lancashire Constabulary and North West Ambulance Service. The service responded to 42 deaths during 2017-18, which was the lowest number for four years, but within the expected range.

We reported in our last annual report that an external review of the SUDC service had been undertaken, by a Public Health registrar, to assess its conformity with Working Together and the strengths and weaknesses of the current model. The review concluded that the nurse led response, within working hours, was effective and generally ran smoothly, but that the out of hours response which disproportionately relied on the on-call acute paediatrician was not of sufficient quality. The quality of this initial response was assessed to be 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 of deaths in a given period can be outside office hours and therefore receive a lower standard response. The report was endorsed by the three pan-Lancashire LSCBs and the CCGs responsible for commissioning the service were asked to review the identified options for expansion. This has resulted in a seven day a week nurse led model being commissioned that will ensure that all parents receive a response within 24 hours of the death, this is projected to commence prior to the end of 2018.

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

Audit activity

When a specific issue is identified by review, data analysis or inspection regimes 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. Our own Multi-Agency Audit Group (MAAG) audits are complemented by audits that we occasionally request from other agencies.

During the reporting period the MAAG has undertaken audits in respect of safeguarding unborn children, intra-familial child sexual abuse, neglect and Early Help Assessment forms, with the findings of the latter two having already been outlined in Chapter 4 above. We also requested that Children's Services audited multi-agency involvement in child protection conferences and core groups. Our audit processes have been influenced by the requirement of JTAIs for partnerships to evaluate a small number of cases within a five day period. We have consequently implemented a standard process and audit tool by which we aim to focus on the outcomes for children of multi-agency interventions.

Safeguarding Unborn Children

This audit was commissioned as a consequence of the Child BW SCR and reviewed the multi-agency response to five unborn children who were subject to child protection plans. We found that referrals were made in a timely way, but that the subsequent assessments were not which resulted in late Initial Child Protection Conferences (ICPCs), although post birth review conferences were timely (this finding was subsequently supported by the CQC inspection noted in Chapter 5, above). There was a lack of multi-agency planning prior to ICPC, with inquorate strategy meetings noted in three cases. There was nevertheless good multi-agency attendance at conferences and core groups and evidence of management oversight, although this did not result in challenges to delays in processes. As a consequence of this audit, more detailed guidance has been provided to practitioners in respect of pre-birth processes and monthly multi-agency meetings, between CSC and specialist midwives, are being introduced to review pre-birth children with safeguarding concerns.

Intra-Familial Child Sexual Abuse

This audit was prompted by increasing national attention applied to the topic due to the Independent Inquiry into Child Sexual Abuse and a recognition that it had been overshadowed by CSE in recent years. The audit of five children subject to child protection plans under the sexual abuse category identified good multi-agency working and information sharing, including to manage perpetrators. Decision making around thresholds was seen to be appropriate. A number of the findings of this audit coincided with those from earlier audit and review activity in that all the strategy meetings were inquorate, child protection plans were not viewed to be sufficiently risk focussed and core groups were not minuted as expected. Work in respect of the former two findings has already been reported in Chapter 6.1 above. In two cases the ICPC was not timely, although this finding does not coincide with our wider auditing or data, so is not considered to be representative of a wider issue.

Child Protection Conferences and Core Groups

This audit was undertaken by the Children's Services Safeguarding, Quality and Review service, at the request of BSCB, and reviewed 20 child protection cases with recent conferences, evenly split between Initial and Review Child Protection Conferences (ICPC and RCPC). The audit concluded that multi-agency attendance at ICPC was good, although there was more room for improvement at RCPC. There was clear evidence of defensible decision making in respect of thresholds in the majority of cases. Core group dates were agreed at conference, however attendance was less positive and in ten cases deemed inadequate, with a further eight requiring improvement. Shortcomings were identified in a number of the supporting processes with three quarters of conference minutes distributed outside the expected timescale, a significant number of reports to conference having not been shared with the parents beforehand, partner agencies not assisting with the minuting of core groups and minutes not being distributed. The audit has resulted in ongoing monitoring of a number of the issues noted and the agreement of revised conference paperwork. Processes for inviting individual agencies have been reviewed and those whose attendance fell short of expectations have been challenged accordingly. The recently published Multi-Agency Standards for Safeguarding document will additionally support this work by making it clear what is expected of all agencies.

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 2017-18 audit returns were requested and received from nine partner agencies. The audit is split into nine sections against which agencies are asked to evaluate themselves as red, amber or green. There was an increase in the number of areas self-evaluated as amber with 10 of 81 areas done so this year, compared to four the previous year. PMEG subsequently moderated these self-evaluations and agreed that 26 areas should have been graded as amber on the basis of the evidence provided (an amber grading reflects appropriate policy and procedures being in place, but evidence not being provided of their application). Partner agencies were written to in respect of areas graded as amber and further evidence or assurance that plans were in place to remedy shortfalls was received (most commonly in terms of safeguarding training). The one area in which partner agencies were least likely to be able to provide appropriate assurance was that of safeguarding supervision. All had appropriate policies and procedures in place, however none could provide systematic evidence of their implementation, although some undertook surveys of staff to capture their experiences of supervision. The need for further assurance in this respect is emphasised by a lack of management oversight being identified in a number of recent SCRs and audits and supervision being identified as an area of weakness in the recent CQC safeguarding and children looked after and HMICFRS Lancashire Constabulary child protection inspections.

BSCB routinely undertakes frontline visits to partner agencies to meet practitioners and test whether their experiences tally with what has been reported within their agency's Section 11 return. During the reporting period BSCB representatives visited the Blackpool offices of Cumbria and Lancashire Community Rehabilitation Company (CLCRC) and HM Prison and Probation Service (HMPPS). During the CLCRC visit practitioners who directly supervise offenders were spoken to, alongside unpaid work and programmes staff. Evidence was seen of effective safeguarding practice, including multi-agency working and information sharing across the company. Staff spoken to reported receiving safeguarding supervision and training. HMPPS practitioners reported effective multi-agency information sharing to support court processes. Staff reported receiving supervision, while awareness of safeguarding issues had recently been raised through a 'safeguarding awareness month'. While HMPPS do not deliver services directly to children they are developing a care leavers' offer, which will support the particularly vulnerable group of care leavers in custody.

Section 175 audits

Under section 175 of the Education Act 2002 schools are required to ensure "that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children". In a similar process to the Section 11 audits noted above, schools are asked to self-evaluate their safeguarding practices on an annual basis through Section 175 audits. At the request of our schools, the timing of this process was changed to the autumn term to allow for the inclusion of any statutory guidance and the submission of safeguarding data for the previous academic year. We received returns from 36 of our 44 schools this year (82%), which continues to fall below our target of 100% returns. Seven primary and one secondary school failed to submit returns, including three schools within a multi-academy trust which has consistently refused to engage in the process.

Returns received provided assurance in respect of compliance with Keeping Children Safe in Education, the provision of safeguarding training, policies, recording (almost all now have electronic safeguarding systems), recruitment and allegations management. All schools reported undertaking surveys or using their pupil councils to assess whether children feel safe. Safeguarding data has been requested as part of the audit process for three years to date and it is evident that schools are increasingly able to respond to the challenge of evidencing their safeguarding activity, with only three unable to provide any data this year. The data provided evidenced early help and safeguarding activity at each stage of the system, including allegations made against staff members. There was a wide range in the reported number of instances of early help provision which is thought to result from some schools including solely behavioural interventions in this category. However, the broader data matched expected patterns of increased safeguarding activity in schools situated in areas of greater deprivation. The was no evidence of any one school making a disproportionate number of referrals to the Front Door and while a greater number of private fostering cases was reported then expected, this has since been clarified to result from misunderstandings in respect of the definition. The self-evaluation programme increases the understanding of both schools and BSCB of their ability to keep their pupils safe, while confidence in the validity of the self-evaluation process is provided by the ongoing programme of audit visits undertaken by the Schools' Safeguarding Advisor. It is similarly noted that no school has received adverse comments from Ofsted in respect of safeguarding practice for three academic years to date.

Dataset

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

During the reporting period BSCB utilised a model developed by Greater Manchester LSCB 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 was produced on a quarterly basis and monitored by PMEG, with the full report being submitted to the Strategic Board on a six monthly basis. Having previously struggled to develop more in depth datasets in respect of areas of particular concern, BSCB appointed a half-time analyst shortly before the start of the reporting period. This has allowed us to develop the CSE/ MFH and DA datasets that are noted in Chapter 4 above, along with greater detail being provided to the overall dataset.

Toward the end of the reporting period BSCB reviewed its use of data and identified an over-reliance on Children's Services data, at the expense of the wider partnership, and a need for greater analysis and understanding as to what the data tells us about outcomes for children in Blackpool. During 2018-19 BSCB will start to use a model in which all partner agencies are asked to submit summaries of safeguarding activity, data, audits and outcomes on a six monthly basis. These returns will be scrutinised by PMEG and challenge provided, where necessary. By doing so it is hoped that a more holistic understanding of the partnership's safeguarding activity can be developed.

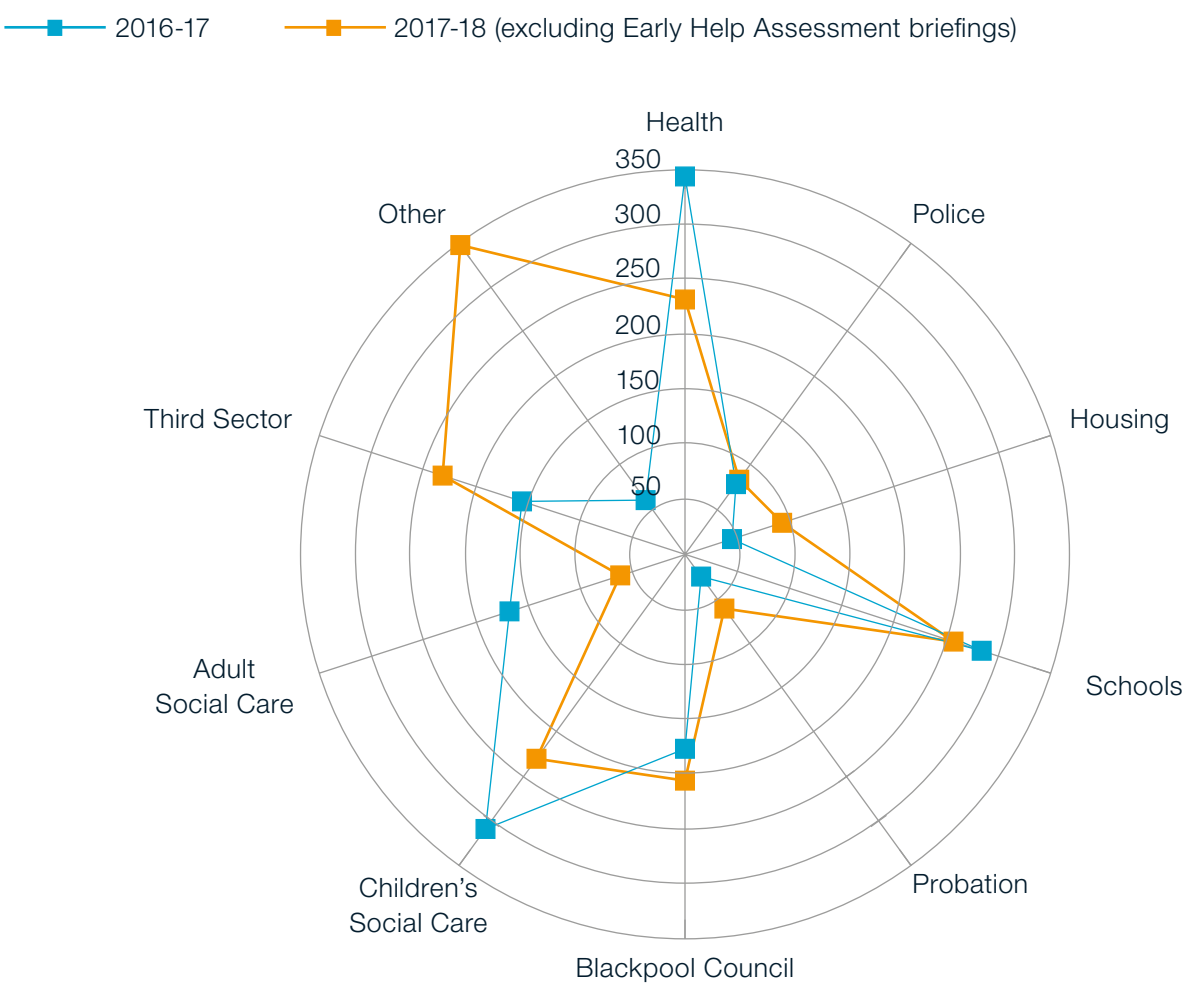
Training

Working Together requires LSCBs 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. This training offer forms the crucial final link in the Learning and Improvement Framework, in that improvements in practice can be promoted.

Our approach to training and development is set out in our Training Strategy 2016-19 and underpinned by our Operating Framework. BSCB delivers a shared training programme with BSAB which allows us to provide courses that cover the full safeguarding spectrum to the children's and adults' workforces, while also maintaining a number of child specific courses. Our two training co-ordinators (1.6 FTE) develop and deliver the programme, with the support of a pool of multi-agency and commissioned trainers. Operational oversight is provided by the Training and Communications subgroup.

During 2017-18 we delivered training to 2,552 practitioners on 130 courses (this omits attendance at courses with solely safeguarding adults content), with a further five courses were cancelled due to trainers becoming unavailable and five due to low numbers of applicants. This represents an increase of 904 attendees on 2016-17, although if the one off series of Early Help Assessment form briefings are discounted there is a more modest increase of 157 attendees. This increase masks variations in attendance by sector with declines in attendance in excess of 25% recorded by the health sector, Adult Social Care and CSC balanced by significant increases in attendance from the third sector, early years settings and residential settings. A number of our core courses have been offered for lengthy periods of time now and attendance is declining, while new courses tend to be over-subscribed. This is an issue that BSCB will seek to address in 2018-19.

Training attendance by sector



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 income received, which is re-invested to fund external trainers and conferences. The non-attendance rate during the reporting period declined to 6.2% (2017: 8.0%), which yielded income of £9,570. CSC practitioners remain the most frequent non-attenders with a rate of 12.7%. Of greater concern is that 16.3% (2017: 21.9%) of participants cancel prior to the day of training, this carries an additional administrative burden for the Board and wastes spaces that we are not always able to fill at short notice.

The training programme is continually reviewed in light of changing practice expectations and learning from audits and reviews. During the reporting period the Resilient Therapies and Risk Sensible models that have been adopted in Blackpool have been incorporated throughout the training programme; with a new course, entitled the Blackpool Way, in development to specifically cover their underpinning theory and application, together with the early help process. A number of new courses have been introduced including New Psychoactive Substances, a generic Designated Safeguarding Lead, Teen Dating, To See or Not to See (pornography and adolescent development), Understanding Child Sexual Abusers and Understanding the Impact of Sexual Abuse on Children.

The Training and Communications subgroup has been grappling with how to measure the impact of training throughout the reporting period. A paper based evaluation system had been in place for a number of years which required participants to fill in pre- and post-course evaluations on the day of training. A review of evaluations from six courses delivered between April and October 2017 provided average scores (graded from 1 to 5, with 5 being most positive) of 4.68 for the training meeting stated aims and objectives, 4.64 for being relevant to the participant's professional role and 4.39 for confidence to apply the material. Participants were also asked to score their knowledge of specific elements of the course content prior to and after the course, with an average increase of 1.61. The review also demonstrated the time consuming nature of analysing paper returns and the limited amount of qualitative feedback provided (although we had acted on feedback in respect of one course that too much content was covered in the day). These findings, together with a recognition of the need to develop an evaluation system that can evidence the impact of training on practice and ultimately the children of Blackpool, has led to the introduction of a web-based evaluation system that will be able to provide aggregated data on returns. This will be supported by the introduction of telephone calls to participants a number of weeks after completing a course to assess the impact of training on practice. Outcomes of this process will be included in our next annual report.

Notwithstanding the difficulties of evidencing the impact of training on practice and the lives of the children with whom the attendees work, on the day feedback is overwhelmingly positive with the following comments made during the year:

"Extremely relevant to my role and it was beneficial to have the training delivered by a health professional"

"The information presented during the course was informative, as well as the presenter being engaging and interesting. The information was delivered well, and this showed by involving the group in group work to demonstrate understanding. The involvement of the fire service put a different perspective on the course, and I believe this to have been extremely useful and informative"

"I really enjoyed this course and found it very useful in my role as a foster carer, the trainers were excellent and very knowledgeable!"

What we will do next

- Undertake a training needs analysis of our partner agencies to inform the development of our ongoing training programme
- Embed the new evaluation process and use this to evidence the impact of training and develop our training programme
- Continue to review demand for our training programme and develop our training offer accordingly

PARTICIPATION

Children

BSCB seeks to understand the experiences of children on an individual and group basis in order to assure itself that safeguarding provision is effective and meets their needs. Until the end of the 2016-17 academic year we had an established Pupil Voice Group which had been attended by children from all Blackpool secondary schools and one special school. Feedback from this group suggested that children predominantly felt safe at home and in school, but less so online, on public transport and in public places. All children nevertheless reported having received online safety input in school. Many of the environmental issues raised are outside the remit of BSCB, however these issues were reported in appropriate forums and work has subsequently been delivered to improve children's safety and confidence on public transport. This group reached a natural conclusion as many participants left the schools that they represented.

This is consequently an area of work that BSCB needs to re-establish and it was agreed shortly prior to the year-end that this would be done in conjunction with the Young People's Engagement Group of the Head Start project. This has the benefit of being an established group with representation from a range of ages and backgrounds. In the meantime BSCB will continue to seek assurance that the views of individual groups of children are captured, for example those open to Awaken and Looked After Children. BSCB will also continue to include routine questions in audits as to whether the views of children are evidenced and acted on. We have seen improved recording of the views of children in the last year, however evidence of it being considered in assessments and acted on is weaker.

Practitioners

BSCB similarly seeks to understand the experiences of frontline practitioners to ensure that multi-agency systems and training enables them to effectively safeguard children. During the reporting period we have moved from a model of a standing Shadow Board that was used to comment on issues considered by the Strategic Board and disseminate Board documents, to one of Multi-Professional Discussion Forums (MPDF) in which bespoke groups of practitioners are drawn together to discuss their experiences of working with a particular issue or group of children, thereby enhancing BSCB's understanding of how systems could be improved.

Our first MPDF considered the issue of Intra-Familial Child Sexual Abuse and was attended by 18 practitioners from a range of agencies. Aspects of good practice were identified, including information sharing once children were within the child protection system, together with the difficulties faced by voluntary agencies in engaging with children who might have been abused. One specific issue in terms of the distance children are required to travel to access therapeutic interventions has subsequently been raised with the commissioner, while BSCB has commissioned training on the issue as a result of feedback received on the day. Subsequent MPDFs will be linked to our audit activity to enable audit findings to be tested against the wider experiences of practitioners, with a joint report being produced.

Communications

LSCBs have a statutory responsibility to communicate with "persons and bodies in the areas of the authority the need to safeguard and promote the welfare of children". A range of activity in this respect has already been noted, including our training programme and practitioner briefings arising from reviews, together with public awareness raising work during CSE awareness week. During the reporting period we have also established a Twitter account which is promoted through our training programme with a primary audience of practitioners. From April 2018 we will also be starting to publish a monthly seven minute briefing, in conjunction with our colleagues in Lancashire, and a newsletter.

We recognise that we could do more to raise public awareness of safeguarding issues and have consequently become part of a pan-Lancashire Communications and Engagement group. This has enabled us to develop a communications strategy and planned series of public awareness raising campaigns for the forthcoming year. An overview and evaluation of these campaigns will be included in our next annual report.

EXAMPLES OF EFFECTIVE MULTI-AGENCY WORK

Parents as Partners programme

Dan and Chloe have five children who were referred for a CSC assessment following a domestic abuse incident. At this point they had ended their relationship and there was not felt to be the need for statutory intervention, however the family was referred to a children's centre for support. When they chose to resume their relationship the children's centre referred them to the Parents as Partners programme. This is a 16 week programme that facilitates discussions between the parents to encourage them to resolve issues that they are having. Participants look at their own relationship, that with their children and their wider family and social relationships.

Through the programme Dan and Chloe have developed strategies to resolve disagreements, including talking away from the children and not shouting. They have developed ways to take time out from each other and to recognise good and bad times to talk. Chloe has gained the confidence to discipline the children, while Dan has started to discuss his own childhood experiences and see how these affect him now. These changes have meant that their children are safer and that they can live together as a family without the need for CSC involvement.

Awaken

Alice is a 13 year old girl who was referred to Awaken following concerns that she was being groomed by an 18 year old male. She had been reported missing from home returned under the influence, while her school attendance was also slipping. She was seen by the Awaken health worker who identified unresolved issues surrounding her dad leaving the family home when she was much younger, the recent death of a friend, alcohol abuse and a considerable degree of immaturity which made her more vulnerable.

As is often the case with Awaken, Alice has required a lengthy period of support which has been mostly provided by the health practitioner as the practitioner able to develop the most effective working relationship with her. She has gradually been supported to access mental health and substance misuse services and did accept emergency contraception. Individual interventions have increased her knowledge of CSE, healthy relationships and sexual health. As underlying issues have been addressed she has also been able to access suitable educational provision.

SUDC Service

Following Peter's tragic death a joint SUDC response was provided by the SUDC nurse and Police, initially meeting the parents, who were understandably very distressed, in A&E.

The following day the SUDC Nurse undertook a home visit and saw both parents and met Peter's siblings. The role of the SUDC Nurse was discussed and the child death process was explained. His parents had lots of questions regarding how this could have happened and were anxious to know when they would find out why their child had died.

Regular support visits were offered in the weeks following the child's death. Mum needed a lot of emotional support and requested regular visits. Initially these were weekly and after several weeks became monthly, with regular telephone contact throughout. The SUDC Nurse provided compassionate support to the mother, father and children.

In addition, the SUDC Nurse supported mother to see her GP and to be referred for mental health support. The SUDC Nurse also referred mother for bereavement counselling and referred the children to Winston's Wish for bereavement support.

The SUDC Nurse liaised with all agencies and professionals known to the family. Peter's parents did not feel able to meet any professionals and declined any follow up appointments once they received the cause of death. The SUDC Nurse liaised with relevant professionals and acted as an advocate for the family in obtaining explanations regarding the cause of death and answering any queries the family had.

The SUDC Nurse continued to offer home visits until mother felt able to deal with her grief and the necessary support was in place for all family members.

Out of area looked after child

Aisha is 17 and living in semi-independent accommodation in Blackpool, but under the care of another local authority. She has been in care since the age of 4 and had numerous different placements. She has a number of physical and mental health needs, and concerns were emerging about her ability to maintain her tenancy. Concerns have been expressed that she is in an abusive relationship and that she has been physically assaulted by her birth mother, with whom she remains in contact.

Following her move to Blackpool she was seen by the CLA team here who supported her to access health appointments and ensured that information was shared between the midwifery team and her placement when she thought that she was pregnant. While this was not the case, she was then referred to BYPS for further support and a Multi-Agency Risk Management meeting was convened to share information and concerns about her partner and the risk that he was assessed to present. As Aisha has not felt able to access formal mental health services the CLA nurse has provided additional individual support. She has been helped to maintain her tenancy which has helped reduce the pattern of repeated breakdowns of placement.

MASH

By piecing together multi-agency information the MASH can enable a fuller picture of risks to be developed. PVPs are graded by Police Officers on the basis of what they identify at an individual incident. Following the submission of a PVP graded as standard the health practitioner in MASH identified that this was the third DA incident between two parents within a few months and that their young baby had been present on each occasion. By seeking health visitor information it was identified that maternal grandmother had expressed concerns about dad's aggressive behaviour and that dad had been making false allegations about mum's mental health to Police Officers. This sharing of information has resulted in CSC starting a full assessment which will ensure that the baby is kept safe.

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 the report and to consider its overall message. The report has sought to meet the statutory requirement 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". Perhaps a more significant question to ask though is what impact has the LSCB and its partners through their operational safeguarding activity had on the lives of children in Blackpool?

The report has highlighted areas in which definite progress was made during the reporting period. We have agreed a pan-Lancashire Continuum of Need that provides the framework by which practitioners can make judgements about the level of intervention that a child needs, while the introduction of the Risk Sensible model allows better informed decision making at child protection conferences. There is early evidence from audit activity that both are becoming embedded in practice. The rate of children receiving statutory interventions in Blackpool continues to be well in excess of those seen nationally. However, reductions have been evident in recent months, notably in terms of child protection plans. This is a positive outcome for children in that it means that more are receiving the right level of intervention to meet their needs, which has been demonstrated in more recent audit activity. This is not the end of the story though and more work is needed to understand the volume of early help work in Blackpool and to obtain assurance that early help is being effectively provided by all agencies at the earliest stage at which unmet needs are identified. Similarly, there remain indications that too many contacts and referrals are being made for statutory intervention and subsequent assessments undertaken. This would suggest wider cultural changes are needed to increase practitioner confidence to deliver early help, in addition to the structural changes already made to establish the Early Help Hub.

A range of multi- and single-agency activity to safeguard children has been showcased, including the ongoing multi-agency response to child sexual exploitation and missing from home. We have been able to demonstrate a better understanding of the scale of each issue in this report, together with a significant volume of multi-agency activity to address them. We do, however need to better understand the outcomes for children of this work. Similarly, new interventions for children living with domestic abuse and means to assess neglect have been outlined, but will need to be judged by the difference that they make to the lives of children in Blackpool in the longer term.

BSCB has continued to experience high levels of serious case review activity, despite not publishing any reviews in year. What has been positive though is emerging evidence of changes made in response to review and audit activity. This has been evident in the work to address repeat findings about strategy meetings, return home interviews and the safeguarding of unborn children. Work in this respect is very much in progress at the year end, but should provide a longer term means by which agencies are able to respond more effectively to children and keep them safer. Reviews have also produced changes in practice on a single-agency basis, with significant changes being made by the NSPCC to their recording processes for Baby Steps as the consequence of issues that they identified as part of the process of developing their chronology.

It can be concluded that BSCB itself remains compliant with statutory requirements in terms of membership and that the majority of strategic board members have met the attendance requirement, which has not been the case in recent years. We have taken the opportunity provided by a change of chair to review the scope of our activities and re-focus on core statutory objectives of seeking assurance that work to safeguard children is effective. Our Section 11 and Section 175 audit activity has continued to provide assurance that partners meet their statutory obligations in respect of safeguarding and these have been triangulated against inspection findings where possible. During the forthcoming year, we aim to enhance our understanding of our partners' activities through our new quality assurance process. We will also seek to step up our engagement with children to better understand their concerns and ensure that they are at the centre of our thinking and that of the successor body to BSCB, which will emerge in 2019.

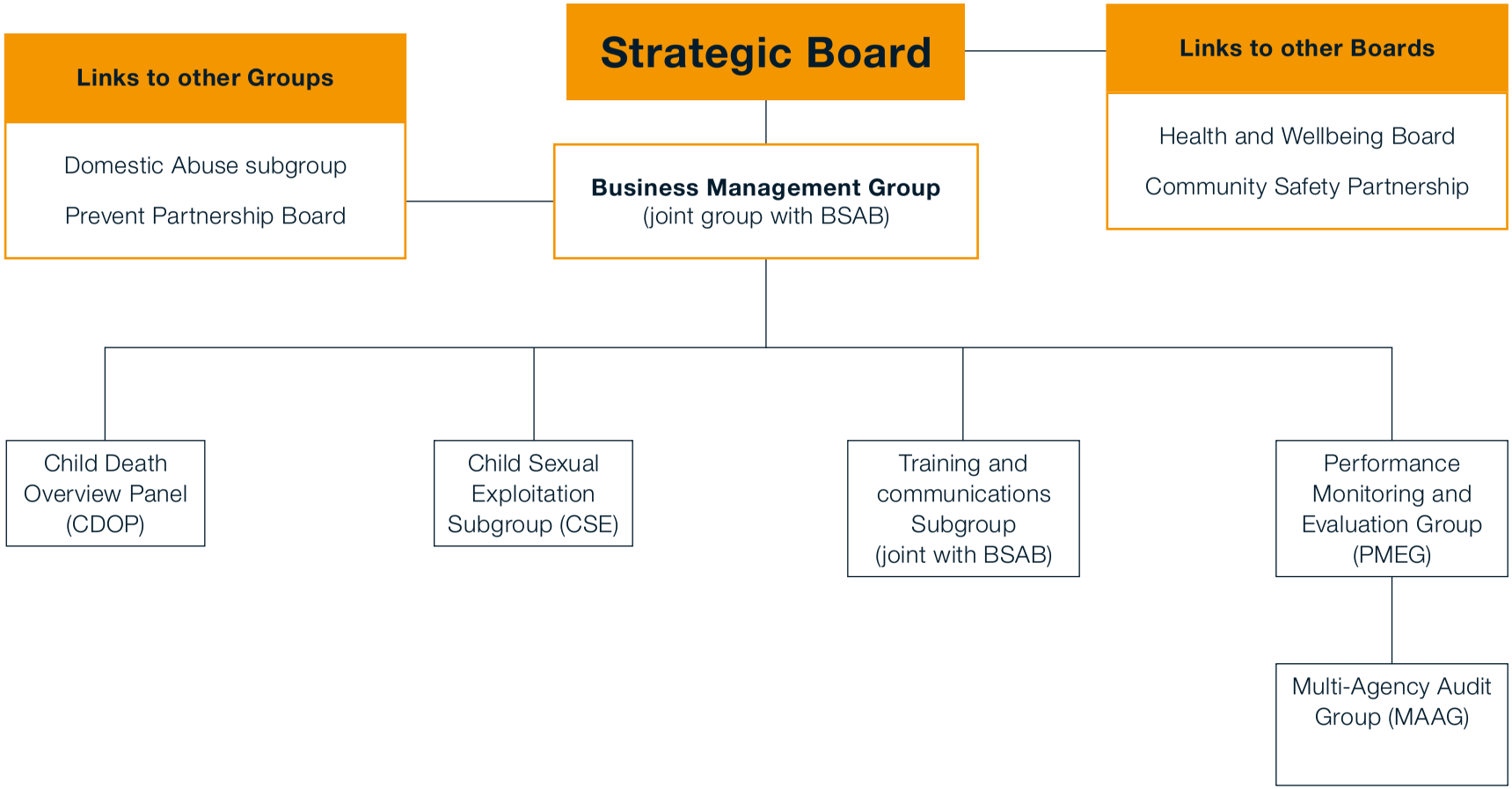
APPENDIX A

Strategic Board members at the time of publication

Name	Title	Agency
Nancy Palmer	Independent Chair	
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	Head of Early Help	Blackpool Council
Louise Storey	Head of Children's Social Care	Blackpool Council
Paul Turner	Head of School Improvement	Blackpool Council
John Hawkin	Head of Leisure and Catering Services	Blackpool Council
Kate Barker	Early Years Improvement Officer	Blackpool Council
Lesley Anderson-Hadley	Chief Nurse	Blackpool CCG
Cathie Turner	Designated Nurse	Blackpool CCG
Dr Nigel Laycock	Designated Doctor	Blackpool CCG
Dr Sujata Singh	GP Representative	Blackpool CCG
Marie Thompson	Director of Nursing	Blackpool Teaching Hospitals NHS Foundation Trust
Hazel Gregory	Head of Safeguarding	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
Amanda Wooldridge	Deputy Headteacher	St John Vianney's RC Primary School
Graham Warnock	Headteacher	St George's Secondary School
Cole Andrew	Headteacher	Woodlands Special School
Wendy Casson	Headteacher	Educational Diversity
Sheena Tattum	Superintendent	Lancashire Constabulary
Eric Halford	Detective Chief Inspector	Lancashire Constabulary
Stephen Dunstan	Director of Finance and Resources	Blackpool Coastal Housing
Jackie Couldridge	Service Manager	CAFCASS
Sonia Turner	Head of North West Lancashire	HM Prison and Probation Service
Elaine Seed	Deputy Director	Cumbria and Lancashire CRC
Amanda Quirke	Senior Service Manager	NSPCC
Faye Atherton	Head of Services	Blackpool Carers Centre (Third Sector representative)

APPENDIX B

BSCB Structure Chart



APPENDIX C

Priority 1: In the context of the Children and Social Work Act and the removal of statutory LSCBs to ensure continuity, clear governance and strategic arrangements during the transition period.			
Actions	**Leads**	**Timescale**	**Update**
1. To ensure that the LSCB continues to deliver through the transition period.	Chair	March 2019	
2. To participate in the development of new multi-agency safeguarding arrangements.	Chair/ LA/ CCG/ Police	March 2019	
3. To work with Pan-Lancashire and Cumbria LSCB to achieve greater consistency in multi-agency safeguarding arrangements and practice.	Chair	March 2019	
4. To develop reporting and mutual challenge within the LSCB and to other strategic boards in Blackpool.	Chair	September 2018	
5. To ensure the full engagement of schools in current and future multi-agency safeguarding arrangements.	Chair/ Paul Turner	March 2019	

Priority 2: Develop a joined up multi-agency learning and outcomes framework.			
Actions	**Leads**	**Timescale**	**Update**
1. To co-ordinate all multi-agency learning and review activity to ensure that emerging themes are explored and that learning is implemented.	PMEG	March 2019	
2. To implement a programme of multi-agency practitioner review panels for cases that do not meet the SCR threshold, but where there is likely to be learning.	BMG	September 2018	
3. To implement a programme of multi-professional discussion forums to explore the frontline response to safeguarding themes.	PMEG	September 2018	
4. To develop an understanding of the impact of BSCB training.	Training subgroup	September 2018	
5. To develop a programme of concise practitioner briefings.	Training subgroup	September 2018	
6. To implement a new quality assurance reporting framework.	PMEG	December 2018	

Priority 3: Understand the impact of multi-agency safeguarding activity on children and families in Blackpool.			
Actions	**Leads**	**Timescale**	**Update**
1. To seek the views of children and families within the multi-agency audit group process.	MAAG	September 2018	
2. To develop and understanding of the impact of training on children and families.	Training subgroup	March 2019	
3. To understand the experiences of children in Blackpool who need safeguarding.	BMG	March 2019	

Priority 4: To develop the multi-agency response to all forms of child exploitation.			
Actions	**Leads**	**Timescale**	**Update**
1. To ensure that Blackpool and pan-Lancashire strategic arrangements enable an effective response to all forms of exploitation.	CSE subgroup	September 2018	
2. To develop a local multi-agency action plan to address exploitation in all its forms.	CSE subgroup	June 2018	
3. To deliver effective multi-agency training (or a conference) that enables practitioners to recognise and respond to exploitation.	CSE/ Training subgroups	December 2018	

Glossary of acronyms

ACE	Adverse Childhood Experiences
BCCG	Blackpool Clinical Commissioning Group
BCH	Blackpool Coastal Housing
BMG	Business Management Group
BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
BTHNHSFT	Blackpool Teaching Hospitals NHS Foundation Trust
BYPS	Blackpool Young People's Service
CAFCASS	Children and Family Court Advisory and Support Service
CASHER	Child and Adolescent Support and Help Enhanced Response service
CCE	Child Criminal Exploitation
CDOP	Child Death Overview Panel
CLA	Children Looked After
CLCRC	Cumbria and Lancashire Community Rehabilitation Company
CON	Continuum of Need
CQC	Care Quality Commission
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DA	Domestic Abuse
DAIV	Domestic Abuse and Interpersonal Violence (subgroup)
EHA	Early Help Assessment
FIN	Families In Need (team)
GCP2	Graded Care Profile 2
HMICFRS	HM Inspectorate of Constabulary and Fire and Rescue Services
HMPPS	HM Prison and Probation Service
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advocate
ISVA	Independent Sexual Violence Advocate
JSNA	Joint Strategic Needs Analysis
JTAI	Joint Targeted Area Inspection
LADO	Local Authority Designated Officer
LCFT	Lancashire Care NHS Foundation Trust
LSCB	Local Safeguarding Children Board

MAAG	Multi-Agency Audit Group
MACSE	Multi-Agency Child Sexual Exploitation (meeting)
MALP	Multi-Agency Learning Panel
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MFH	Missing From Home
MPDF	Multi-Professional Discussion Forum
NICE	National Institute for Health and Social Care Excellence
OPCC	Office of the Police and Crime Commissioner (for Lancashire)
PMEG	Performance Management and Evaluation Group
PRU	Pupil Referral Unit
PVP	Protecting Vulnerable People
RCPC	Review Child Protection Conference
RHI	Return Home Interview
SCR	Serious Case Review
SEND	Special Educational Needs and Disabilities
SUDC	Sudden Unexpected Deaths in Childhood
YOT	Youth Offending Team

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