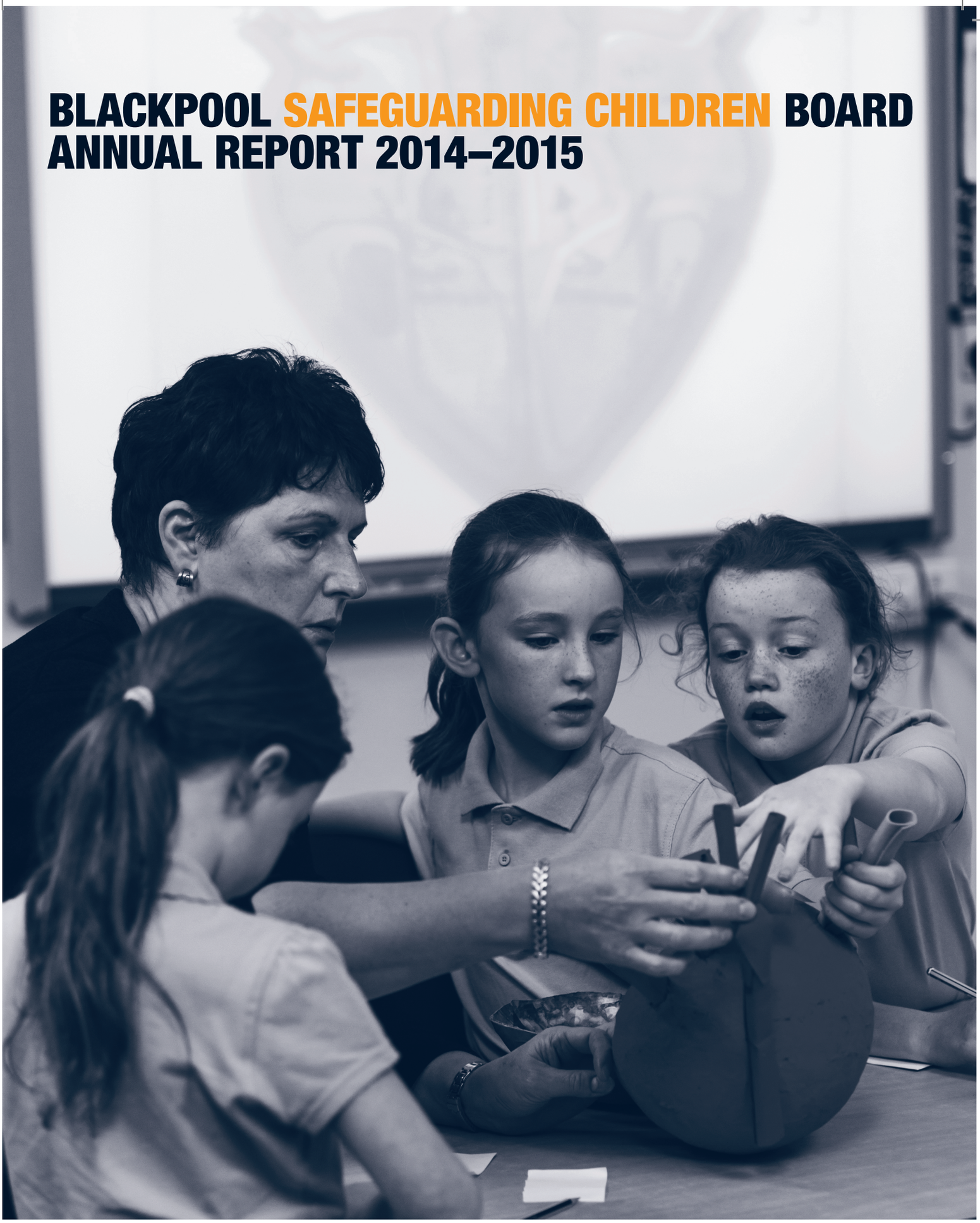
BLACKPOOL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014–2015



BLACKPOOL SAFEGUARDING CHILDREN BOARD

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INTRODUCTION

I am pleased to present the 2014/15 Annual Report of Blackpool Safeguarding Children Board (BSCB). It outlines the work of the Board during the year, assesses how effectively children are safeguarded within the area and outlines the challenges ahead for all agencies as we seek to work together to keep children safe from harm.

It has been a year of change for the BSCB, not least in the role of Independent Chair which I assumed in November 2014. My predecessor, Pauline Newman, led the Board through a difficult period following the 2012 Ofsted Inspection and I would like to take this opportunity to recognise her contribution to the progress that has been made. In the eight months that I have been in post I have been impressed by the energy and commitment of Board members; their obvious willingness to challenge each other to improve outcomes for children will stand us in good stead for the future.

Throughout the reporting period BSCB has been accountable to the Children's Improvement Board under the terms of the Improvement Plan imposed followed the 2012 Ofsted inspection of Local Authority Children's Services and of BSCB, which deemed both to be inadequate. The publication of a further inspection in September 2014 that judged both to require improvement demonstrated a positive direction of travel, but also the work yet to be done. I am pleased to report that since the year end the Improvement Plan has been signed off as complete and that BSCB will resume its full statutory duties.

Like all LSCB we are working in a time of increasing challenges within our population, but at a time of public sector re-organisation and dwindling resource. Our challenge is to ensure that all agencies with responsibilities to safeguard children in Blackpool are represented on BSCB and that we understand their work, I am consequently pleased to see early signs of progress in terms of developing our discourse with schools and GPs. It is also crucial that all agencies respond to the challenge of ensuring that BSCB is provided with the proper financial resources to be effective in its role.

The reporting period has been characterised by considerable learning activity for BSCB. We are in the process of undertaking an unprecedented number of serious case reviews, while the multi-agency audit programme was commended by Ofsted and continues to challenge and develop practice. Our reviews of child deaths have resulted in awareness raising campaigns for professionals and the continuing 'Safer Sleep' campaign for new parents. Over the next year we will collate this learning to identify what it tells us in totality and use this to drive systems changes.

Considerable progress has been made in terms of our provision of training during the last six months, aided by the recruitment of a Training Co-ordinator after a two year vacancy. This has allowed us to develop a training programme that reflects our current priorities and which provides a range of styles of training to meet to needs of a diverse group of professionals. Over the next year we will seek to better understand the effectiveness of our training to improve practice and to change the lives of children.

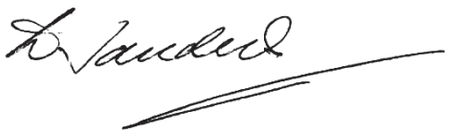
Safeguarding in Blackpool continues to be characterised by high numbers of children in need of help, at every stage of the system. Over the reporting period BSCB has sought understand this and to challenge agencies to ensure that referrals are appropriate and that help is provided at the earliest possible stage. I will ensure continuing oversight of the Getting it Right (GIR) assessment and referral framework and the Multi-Agency Safeguarding Hub (MASH). The successful establishment of these are critical to ensuring a prompt and effective response to lower levels of need which should reduce the pressure on higher tier services and, more importantly, the harm caused to children.

Like all Local Safeguarding Children Boards (LSCB) we have paid close attention to the plethora of national reports on child sexual exploitation (CSE) and have made some progress in understanding CSE within our area, which we know does not conform to the nationally understood model. Our CSE team continues to represent an effective multi-agency response to CSE, while local and pan-Lancashire oversight of CSE has been developed to ensure that a disconnect between the operational and strategic responses does not form. However, we must do more to understand what is an effective response to CSE, to raise professional and public understanding of CSE and to develop our knowledge of children who go missing.

Safeguarding children in Blackpool is the responsibility of numerous frontline professionals, to whom I would extend the thanks of all BSCB. I recognise that their understanding of safeguarding in Blackpool may not always be that of Board members and am keen to listen to what they can tell us. I am therefore pleased to report the establishment of Multi-Professional Discussion Forums (MPDF) and the Shadow Board which will provide an ongoing means to achieve this.

Our members have identified four safeguarding priorities for the next two years which are reflected in our new Business Plan. These are CSE, Neglect, Early Help and the Toxic Trio of parental mental health, substance misuse and domestic abuse. That these are reflected throughout this report is therefore no surprise and emphasises the challenge of tackling these. Finally, the voice and experience of children and young people should be at the centre of everything that we do. This is an area of our work that we need to do better and which I will prioritise over the next year.

Finally I would like to thank all members of the Board and the safeguarding team for their unstinting support, enthusiasm and sheer hard work in tackling safeguarding issues and reducing risk to children and young people in Blackpool.



David Sanders
Independent Chair, Blackpool Safeguarding Children Board

CHAPTER 1 - WHO WE ARE AND WHAT WE DO

The Blackpool Safeguarding Children Board (BSCB) is the partnership body responsible for co-ordinating and ensuring the effectiveness of services that safeguard and promote the welfare of children in Blackpool.

BSCB was established in 2006 in compliance with the Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. During 2014/15 the work of BSCB was governed by the statutory guidance of Working Together to Safeguard Children 2013, which sets out how organisations should work together to safeguard children.

We aim to fulfil our remit in two ways:

We co-ordinate local work by:

- Developing robust policies and procedures that are shared by all our members
- Participating in the planning and commissioning of services in Blackpool
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done

We ensure the effectiveness of local work by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children
- Undertaking serious case reviews, multi-agency learning reviews and audits and sharing learning opportunities
- Collecting and analysing information about child deaths
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Blackpool

Our Organisation

Key Roles

Independent Chair

BSCB is led by an Independent Chair. This ensures that we are able to speak with an independent voice and to challenge any of our member agencies.

During the period covered by this report Pauline Newman resigned from this role in September 2014 and was replaced by David Sanders in November 2014.

The Independent Chair is appointed by and accountable to the Chief Executive of Blackpool Council for the effective working of BSCB. The work of BSCB and the Independent Chair is supported by a full-time Business Development Manager and part-time Training Co-ordinator, with appropriate administrative support.

Blackpool Council

Blackpool Council is responsible for the establishment and maintenance of BSCB.

The Chief Executive, in conjunction with the Leader of the Council, and drawing on the expertise of Board members holds the Independent Chair to account for the effective working of BSCB.

The Director of Children's Services has the legal responsibility for the provision of all services to children by the Council, including safeguarding, and sits on BSCB. During the reporting period Del Curtis replaced Sue Harrison in this role. She is held to account by the Lead Member for Children's Services, Councillor Ivan Taylor (replaced by Councillor John Jones following the year-end), who sits on BSCB as a participating observer and therefore informs but is not part of decision making processes.

Partner Agencies

BSCB comprises of a range of partner agencies (full membership is detailed in Appendix 1), all of whom have a statutory responsibility to safeguard and promote the welfare of children and are committed to the effective operation of BSCB.

A number of our partner agencies have a statutory responsibility to sit on BSCB, while others have been invited to join due to the significance of their work in Blackpool.

Board members all hold a strategic role within their agency and are able to speak for their agency with authority, commit their agency on policy and practice matters and hold their organisation to account.

Designated Professionals

Health commissioners should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children in the locality. Designated professionals are a vital source of professional advice on safeguarding matters to partner agencies and BSCB. Both are Strategic Board members and in Blackpool chair the Case Review and Training and Development subgroups respectively.

Lay Members

LSCB should take reasonable steps to appoint two lay members to make links with community groups, to support stronger public engagement and improve local understanding of safeguarding children. The lay member acts as an independent voice within the Board to question decision making and hold agencies to account. At the end of the reporting period BSCB had one lay member in post. The recruitment of a second lay member should be prioritised in the forthcoming business year.

Key Relationships

Children's Improvement Board

The combined inspection of Blackpool Council's services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of BSCB by Ofsted in 2012 judged both to be inadequate.

An Improvement Plan, under the governance of the Children's Improvement Board (CIB), remained in place throughout the reporting period. BSCB consequently became accountable to the CIB, which assumed some of its functions. The Independent Chair and other Board members also sit on the CIB.

Following the Ofsted inspection in July 2014 (detailed below), BSCB started to resume scrutiny of a number of areas previously held by the CIB. In June 2015, following the end of the current reporting period, the Department for Education signed off the Improvement Plan as complete, thereby dissolving the CIB and returning all statutory functions to BSCB.

The Health and Wellbeing Board

This Board brings together the Local Authority, NHS agencies and other partners to work together to understand local health needs, to identify priorities and to encourage commissioners to work in a joined-up way. BSCB submits its annual report to the Health and Wellbeing Board (H&WBB) and, in return, holds it to account to ensure that the safeguarding of children is prioritised in the delivery of services.

During 2014/15 BSCB scrutinised the H&WBB action plans in respect of sexual health, alcohol use and mental health.

Blackpool Children and Young People's Partnership

The Children and Young People's Partnership was established in 2014, as the successor to the Children's Trust, and is a partnership of agencies in the locality committed to working together to improve all outcomes for children.

BSCB reports annually to this body and, in return, holds it to account for ensuring that commissioned services adequately safeguard children.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is elected by residents of Lancashire and is charged with securing effective and efficient Policing within the area. BSCB is required to present its annual report to the PCC and will use its influence to outline key safeguarding challenges and policing action necessary in response. The PCC has identified protecting vulnerable people (including children) as part of his four point plan.

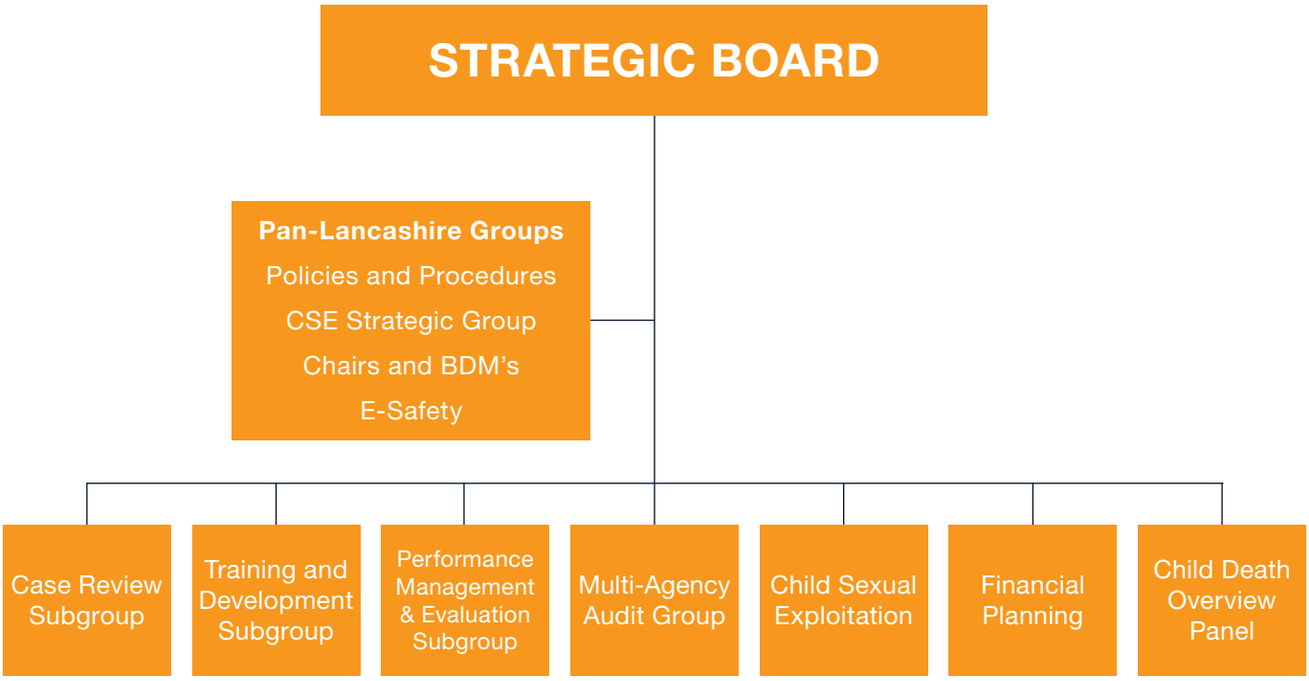
Developing relationships

As the work of BSCB progresses and new safeguarding priorities become apparent, BSCB will develop relationships with other strategic boards, seek to influence their agenda and hold them to account for their responsibility to safeguard children. In the forthcoming year relationships with the Community Safety Partnership, Blackpool Safeguarding Adults Board and the YOT Management Board will be developed.

How we work

The work of BSCB is driven by the Strategic Board which met eight times during the reporting period. The delivery of the BSCB business plan and other statutory functions are delegated to a number of subgroups, some of which are shared with Lancashire and Blackburn with Darwen LSCB. Subgroup members are drawn from the agencies considered necessary for it to meet its objectives, while chairs are Strategic Board members with the necessary expertise to tackle to area in question.

Structure Diagram



Financial Arrangements

Funding for the operation of BSCB continues to be provided by a core group of partner agencies and has remained unchanged for the last five years. The contribution of other resources 'in kind' by the wider membership is acknowledged and remains critical to the ongoing functioning of BSCB.

Contributions for 2014/15 totalled £178,570. An underspend from previous years made the total income available to BSCB £237,488 and ensured that the overall running costs of the Board were met. BSCB has agreed to carry forward an underspend of £52,888 to the 2015/16 budget.

Board staffing remains the largest area of expenditure, although the primary pressure on the BSCB budget continues to be the unprecedented number of Serious Case Reviews that have been undertaken recently.

Income and Expenditure Summary

Income		Expenditure	
Blackpool Council	95,369	Staffing Costs	96,920
Blackpool CCG	51,867	Training programme	10,549
Lancashire Constabulary	21,697	Board support costs	31,132
Blackpool Coastal Housing	2,793	Serious Case Reviews	36,000
Probation	6,294	Council support	10,000
CAFCASS	550		
	178,570		**184,601**

What did we do in 2014/15?

The work of BSCB during the early part of the reporting period was hindered by the lack of a business plan. The following priorities were, however developed and adopted over the summer of 2014 and provided the framework for work over the remainder of the period.

Priority One

We will undertake work to improve our understanding of the impact on local children exposed to harm from key risk factors, to evaluate the quality of support and services offered and whether they have led to improved outcomes.

- BSCB has scrutinised service provision for adults and children who misuse alcohol and illicit substances and for children with mental health issues.
- The commissioners and providers of these services have agreed action plans to address identified gaps in services and will report progress back to BSCB.
- A Blackpool CSE subgroup has been established and expanded to include a wide range of agencies, thereby ensuring that all work to keep children safe.
- A comprehensive Child Sexual Exploitation (CSE) action plan has been developed and agreed. The content and delivery of this action plan is reported below.
- Further work against this priority will include providing scrutiny to the forthcoming re-commissioning of Domestic Abuse services in Blackpool and developing the strategic oversight and performance monitoring of responses to CSE.

Priority Two

The Board will continually monitor the safeguarding activities of staff and partners and the systems used to protect our children and young people to ensure work is of a consistently high standard

- BSCB has provided scrutiny to its partner agencies through its monitoring of performance information, for example seeking explanation and addressing issues with Looked After Children (LAC) health assessments and in ongoing work to understand the reason for high numbers of children admitted to A&E following incidences of self-harm.
- BSCB has provided scrutiny to H&WBB actions plans that have direct safeguarding implications for children. Action plans have been developed as a result and reporting arrangements for these are in place.
- Further work against this priority will include the development of a dataset that more fully represents the work of our full range of partner agencies.

Priority Three

The Board will ensure that people who work with children and young people are doing their jobs well and to the high standards that we expect, and we will challenge them when necessary

- Direct scrutiny of partner organisations was provided through the Section 11 audit process and the equivalent Section 175 process for schools. Agencies were asked to complete a self-evaluation and subsequently invited to attend a scrutiny day at which further evidence was sought and an action plan developed to address any gaps identified. All of these action plans had been completed by the end of the year.
- Further work in this respect is planned to develop joint ways of working with Blackpool Safeguarding Adults Board, thereby providing assurance that staff in agencies who primarily work with adults also safeguard children.

Priority Four

The Board will continually review and develop policies, procedures and training practice; applying the learning from research, reviews and national policy to improve services which help to protect local children

- BSCB continues to maintain a Policies and Procedures website (in conjunction with our pan-Lancashire partners) and has, this year, developed a new missing from home protocol and sought external assurance from the NSPCC that our Harmful Sexual Behaviour policy is fit for purpose.
- The BSCB training programme has been reviewed and significantly improved to meet changing training needs and to provide a range of styles of training.
- A Training Impact Analysis strategy has been agreed that will allow for the evaluation of the effectiveness of the training programme, both in terms of staff practice and its impact on children and families.
- The programme of multi-agency audits has continued to make recommendations for single- and multi-agency improvements in practice and findings have been disseminated to staff through 'Lessons Learned' newsletters.
- Two serious case reviews have been published and action plans have been developed to make changes in practice, based on the findings.
- BSCB is a learning organisation and work in this respect will always remain ongoing with further serious case reviews, a multi-agency learning review and audits all due to report over forthcoming months.

Priority Five

The Board will have effective and strong relationships with other agencies, taking and sharing responsibility for keeping children safe from harm

- BSCB has developed its own membership during the year to ensure that it meets statutory requirements and more fully represents all organisations with a responsibility to safeguard children in Blackpool.
- The programme of multi-agency audits continues to seek evidence and provide challenge to ensure that all organisations contribute to the safeguarding of children. This has included a repeat audit of core group attendance which has identified year on year improvements and some ongoing areas for concern.
- BSCB is developing its ability to engage with staff on all levels of partner agencies through its new programme of Multi-Professional Discussion Forums and the Shadow Board.
- Regular reporting from and engagement with the MASH and GIR steering groups ensures that scrutiny is provided to multi-agency safeguarding processes in Blackpool.
- Further work in this respect is planned to formalise working arrangements with other strategic boards in Blackpool.

Priority Six

The Board will ensure that all agencies communicate with each other; understand their role in relation to safeguarding and ensure that children, young people and their families are listened to and know where to get help and how to keep themselves safe

- BSCB has commissioned a new website, which will include specific sections for parents/ carers and children.
- The pan-Lancashire Child Death Overview Panel (CDOP) has continued its safer sleep campaign which has now attained national recognition.
- A campaign to raise public awareness of private fostering has been developed and will be launched in the summer of 2015.
- Further work is planned to identify existing children's participation groups in Blackpool and to identify ways that BSCB can effectively listen to the voice of the child.

Having taken the opportunity to review the work of BSCB following the change of Independent Chair and in light of the recent Ofsted inspection, BSCB has chosen to adopt a new two year business plan for 2015-17. This includes the further work identified above and seeks to address the key safeguarding themes identified in Blackpool. More information in respect of our plans for the future is provided in Chapter 4, below.

The work of our subgroups

Performance Management and Evaluation Group (PMEG)

PMEG is responsible for the delivery of an open and transparent multi-agency performance management and quality assurance process for safeguarding in Blackpool. This is primarily achieved through the delivery of a dataset, the Section 11 and Section 175 audit processes and a programme of 'deep dive' audits into single agency practice.

What has been achieved by PMEG in 2014/15?

- PMEG has chosen to adopt a new core dataset that is being utilised by a significant number of north-west LSCB. This should improve our ability to collect multi-agency data and allow for comparisons across the region. The core element of the dataset was largely in place at the end of the reporting period.
- Scrutiny was provided to BSCB partner agencies through a Section 11 interview day in which senior managers were invited to meet the Independent Chair and PMEG members to provide further evidence to support their returns.
- An abridged Section 175 audit was utilised and returns were received from all apart from two schools.
- A programme of 'deep dive' audits of individual agency practice has been undertaken. This has included providers of children's mental health and substance misuse services who were invited on the basis of questions raised by reviews, inspections and through scrutiny of the dataset. Audits are a two way process in which action plans are developed for the agency and a forum is provided in which they can discuss barriers that they face.
- Scrutiny of specific issues, for example low take up of health assessments by LAC was identified as a problem, feedback from the LAC engagement officer was sought and challenge provided to agencies. This has resulted in additional funding being provided by the CCG for staff in this respect and an improved take up rate.
- The initiation of an ongoing programme of Multi-Professional Discussion Forums which are designed to ensure that BSCB understands the views and experiences of front line practitioners dealing with specific issues. The first event addressed professionals' understanding and experience of the Getting it Right (GIR) referral process.

Challenges and Areas for development in 2015/16

- Securing a full range of multi-agency data, with analytical commentary to ensure that we understand its significance.
- Assessing whether information provided by agencies in their Section 11 audit returns matches the perceptions of their frontline staff.
- Developing our Section 175 audit programme of schools to scrutinise what they are telling us.
- Identifying a plan of work that will respond to and enhance the understanding of services to safeguard children that we have developed through our dataset and audit activities.

Case Review subgroup

The case review subgroup is tasked with discharging BSCB's responsibilities in respect of conducting serious case reviews. The circumstances in which a review is commissioned and details of those undertaken by BSCB are detailed in Chapter 3 below, this section will outline the work of the subgroup during the year.

What has been achieved by the Case Review subgroup in 2014/15?

- The two Serious Case Reviews in progress at the start of the year were published and actions plans were in the process of being developed and delivered at the year end.
- A further five cases for consideration were received, resulting in the commissioning of four Serious Case Reviews and one Multi-Agency Learning review.
- The action plan from the SCIE systems review of children subject to a child protection plan as a consequence of neglect that was presented to Board in March 2013 was completed. This review has resulted in the introduction of single agency quality assurance processes for Getting it Right referrals and the commissioning of a bespoke neglect assessment tool for use in Blackpool.
- An action plan was developed in response to the publication of the Child R SCR by Lancashire LSCB in view of the involvement of a number of Blackpool agencies.
- Learning from Serious Case Reviews has been disseminated in pan-Lancashire seminars to ensure as wider audience as is possible.

Challenges and areas for development in 2015/16

- The number of reviews under way presents a significant challenge in terms of capacity for the BSCB business unit and subgroup members and financially for the Board. Following publication, there becomes a comparable demand on partner agencies to implement action plans.
- Securing Independent Reviewers has proved problematic. This is being addressed through a regional plan to train more reviewers.
- Working Together 2015 was published in late March and introduces a requirement for all Ofsted Serious Incident notifications to be submitted to the LSCB. The Case Review Subgroup will review these notifications, the impact on its capacity has yet to be determined.

Training and Development Subgroup

Working Together requires LSCB to monitor and evaluate the effectiveness of training. Like most other Boards, BSCB also chooses to deliver its own programme of training as a means of promoting good quality, multi-agency working.

The purpose of the Training and Development subgroup is to promote learning and development and to be responsible for the planning, delivery and evaluation of multi-agency training and the verification of single agency training.

What has been achieved by the Training and Development Subgroup in 2014/15?

- The BSCB training programme has been significantly revised and developed, this has been made possible by the appointment of a part-time training co-ordinator after a lengthy period in which the post was vacant.
- The training programme now involves a range of training styles, including seminars, half and full day events. The Working Together course that was previously delivered over two days is now modular.
- A pool of trainers drawn from Board partners has been identified. This shares expertise and reduces reliance on commissioned trainers, thereby increasing capacity.
- An Impact Analysis strategy has been implemented which will provide for a longitudinal assessment of the impact of a training course on practice.
- Attendance at training has been improved through the adoption and implementation of a consistent policy of charging for non-attendance.
- A joint training subgroup has been established with BSAB, which will be put in place from April 2015.

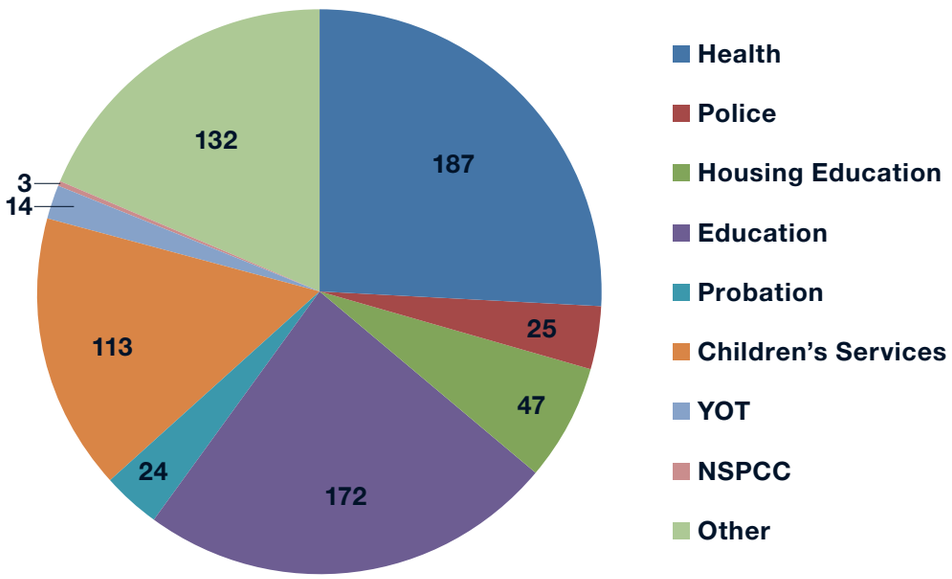
Challenges and areas for development in 2015/16

- Developing a joint approach to training with BSAB to share good practice, develop efficiencies of scale and ensure that a wider range of staff receive appropriate training to enable them to safeguard and promote the welfare of children.
- Ensuring that training is provided to meet current and emerging Board priorities for staff of all grades.
- Delivering a programme of seminars or briefings to disseminate learning from current SCR and evaluating the impact of these on practice.
- Development of single agency safeguarding and CSE courses which will be made widely available and allow BSCB to be more readily assured of the quality of training delivered by agencies for their own staff.
- Understanding the training needs of professionals in Blackpool.
- Evidencing the impact of training on the lives of children in Blackpool.

During 2014/15 we have delivered the following training courses:

- Harmful sexual behaviour
- Working together
- Working together refresher
- Core groups
- Injuries to non-mobile infants
- Fabricated and induced illness
- Serious Case Review briefing
- Child sexual exploitation
- Mental health and safeguarding
- Working with fathers
- E-Safety live
- Substance misuse and the effects of children
- Hidden harm

The 718 attendees at BSCB training courses came from the following agencies



Multi-Agency Audit Group

The MAAG undertakes audits of multi-agency work to safeguard children, each with a specific theme. Audits are typically intensive pieces of work that require group members to research their own agency's involvement, before these are reviewed by the group and collated, by the Chair, into a report with recommendations. Recommendations are tracked by PMEG and result in changes to single- and multi-agency practice, while also enhancing BSCB's understanding of safeguarding practice in Blackpool. Findings from audits therefore inform our understanding of safeguarding practice in Blackpool which is outlined in Chapter 2.

What has been achieved by the MAAG in 2014/15?

- The completion of ten themed audits incorporating core groups (twice), early help, children of adults in mental health services, harmful sexual behaviour, neglect, core group attendance, domestic abuse, CSE and missing from home.
- The core group attendance audit was a file audit of 231 core group meetings, the remaining nine audits examined 39 cases in total, either in groups of five or as 'deep dive' audits of one or two cases.
- Audits have started to incorporate questionnaires for involved front line practitioners to ensure that the group properly understands their actions.
- A wide range of agencies has participated in audits, ensuring that findings are as comprehensive as possible.
- The findings of audits have influenced the development of a Domestic Abuse perpetrators' programme and the implementation of training for harmful sexual behaviour work with children under the age of 10.
- Examples of single agencies improving practice as a result of audit findings include improved school nurse attendance at core groups, the Local Authority introducing a tracking system for the timeliness of distribution of Child Protection Conference (CPC) minutes and Probation developing a tracking system for CPC invitations and attendance.
- Lessons Learned from audits are distributed to front line professionals through a series of newsletters.

Challenges and areas for development 2015/16

- The completion of audits is time consuming and intensive. Ways to make the work of the group as efficient and effective as possible need to be explored, together with the means to distribute responsibility for audits.
- Ensuring that the recommendations of audits can be achieved and their impact is evidenced and evaluated.
- Finding ways to listen to the experiences of children and families when we audit the way agencies have worked with them.

Child Sexual Exploitation Subgroup

The CSE subgroup provides strategic oversight to the multi-agency response to CSE in Blackpool. Representatives of this group also sit on a Pan-Lancashire group to ensure that a consistent approach is delivered across the wider Lancashire Constabulary area. The effectiveness of the operational response to CSE is assessed later in this report.

What has been achieved by the CSE subgroup in 2014/15?

- A multi-agency strategy has been agreed for 2015-18. The strategic priorities are:
  1. Leadership
  2. Prevention: Public confidence and awareness
  3. Protect: Protect, support and safeguard victims and manage risk
  4. Pursue: Identify and bring offenders to justice
  5. Partnerships: Co-location and co-working
  6. Intelligence and performance monitoring
  7. Learning and Development
- The CSE subgroup has developed its membership to include representatives from public health, YOT, Probation, the education sector and licensing, thereby widening the range of organisations that work together to tackle CSE.
- A comprehensive training programme has been developed to provide briefings, together with more in depth training packages, ensuring staff are trained to a level appropriate to their role.

Challenges and areas for development in 2015/16

- BSCB oversight of the response to CSE has been inconsistent and needs to be strengthened. Appropriate reporting mechanisms, both within Blackpool and pan-Lancashire have been established but must be implemented consistently.
- Continually refining our understanding of CSE in Blackpool through the Lancashire Constabulary problem profile and the CSE element of the BSCB dataset. Particular attention should be applied to the numbers of male and LGBT victims, who are seemingly over-represented.
- While we have been able to develop our understanding of what CSE looks like in Blackpool, more work is needed to help us know whether our work to protect victims and to pursue perpetrators is effective.
- Engaging the wider community to act against CSE, specifically targeting taxi drivers and the hospitality industry, together with minority groups who may otherwise be excluded, or at heightened risk of victimisation.
- Understanding the experiences of CSE victims and using this to inform how we deliver services to them.

E-Safeguarding

The E-Safeguarding group is a pan-Lancashire group that aims to provide children with a safe online environment, through its four strategic objectives of Safer Management, Safer Access, Safer Learning and Safer Standards.

What has been achieved by the E-Safeguarding subgroup in 2014/15?

- The development of a central web presence to distribute consistent and timely messages.
- The raising of practitioner awareness through the E-Safety Live event, which is also used to collate information about current issues for practitioners.
- Provision of practical support to member agencies to address E-Safeguarding issues.
- Participation in national projects to improve online safety, ensuring that we remain alert to the latest developments in a fast moving area.

Challenges and areas for development in 2015/16

- Given changes in technology a responsive approach to E-Safeguarding is necessary.
- Understanding what children and young people would see as important.
- Developing the means to cascade information as widely as possible, by securing as broad engagement with schools as is possible.
- Linking the work of the E-Safeguarding subgroup to that of the CSE subgroup to ensure a joined up and effective response to online grooming.

Understanding the views and experiences of front line staff

BSCB has recognised the need to ensure that its own work to set the strategic direction for multi-agency safeguarding practice in Blackpool is grounded in the reality of the experience and views of front line staff who deliver the services. This guards against strategic and operational staff working in isolation from each other, which was identified as a factor in the inquiry into CSE in Rotherham. Two ways of listening to frontline staff have been implemented:

Shadow Board

The Shadow Board (SB) was established in March 2015, so at the completion of the reporting period was very much in its infancy. It is based on the multi-agency Shadow Children's Improvement Board which ran alongside the CIB over its final two years. The SB meets in the week prior to the Strategic Board and considers the same papers, enabling the views of practitioners to be fed into the Strategic Board.

Multi-Professional Discussion Forums

Multi-Professional Discussion Forums (MPDF) draw together groups of practitioners to discuss individual themes to enable BSCB to gauge their views of specific areas of service provision. The first event, in November 2014, considered thresholds for referral into Children's Social Care and, amongst other issues, identified the need for consistent feedback on referrals, for better provision of Early Help and better step down procedures. These views were fed back to the relevant agencies to influence the ongoing development of the referral process. MPDF will be held on a six monthly basis, considering themes relevant to the ongoing delivery of the Board's business plan.

Challenges and areas for development in 2015/16

- SB members need to develop ways of working within their own agency, in conjunction with their Strategic Board representative, to raise awareness of the work of BSCB and the SB and to ensure that they represent the views of front line staff as widely as possible.
- Both the SB and MPDF should develop checks and balances to ensure that they are truly representative of the views of multi-agency professionals in Blackpool and not just individual members.

Learning and Improvement Framework

BSCB is a learning organisation. Working Together 2013 emphasises the need for professionals and organisations to reflect on the quality of their services and to learn from their own practice and that of others. This fosters an understanding of what works well and provides a forum for a rigorous and objective assessment of what has not worked to reduce the risk of future harm to children.

LSCBs are consequently required to maintain a Learning and Improvement Framework (LIF), which is shared across organisations, to enable them to be clear about their responsibilities, to learn from their experiences and to improve services as a result.

The LIF should support the work of the LSCB and their partners to ensure that:

- Reviews are conducted regularly on cases that meet the statutory criteria and those that could otherwise provide useful insights, the learning from which should be widely shared.
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings.
- Actions taken result in lasting improvements to services which safeguard and protect the welfare of children.
- There is transparency about findings and actions taken to address these, including the sharing of SCR reports with the public.

The LIF should cover the full range of audits and reviews that are aimed at driving improvements to safeguard and promote the welfare of children, at a minimum including child death reviews, SCR and other multi- or single-agency case reviews and audits. The LIF can also incorporate relevant reviews conducted by other bodies, for example, Domestic Homicide Reviews.

How are we doing?

BSCB has a well-established programme of learning and improvement activities, primarily exercised through the work of the Case Review subgroup, the MAAG and the CDOP, the findings of which are referred to throughout this report. A wider culture of learning is evident in how we seek to review and continually improve our processes and practices.

The work of the MAAG was singled out for praise by Ofsted as being an effective means by which issues were identified, improvements made and progress evaluated. The more recent development of this group to include a broader spectrum of agencies and to seek out the views of front line professionals will enable more accurate conclusions to be drawn as to whether findings are specific to individual cases or representative of practice in general.

Having had an established audit programme and CDOP for a number of years and, more recently, embarked on a significant number of SCR, BSCB is in a position in which it has learned a considerable amount about practice in the locality. In turn, the resulting volume of action plans provides a considerable logistical challenge for partner agencies to implement and BSCB to co-ordinate. To date, insufficient work has been undertaken to evaluate the outcomes of changes made and to collate broader themes that emerge from the totality of learning.

In the forthcoming year it is therefore essential that the LIF is redrafted, in accordance with statutory requirements, to illustrate the Board's combined learning from a range of processes, its consequent plans to make changes to practice and to evaluate the effectiveness of this process. By drawing together the streams of learning into one document a more co-ordinated approach can be developed, reducing the risk of duplication, and providing a robust means to recognise emerging themes in learning. Consequently, ways of evaluating learning, for example by repeated audits or changes in the dataset can be introduced. The LIF should therefore become the central means by which the Board's learning and improvement activities are co-ordinated and shared with partner agencies.

What Ofsted said and what we did

BSCB was reviewed by Ofsted in July 2014 and was found to require improvement. Following the review an action plan was drawn up to address the key areas identified by Ofsted, which we worked to implement over the following months.

Ofsted said *"BSCB is not yet compliant with all its statutory duties… not all statutory partners attend or fully contribute to the work of the Board, although membership and participation is improving"*

What we did:	**What we will continue to do:**
We invited CAFCASS, North West Ambulance Service, the Director of Public Health, YOT and a primary schools representative to become Strategic Board members. We widened subgroup membership, for example to include Licensing within the CSE subgroup, North West National Probation Service in the Case Review Subgroup and Substance Misuse Services in MAAG. We introduced Schools' Twilight Sessions as a means of engaging directly with schools to meet the challenge of an increasingly diverse range of provision within the locality. Funding has been agreed for the employment of a Schools' Safeguarding Advisor, part of whose role will be to act as a conduit between schools and BSCB.	We will work to ensure that all agencies that are responsible for safeguarding children in Blackpool are represented on or engaged with the work of the Board. We will work to ensure that all providers in the increasingly diverse range of schools and GPs are accountable for their safeguarding practice and able to access the support and expertise of the Board. Secure more balanced representation between agencies, be it financial, through attendance at and/ or chairing of meetings or simply through contributions made within meetings.

Ofsted said *"Performance information is not yet provided by all partners to support the robust scrutiny of service effectiveness"*

What we did:	**What we will continue to do:**
We adopted a new framework for our dataset that includes a range of multi-agency performance information. The same framework is being used across the north- west, which means that we should be able to obtain and compare information more easily. Information obtained from the dataset is used to determine a programme of 'deep dive' audits in which the work of single agencies is scrutinised and action plans developed to address identified weaknesses.	Develop our dataset to obtain more in depth information about our safeguarding priority areas drawn from as many agencies and sources of information as possible. Use this information in our LIF to judge changes made in practice and to identify further changes needed.

Ofsted said *"Thresholds for the provision of early help and referrals to children's social care are not understood by all partners"*	
What we did: Held a Multi-Professional Discussion Forum to seek the views of front line practitioners about thresholds. Supported the work of the GIR steering group to establish a network of over 70 GIR champions throughout Blackpool to promote effective use of the process within their own agency.	**What we will continue to do:** Develop stronger ownership of GIR as a partnership and assume oversight of training for professionals in this respect. Establish regular reporting of the work of the GIR Steering Group into BSCB. Audit a series of referrals to Children's Social Care to identify how systems could be improved to help staff who need to refer.

Ofsted also commented that *"an appropriate range of multi-agency training is provided, and positive impact on practice in some areas has been identified through case audits… Learning from national serious case reviews and local reviews is used to drive improvements in practice".*

CHAPTER 2 - THE CHILD'S JOURNEY

What we know about children in Blackpool

Blackpool is a seaside town in the north west of England. Its population of 141,400 people living within an area of 34.92 km2 renders it one of the most densely populated areas outside London. Transience is a significant feature of the town with 8,000 people estimated to move in and out of the town annually.

There are approximately 28,853 children and young people aged under 18 living in the area, making up 20.4% of the population. Children and young people from minority ethnic groups form 8.5% of the school-age child population, compared to 27.8% nationally. Approximately 1,000 children qualify for Disability Living Allowance. Life expectancy for children born between 2011 and 2013 is estimated to be 74.3 and 80.1 for boys and girls respectively, compared to 79.4 and 83.1 nationally.

It is estimated that 8,300 children aged 0-16 (31.3% of this population) live in poverty. Blackpool itself experiences considerable deprivation and in 2010 was ranked as the 6th most deprived local authority area out of 326 in England, a position that had worsened since previous assessments. 46 out of 94 smaller areas within Blackpool are amongst the most deprived 20% in the country, while none are within the most affluent 20%.

Outcomes for children reflect those associated with high levels of deprivation, for example attainment at Key Stage 4 is lower than average, while levels of teenage pregnancy and hospital admissions due to substance and alcohol misuse and self-harm are amongst the worst in the country.

Within Blackpool there were 1826 children in need as of 31st March 2015 (2014: 1872), equating to 629 per 10,000 population. This is considerably in excess of both the national average of 346.4 and that of our statistical neighbours of 503.7 (2014 figures).

Early Help

Professionals within Blackpool work to the BSCB "Thresholds for Intervention" document, which was published in 2013. This outlines the level of intervention that should be provided to a child based on their assessed needs.

The GIR framework provides a combined continuous assessment tool for children with lower levels of need, together with a referral form for Level 3 and 4 interventions from either the Early Assessment Team or Children's Social Care. Individual agencies are expected to assess, co-ordinate and provide early help for those assessed in need of Level 2 intervention.

Our partner agencies deliver a range of early help initiatives within Blackpool including:

Baby Steps

The NSPCC has delivered the Baby Steps programme within Blackpool for three years to date. This is an evidence based perinatal education programme for parents with additional needs and is designed to strengthen protective factors such as family relationships, social networks and emotional well-being. Baby Steps will now be scaled up as part of the Better Start programme.

Better Start

Better Start has obtained £45 million of Big Lottery funding over the next ten years to improve the life chances of children aged 0-3 and their families. The multi-agency project, led by the NSPCC, has two outcomes: healthy gestation and birth and school readiness. The Better Start approach is built on four 'cornerstones': improving public health outcomes, changing systems to provide services for those with additional needs, ensuring evidence based interventions are delivered to address specific needs and to build and share learning from work undertaken.

The Better Start programme will be rolled out gradually, initially providing an evidence based ante-natal programme to all parents in seven wards, which will subsequently be extended throughout the town. Future interventions will target parents in treatment for alcohol and substance misuse, parents of children at risk of neglect or maltreatment, improved parental attachment and parents who were neglected in their own childhood. By the conclusion of the funding period changes should be embedded to the extent that they are part of the overall system and children are born into an environment in which help is provided at the earliest opportunity, thereby improving their life chances and reducing the demand for more costly, higher tier services.

Head Start

Blackpool Council is the lead organisation for the Head Start partnership which has secured Big Lottery funding for the pilot of a project to raise the emotional resilience of 10-14 year olds. Interventions will be based on an ecological approach that aims to create an environment in which young people are able to flourish. The project aims to create a whole systems change that will provide and embed universal and targeted interventions that will continue beyond the time frame of the initial funding.

In addition to the larger multi-agency early help initiatives there are a range of single agency early help initiatives that were evident in a BSCB multi-agency audit of early help undertaken in June 2014. By expecting single agencies to co-ordinate and provide early help there is a risk of a lack of understanding of available services and consequent inability to gain assurance that adequate provision is available for all children in need of intervention. In the forthcoming year BSCB will consequently attempt to map early help service provision and provide an online resource for professionals to enable them to access appropriate services for the child that they are working with.

BSCB's understanding of the need for and provision of Early Help is significantly hindered by the lack of data as to the number of children assessed as meeting the Level 2 threshold of need. Whereas a central record of open Continuous Assessment Frameworks used to be maintained, the introduction of the GIR framework did not provide for any collation of completed Continuous Assessment Tools where single- or multi-agency intervention was provided at a lower tier. This introduces a risk of duplication between agencies and a lack of understanding as to levels of need and pressures within the system for commissioners of services.

Points of entry into safeguarding services

'The Front Door'

All referrals to the Early Assessment Team or Children's Social Care are routed through the Front Door and are expected to be received on a GIR referral form. This process was launched in October 2013, so remains in its relatively early days. In summer 2014 Ofsted commented on the variability in quality of referrals and noted *"that some agencies do not fully understand thresholds for services"*. A subsequent BSCB Multi-Professional Discussion Forum for front line practitioners enabled an open dialogue between referrers and the Duty and Assessment Team. Professionals present were adamant that they did understand thresholds, however it was evident that individual agency interpretation was not always shared.

In order to address this issue, agencies have been asked to introduce quality assurance processes for referrals, while the GIR training has been subject to considerable revision. A network of GIR champions has been established, providing professionals with an immediate source of reference for advice about the framework. To date evidence of improvements in the quality of referrals is mixed.

During the forthcoming year, BSCB intends to assert greater partnership ownership of the GIR framework in order to counter any perceptions of it as a Local Authority process, will continue to monitor data regarding referrals and will undertake a thresholds audit to identify whether referrals are made at the appropriate stage. In the longer term BSCB intends to assume oversight of GIR training, which is currently provided by the Local Authority, in order to be better assured that it fosters a shared partnership understanding.

Blackpool MASH

Lancashire Constabulary, in conjunction with the three pan-Lancashire children's services, health and other agencies established the Lancashire Multi-Agency Safeguarding Hub (MASH) in April 2013 to handle Police vulnerable child referrals. In June 2014 the Blackpool element of the MASH was disaggregated and returned to be physically located within the area.

The MASH currently only accepts referrals from the Police (although in practice some referrals may be made by other agencies and then placed on the system by the Police). Information about the referrals is then shared with partner agencies to build a multi-agency chronology and to ensure that the child involved is referred on to appropriate services.

This should ensure that interventions can be provided at the earliest possible stage and promotes effective sharing of information between agencies. A key feature of the MASH is co-location of agency staff. At the end of March 2015 Police, Health, Pupil Welfare, Early Help, Children's Social Care, Children's Centres and YOT were all represented, while information is additionally shared with substance misuse services, Fire and Rescue, Probation and Adult Social Care.

A second phase of development is projected to start later in 2015, which will expand the scope of the MASH to include CSE referrals and eventually will allow for referrals to be received from all agencies. The longer term goal is to route all current Front Door referrals through the MASH, allowing for initial multi-agency information sharing and responses.

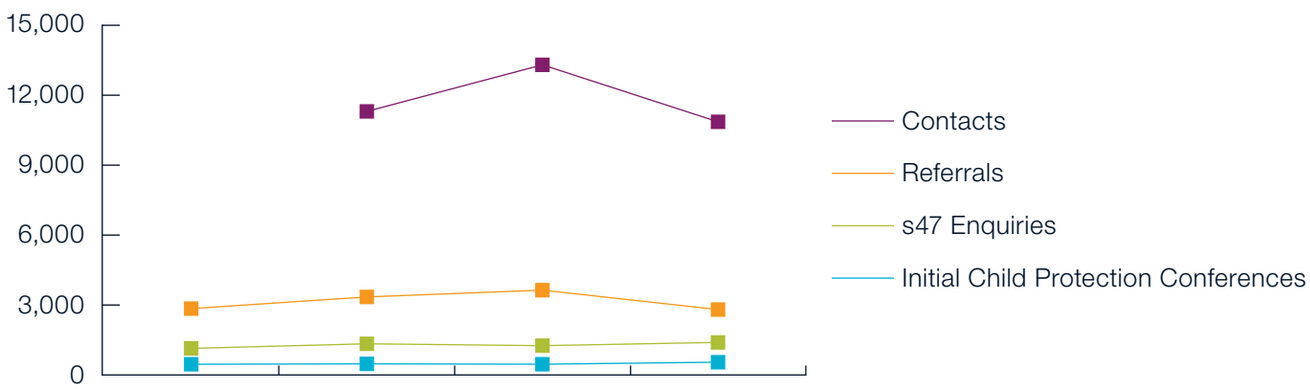
BSCB has been apprised of the development of the MASH, but should assume greater strategic oversight of its work, to drive multi-agency collaboration and to better understand its performance through the scrutiny of performance indicators.

Referrals

In 2014/15 the Front Door received 10,832 contacts (2014: 13,276). A contact, in this context, can include anything from a request for urgent safeguarding action to pieces of information that required sharing, but no further action. The combination of all contacts into this figure renders analysis of the conversion rate into referrals difficult, as some clearly are not intended to lead to referrals, and means that conclusions cannot be drawn from breakdowns of contacts by agency. While the reduction since 2014 is welcome, this masks an upward trend at the year end and continues to place significant pressure on a small team.

Of the 10,832 contacts, 3,096 (28.6%) (2014: 28.1%) were referred on to Children's Social Care and 1,843 (17.0%) (no 2014 figure available) to the Early Assessment Team for further assessment, while the remainder required no further action. Longer term comparison of the conversion of contact to referral to Section 47 Enquiry to Initial Child Protection conference is included on the graph below.

Blackpool's rate of referrals and of children at every subsequent stage of the safeguarding process remains well in excess of those of both its statistical neighbours and England as a whole. It is of similar concern that 31.0% of referrals are repeats (that is having been previously referred within the last 12 months), compared to 23.4% amongst our statistical neighbours and 24.9% across England (2014 figures).



Child Protection Plans

If professionals at an ICPC are concerned that a child is at risk of significant harm due to neglect, emotional, physical or sexual abuse then the child is made subject to a child protection plan. The plan sets out what family members and professionals must do to keep the child safe and well. The plan is managed through regular core group meetings and reviewed at child protection conferences.

On the 31st March 2015 there were 355 children subject to a child protection plan in Blackpool, a 15.7% increase on the previous year (this is a rate of approximately double that of our statistical neighbours and treble the national average figures for 2014). Of the 455 children who became subject to a child protection plan during the year, 83 had previously been subject to a plan, representing a rate of 18.2% compared to the national average of 15.6%. This potentially indicates that plans are being ended before changes made to protect the child are sufficiently embedded. Data in respect of gender, ethnicity and ages of children subject to child protection plans all conforms to expected levels, in view of Blackpool's population.

The most common reason for a child protection plan being put in place was emotional abuse (67.1%) followed by neglect (54.5%). Both figures are in excess of the most recently published national figures of 32% for emotional abuse and 42% for neglect (although this may, in part, be explained by Blackpool's practice of allowing registration in more than one category, whereas some areas only list a primary category). Concerns regarding emotional abuse most commonly relate to a child experiencing domestic abuse. The difference between Blackpool's and national rates may therefore reflect the known high prevalence of domestic abuse within the town. There has however, been a considerable increase in plans made in this respect since 2014, which needs to be better understood. The rate of plans in respect of neglect remains stable and may reflect the levels of poverty within the locality.

Despite the high numbers of children within the system, Blackpool perform well in some respects, holding 91.7% of initial child protection conferences within 15 working days of the start of the section 47 enquiry (compared to a national figure of 69.3%); reviewing 97.7% of child protection plans within time scale (94.6%) and having 2.7% of plans in place for over 24 months (4.5%). All child protection plans are managed by qualified social workers.

There has been considerable multi-agency effort to understand the continuing high level of child protection activity within Blackpool, which is evident at every stage of the system. Rates in excess of the national average would be expected in view of the levels of deprivation in the locality, however Blackpool continues to experience rates well in excess of those of its statistical neighbours. A single agency audit of children becoming subject to a child protection plan in the summer of 2014 did identify some plans that had been put in place where it was not considered that the threshold had been met, although this would in no way account for Blackpool's overall high rates. It would also be fair to say that the overall multi-agency audit activity of BSCB does not indicate that there is a significant issue with children being inappropriately assessed as meeting the threshold for a child protection plan. BSCB will continue to seek to assure itself that the high numbers of children referred to and within the child protection system are in need of this level of intervention, or whether this number could be safely reduced. However, it is also imperative and that an understanding is achieved as to the high level of need. One explanation could be that appropriate early help is not being provided to address needs before they become acute. Work will therefore be undertaken to inform our understanding of the effectiveness of early help services.

In view of the high levels of need in respect of domestic abuse and neglect, BSCB will seek to influence commissioning of services in this respect, for example to close the gap in provision for an intervention for perpetrators of domestic abuse and to provide a robust assessment tool for neglect.

Core Groups

Core group attendance and functioning was identified as a significant area of concern in the course of the 2012 Ofsted inspection. In the intervening period BSCB has required all partner agencies to take steps to address this issue and has provided training to 202 professionals.

In their 2014 inspection findings Ofsted commented *"There is now generally better attendance by relevant practitioners. Recent cases were seen where core groups were monitoring the progress of child protection plans effectively, and amending them as appropriate".*

BSCB has completed two recent audits of core groups. The first was an in depth audit of five child protection plans and identified improved timeliness of core groups, effective management of the child protection plan by the core group and good inclusion of the parents. The explicit consideration of the views of the child was noted to be insufficiently evident.

A second audit of agency attendance at core groups noted continued good social worker attendance, improved school nursing and schools attendance, but a slight decrease in parental participation and ongoing poor attendance from adult mental health services and CAMHS.

Partner agencies are now being asked to develop their own systems for recording attendance to enable them to provide evidence of their own effective practice.

Neglect

Neglect has been an area of ongoing concern for BSCB. This was initially identified by a thematic review of neglect that was undertaken in early 2013 in response to which we made the following changes:

- Ensured specific reference to neglect was included within our new thresholds document.
- Implemented a concerns resolution process to encourage professionals to challenge each other's decision making.
- Worked with child protection conference chairs to help them set more realistic and effective objectives.
- Developed and implemented a set of core professional values to promote a child centred approach.

It has therefore been disappointing to note the continued increase in the number of children subject to a child protection plan, out of which the proportion in place due to neglect remains above the national average. A 'deep dive' multi-agency audit of two such plans undertaken this year furthermore concluded that despite intensive intervention over a sustained period, levels of improvement were not as would have been expected.

A further recommendation of the original thematic review was the need to adopt a specialist assessment tool for neglect. This should enable professionals to identify and address neglect at an earlier point, thereby limiting the harm caused to the child and reducing the demand on services. There has been considerable delay in the delivery of the assessment tool, initially caused by difficulties identifying a suitable tool for use in Blackpool. A bespoke suite of neglect assessment tools has now been identified, in conjunction with the NSPCC, which will allow practitioners to select the right assessment for their concerns and area of professional expertise. Consistent use of the tool throughout interventions with a family will enable change to be measured and concerns to be identified and addressed.

Following the conclusion of this reporting period a Neglect Subgroup has been established to drive this process forward, however it is essential that the assessment tool is delivered at the earliest possible opportunity and that implementation is not allowed to drift.

Child Sexual Exploitation

When a child is believed to have been a victim of CSE they are referred to the multi-agency Awaken team. The team includes staff from Health, Police, Children's Social Care, Education and a missing from home co-ordinator. The lead professional for each child will be the person who it is felt they will work with most effectively, although Social Workers will always fulfil their statutory responsibilities toward a child. Children may, in turn, be referred on to other services, for example the WISH team who provide interventions for those in need of less intensive support. The work of the team is co-ordinated through weekly operational meetings in which individual issues and emerging trends are discussed. Senior managers are briefed as to the content of these meetings.

The Awaken team is a well established response to CSE within Blackpool, having been in place for over ten years. The wider partnership has also worked to raise the profile of CSE within Blackpool, for example through the provision of training for elected members and through the delivery of PHSE lessons by the WISH team to pupils in Years 7 and 9. A pan-Lancashire CSE awareness week is held each year in November and includes publicity campaigns, a conference for professionals and increased police enforcement and disruption activity.

In Blackpool in 2014-15 there were 243 referrals to the Awaken team, of which 152 were assessed as high risk (the risk assessment is based on the perception of the person making the referral, so is not based on a formal CSE risk assessment), which continues the broadly stable trend seen over the last four years that is also reflected pan-Lancashire. On a pan-Lancashire basis and during 2013-14 (the most recent data available) 62% of victims were aged between 13 and 15, while in 40% cases the perpetrator was fewer than five years older than the victim.

There have been a considerable number of reports published nationally in respect of CSE in the last year, however our understanding of CSE within Blackpool does not conform to the national stereotype. In Blackpool the predominant model of CSE is of white men operating alone, coming into contact with victims online, at parties or through hotspots. There is little evidence of gang related or taxi linked offending or of perpetrators being disproportionately drawn from ethnic minority communities. While full data is not available, a higher than expected number of male victims has been identified, as a consequence of which specialist support is provided through a Children's Society worker.

Recent analysis of a cohort of victims identified other vulnerabilities including being the victim of other forms of abuse or violence within the family home, incidences of going missing, being a looked after child, family disputes, mental health problems, school exclusions and association with other victims. A multi-agency audit of five cases also identified a high prevalence of domestic abuse within the victim's home and multiple previous referrals to children's services. Further work is needed to understand whether Blackpool's high incidences of sexually transmitted diseases and A&E attendance due to self-harm are reflective of CSE.

Blackpool has a distinct economy, which is heavily dominated by the hospitality and leisure industry. Consequently many who work within this sector may have contact with perpetrators or victims of CSE so may provide an additional means by which victims can be protected. Awareness raising work in this respect has been limited to date and should be further developed.

It is recognised that while there is a well-developed operational response to CSE in Blackpool, that the strategic oversight has not always been as robust as is required. More recent progress has been evident though in the development of the CSE subgroup to more fully reflect the partnership approach needed, the agreement of effective reporting mechanisms and the establishment of a pan-Lancashire strategy and Blackpool specific action plan. In forthcoming months the Standard Operating Protocol for CSE teams will be updated and further work undertaken to develop the CSE dataset.

Children who go missing from home

Children who are missing from home are vulnerable at that time, quite simply because those responsible for their care are unable to ensure that they are safe. Research into longer term risks would also suggest an increased likelihood of becoming a victim of abuse, committing or being a victim of crime and involvement in substance use. The already vulnerable group of Looked After Children (LAC) are over-represented amongst those going missing (although this may, to some extent, reflect a greater willingness of care homes over parents to report children who go missing), while locally a correlation between incidences of missing from home and being a victim of CSE has been identified. This is evident in seven of the ten most children most frequently missing from home being open to the Awaken team.

The multi-agency response to MFH is delivered according to a revised pan-Lancashire LSCB protocol that was launched in September 2014. The priority in responding to any child who goes missing is ensuring their safety. Once they have been returned home a return interview should be carried out within 72 hours to try to understand why the child went missing and what can be done to reduce the risk of them individually and children more generally going missing again. Toward the end of the reporting period, a standard question about CSE was introduced to the interview pro-forma.

A degree of professional decision making is allowed for as to whether the interview is necessary and the child may decline to participate, as a consequence of which it cannot be expected that all interviews will be undertaken. However, there is currently a lack of standard recording and reporting of these interviews as a consequence of which it is unclear how many are completed or what they tell us about why children go missing. This represents a considerable gap in our understanding of the issue. For BSCB, these interviews represent a potential source of information both as to the reasons why children go missing and to the experiences of the child, that has not been utilised to date.

Our understanding of children who go missing from home in Blackpool is hindered by changes in data collection processes and definitions. This has most recently been evident in Police data no longer including children reported as 'absent' (that is, simply not where they are expected to be, as opposed to positively missing). Consequently, the broadly stable figure of 378 children having been missing during the year (although each child will typically be reported as missing on more than one occasion), may mask an increase now that absences are no longer included. Likewise, the increase of LAC identified by their Independent Reviewing Officer to be involved absconding or going missing from 4.5% to 8.1% requires further exploration.

BSCB should seek to ensure that better information is available to enhance its understanding of children who go missing, both in terms of their experiences, links to CSE, and in terms of securing robust, comparable data.

Children in Care

When it is no longer possible, or in the best interests of the child, to remain within their own family they are placed in the care of the local authority, either with the agreement of their parents or under the terms of a court order. Many children who are looked after are vulnerable and the local authority, as their corporate parent, is responsible for ensuring that they remain safe, healthy and are able to realise their potential. All children in care are subject to regular independent reviews of their care, while the overall work of the local authority and its partners to provide for children in care is co-ordinated by the Corporate Parenting Panel. Children who are remanded in custody also become looked after and the YOT partnership maintains oversight of their treatment, while also working to reduce the rate of re-offending by LAC.

There were 454 children in care on at the end of March 2015, compared with 443 in 2014, which represents an increased rate of 156.4 per 10,000 of the child population compared to 152.4 in 2014. That this is well in excess of the national rate of 60.0 (2014), is expected given the high numbers of children throughout the system.

As corporate parents, the local authority seeks to reduce the disruption that each child experiences. The level of children placed more than twenty miles outside Blackpool has remained stable in recent years (currently 10.3%), while the 9.9% experiencing three or more placements within a 12 month period compares favourably with the national average of 10.7%. A significant number of LAC from other areas continue to be placed within Blackpool, this figure stood at 120 at the end of the reporting period. The strain that this places on local services has been exacerbated by guidance from April 2014 that local health providers should provide for their health assessments.

Where the best interests of the child would be served by their being permanently adopted, it would be expected that this is achieved as quickly as is possible. In 2014-15 50 children were adopted, although the number of days between their entering care and being placed with their adoptive family stood at 752, compared with a national average of 647.

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 10 private fostering arrangements that were in place in April 2014, 11 commenced and 14 ended during the year, leaving a total of 7 in place at the end of March 2015. This figure has remained broadly stable during the last five years, reflecting the national picture.

BSCB accepted the 2014 Ofsted inspection finding that it had paid insufficient attention to children in private fostering arrangements and has established a pattern of six monthly reporting to the Board in this respect. A publicity campaign is being developed to improve public and professional awareness of the need to make notifications.

The work of the Local Authority Designated Officer (LADO)

The LADO works with local employers and voluntary organisations to decide whether a complaint or allegation about an adult working with a child is true or not. By operating independently, the LADO should be able to provide a fair and speedy resolution to concerns that are raised and ensure that unsuitable people are removed from the children's workforce.

During 2014/15 there were 91 formal referrals to the LADO. The greatest number of referrals came from Children's Social Care (43%), education providers (23%) and the Police (13%). Referrals were predominantly concerned with those working within education (43%), foster carers (23%) and voluntary organisations (23%). In 30 cases the allegation that was investigated was substantiated.

The LADO also undertakes work to raise awareness of safer recruitment practices and has worked with one voluntary organisation to develop their safeguarding practices to standard at which they can be used to demonstrate good practice.

During the forthcoming year the LADO will work with schools to ensure that all providers within Blackpool are aware of and utilise the service, where necessary, and with the Police and Health providers to try to understand whether the low number of referrals in respect of staff in these organisations is an issue that requires further attention.

In the course of the reporting period the LADO role was moved from the BSCB business unit, to sit within the local authority safeguarding team. BSCB will maintain oversight of the work of the LADO through the receipt of an annual report and other exception reporting.

CHAPTER 3 - WHAT HAPPENS WHEN A CHILD DIES OR IS SERIOUSLY HARMED IN BLACKPOOL?

Serious Case Reviews

LSCB are required to undertake a SCR when abuse or neglect is known or suspected and either a child dies, or is seriously harmed and there is cause for concern as to the way professionals have worked together to safeguard the child.

SCR form part of the Learning and Improvement Framework and should establish what happened and why and whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. LSCB are required to publish SCR and their response to the findings.

BSCB is also committed to undertaking smaller scale reviews of cases in which the threshold for a SCR is not met, but in which it is felt that useful learning could be secured.

A summary of the work of the Case Review Subgroup's management of the SCR process is included in Chapter 1.

This year BSCB published two SCR.

Child BR

What happened?

A 15 year old child was found dead at the family home, which a subsequent post-mortem examination attributed to methoxetamine (a synthetic Class B drug) toxicity, chronic renal failure and hypertensive heart disease. Child BR suffered from a significant and potentially life limiting chronic health condition and there had been previous concerns regarding neglect. In the years prior to Child BR's death securing engagement with specialist medical treatment, at a distant location, proved increasingly difficult.

Child BR had consequently been the subject of considerable interventions from healthcare providers and children's services, as the consequence of successive child protection and child in need plans. The challenge for practitioners was of a young person with a significant health problem who resisted treatment and whose parents were unable to enforce attendance.

What did it tell us?

The report concluded that "professionals and family worked tirelessly to try to influence Child BR to make appropriate choices about accessing health care", noting that the family believed that there was nothing more that professionals could have done. Interagency working and communication were assessed to have been excellent.

There were, nevertheless, six learning points identified:

- The need to explore the effectiveness of joint working between primary health care and tertiary centres for children and young people with chronic health conditions.
- When brief interventions are successful, the ways that these can be maintained over longer periods should be explored.
- Agencies should ensure that staff are appropriately supported at times of increased pressure e.g. the death of a child or when cases prove particularly challenging.
- Arrangements should be available for multi-agency discussion of 'stuck' cases.
- Children's social care should ensure that assessments are reviewed following significant events in a child's life.
- Commissioners of tertiary healthcare should ensure that children with chronic medical conditions and their families have prompt access to psychological support.

What are we going to do?

At the end of the reporting period an action plan was under development and will be included in next year's annual report. Work was already under way to develop multi-agency forums for 'stuck' cases and to revise assessment training.

Baby Q

What happened?

A three week old baby was found to be unresponsive in the course of a home visit by a health visitor. On admission to hospital Baby Q was found to have an unexplained head injury, for which the mother has subsequently been convicted. Baby Q's young age at the time of the incident was such that the family's involvement with services had been brief.

Prior to birth there had been a referral to children's social care due to mother's poor engagement with maternity services and concerns about her vulnerability, although no action was deemed necessary. Following birth the perceived anxiety of the parents resulted in more frequent than expected contact with midwifery and health visiting services, while Baby Q was seen at hospital twice. On the latter occasion a laceration to the mouth was initially treated as unexplained, prompting the involvement of children's social care, however no further action was taken after a change of diagnosis to a medical explanation.

What did it tell us?

The review concluded "that there was little evidence that indicated that the harm to Baby Q could be predicted or prevented". Good practice was noted in the identification and response to the family's vulnerability by midwifery and health visiting services.

Recommendations were made to ensure that:

- Pregnancies are notified to health visitors at an early stage, to allow for effective co-ordination of enhanced midwifery and health visiting services.
- Professionals ask about parental substance misuse, mental health and domestic violence in all cases, the latter being undertaken in an environment in which disclosure can be made safely.
- Professionals guard against acceptance of self-reporting.
- Handover procedures are in place for hospital doctors when there are suspected non-accidental injuries to children and in these cases that wider child protection processes are not stopped until all information has been fully evaluated.
- When midwifery services are transferred between areas that all vulnerabilities are recorded and transmitted.
- Steps are taken to reduce the risk of losing information as a result of different surnames being used for the same child.
- Children are able to access GP services regardless of the nature of their accommodation in Blackpool.

What are we going to do?

An action plan in respect of this SCR was also in development at the end of the reporting period and will be fully reported in the next annual report. Due to the time elapsed since the incident some improvements have already been made, including automatic reporting of all pregnancies to health visitors at the time of booking.

It is anticipated that BSCB will have published four SCR within a seven month period by the summer of 2015. Partner agencies are expected to disseminate the learning to staff, while BSCB will develop a series of briefings for multi-agency staff to explore themes in more detail.

Full copies of these reports are available on the BSCB website.

Child Death Reviews in Blackpool

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

By its very nature the death of a child is very distressing for parents, carers, siblings and clinical staff. CDOP carries out a systematic review of all child deaths to help understand why children die and to help prevent future deaths. By identifying modifiable factors, the panel can recommend measures to help to improve child safety and prevent future deaths. Broader findings can be used to inform strategic planning and commissioning of services.

Within Blackpool there were 14 child deaths during the reporting period and CDOP reviewed 12 deaths (a CDOP review occurs after all other legal processes are completed, as a result of which the number of reviews will always differ from the number of deaths).

Of the 12 deaths reviewed:

- 5 (42%) were deemed to have modifiable factors (circumstances that, if changed, would reduce the risk of future child deaths)
- 7 (58%) were expected (predictable 24 hours prior to death)
- 6 (50%) were aged under one year
- 8 (67%) were female

CDOP uses learning from reviews to inform awareness raising campaigns amongst professional and the public.

During the reporting period these have included:

- Continuation of the well-established Safer Sleep campaign, which has been recognised as good practice by NICE and included on their website as such.
- Publication of a first CDOP newsletter for professionals highlighting, amongst others, the dangers of swallowing lithium batteries.
- Disseminated a dangerous dogs presentation to assist professionals to identify banned breeds.

How are we doing?

The weakness of considering Blackpool (and even pan-Lancashire) figures alone is that the low numbers (80 in seven years) are statistically insignificant. Consequently, while individual cases may cast light on risk factors or issues with service provision, extreme caution has to be utilised in drawing general conclusions. Nevertheless, CDOP has now collected seven years' data since its inception which begins to build a picture of child deaths pan-Lancashire. Analysis of this data has been hindered by the lack of a database, which is being addressed as a matter of priority. The ability to undertake more detailed statistical analysis (for example, in respect of parental risk factors) will enable CDOP to draw evidence based conclusions that can be used to inform local planning.

Work has begun to assess the consistency of decision making by the pan-Lancashire CDOP panel, however a greater understanding is necessary as to whether regional and national panels are consistent. Without this it is not possible to compare data with any degree of confidence.

Sudden Unexplained Deaths in Childhood (SUDC)

When a child dies unexpectedly a rapid response process is set in motion to review the circumstances of the child's death. Multi-agency colleagues work together to share information to ensure a thorough investigation, to ensure that the bereavement needs of the family are met and that lessons are learnt from the death, where possible. The pan-Lancashire SUDC service is well-established and led by two nurses (outside office hours initial co-ordination is provided by the police), in conjunction with a range of multi-agency partners, including Children's Services, Acute Hospital Trusts, North West Ambulance Service and Lancashire Constabulary.

A new SUDC protocol was implemented during the reporting period to strengthen and standardise the service provided, while training has been provided for multi-agency staff. In the forthcoming year we intend to undertake a thematic review of unexpected deaths that the service responds to, as a means of ensuring that any wider learning is identified and acted on.

A more full analysis can be found in the CDOP annual report which is available on the BSCB website.

CHAPTER 4 - THE CHALLENGES AHEAD

BSCB's current activity is driven by a two year business plan, which is available on the Board website. The plan addresses four key safeguarding themes that were identified by Board members during the course of a development day in January 2015. These themes were considered to represent the primary areas that need to be addressed in order to keep children safe in Blackpool. A final part of the business plan concentrates on the Board's own functioning and development, building on the action plan that was compiled following the 2014 Ofsted review.

The analysis contained within this report raises additional challenges for the Board that can be grouped under the safeguarding themes of the business plan:

Child Sexual Exploitation

- Do we utilise all available sources of information to know what CSE looks like in Blackpool and to understand whether our response is effective?
- How do we raise awareness of CSE amongst all professionals, children and members of the public, including those in employment in the taxi and leisure industries?
- How do we develop our understanding of children who go missing from home and how we can keep them safe?

Early Help

- Does the high number of children subject to child protection plans or looked after represent a failure to deliver effective early help for children at Level 2 and 3 thresholds?
- Is there sufficient early help provision for children in Blackpool?
- How can we better understand the level of need for lower level intervention, in view of the absence of a central record of children assessed as being in need of Level 2 services?

Neglect

- The implementation of a neglect assessment tool has been significantly delayed, what action is necessary to prevent further delay?
- In view of the recent multi-agency audit in respect of neglect, are we confident that effective services to tackle neglect are in place?

Toxic Trio
Children living with parental domestic abuse, substance use or mental health issues

- Given that child protection plans implemented in respect of emotional abuse are typically indicative of domestic abuse, what does the significantly increased proportion of plans under this category tell us?

BSCB development

- BSCB has accumulated a wealth of learning from reviews and audits. How can we ensure that broader themes are understood and result in meaningful systems changes?
- How can we measure the impact of actions taken on systems, on professionals and, most importantly, on children and families?
- How can we be assured that we collect the right data from all our partner agencies to capture safeguarding activity in Blackpool and that we properly understand it?
- BSCB has not undertaken sufficient work to listen to what children are telling us or to understand the lived experience of children in the town. How do put in place processes to achieve this?

CHAPTER 5 - MESSAGES FOR OUR STAKEHOLDERS

Children and Young People

You are at the heart of everything we do in the child protection system and there are lots of people ready to listen to you. If you ever need help please speak to someone you can trust, this could be if you feel bullied, sad or unsafe. BSCB is here to keep you safe and we will find more ways to listen to what you tell us.

The people of Blackpool

Keeping children safe is everyone's responsibility and you could be the person who is able to make sure that a child is protected. **If you are worried about a child please call the Duty and Assessment Team on 01253 477299. You will not have to leave you name if you would prefer not to.**

Elected Members

Demand the best for our children. When you scrutinise plans ask what effect they will have on children and how they will ensure that they are safeguarded. Expect agencies to provide evidence that their actions are improving the lives of children. You are Corporate Parents for the Looked After Children in Blackpool. Use your role to ensure that they have the care and life chances that they deserve. Take advantage of the training opportunities provided by BSCB.

Front line staff

Thank you for your unceasing work to keep children safe in Blackpool. We want to make sure that we communicate with you. Take advantage of our multi-professional discussion forums and shadow board to let us know what you think. Keep yourself up to date with our work through our website and other publications. We provide a wide range of training, take advantage of it. If you manage staff please give them the space and support to reflect on their work to safeguard children.

Chief Executives

We need to be assured that you continue to meet your duties under Section 11 of the Children's Act 2004. Help us understand how you safeguard children and the impact of any changes in your organisation by prioritising your contribution to BSCB. Ensure that your workforce is able to attend and contribute to the delivery of the BSCB training programme.

Police and Crime Commissioner

Please use this annual report and those of our pan-Lancashire counterparts to inform your planning. In particular we would ask that CSE remains a high priority. Ensure that the voices of child victims are heard loudly in the criminal justice system and that agencies effectively work together to share information about those who pose a risk to children.

Commissioners

This means you if you have control of a budget that is used to provide a service for children. Ensure that you listen to the voice of the child when you make decisions. Understand the services that you commission and hold your providers to account to meet their responsibilities to safeguard children.

Schools

You are better placed to understand the experiences of a child than almost any other agency. Please share that understanding to help others work more effectively. Assist your staff to access our training and let us know what training would benefit you. We are keen to communicate more effectively with you, please come to our twilight meetings and let us know what you would want to discuss at them. Consider whether you could become a member of our strategic board or subgroups.

APPENDIX A

Strategic Board Membership (at the time of Publication)

Name	Title	Agency
David Sanders	Independent Chair	
Helen Skerritt	Chief Nurse (Deputy Chair)	Blackpool CCG
Cllr John Jones	Elected Member	Blackpool Council
Delyth Curtis	Director of Children's Services	Blackpool Council
Dr Arif Rajpura	Director of Public Health	Blackpool Council
Amanda Hatton	Assistant Director of Early Help and Children's Services	Blackpool Council
Linda Evans	Principal Social Worker	Blackpool Council
Andrew Lowe	YOT Service Manager	Blackpool Council
Sharon Cooper	Safeguarding, Quality and Review Service Manager	Blackpool Council
Cathie Turner	Designated Nurse	Blackpool CCG
Dr Sujata Singh	GP representative	Blackpool CCG
Marie Thompson	Director of Nursing and Quality	Blackpool Teaching Hospitals Foundation NHS Trust
Dr Rob Wheatley	Designated Doctor	Blackpool Teaching Hospitals Foundation NHS Trust
Bridgett Welch	Assistant Director of Nursing	Lancashire Care Foundation Trust
Sue Warburton	Deputy Director of Nursing	NHS England
David Rigby	Sector Manager	NW Ambulance Service
Nikki Evans	Detective Superintendent	Lancashire Constabulary
Tony Baxter	Detective Inspector	Lancashire Constabulary
John Donnellon	Chief Executive	Blackpool Coastal Housing
Karen McCarter	Head teacher	Norbreck Primary Academy
Chris Thomas	Director 14-19	Blackpool and the Fylde College
Jackie Couldridge	Service Manager	CAFCASS
Tracy Buckley	Service Manager	NSPCC
Sonia Turner	Assistant Deputy Director	NW National Probation Service
Louise Fisher	Assistant Chief Executive	Cumbria and Lancashire CRC
Jenny Briscoe	Lay Member	

Glossary of Acronyms

BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
DA	Domestic Abuse
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIB	Children's Improvement Board
CPC	Child Protection Conference
CSE	Child Sexual Exploitation
GIR	Getting it Right
H&WBB	Health and Well-being Board
LAC	Looked after Child/ren
LADO	Local Authority Designated Officer
LIF	Learning and Improvement Framework
LSCB	Local Safeguarding Children Board
MAAG	Multi-Agency Audit Group
MASH	Multi-Agency Safeguarding Hub
MFH	Missing from Home
MPDF	Multi Professional Discussion Forum
PCC	Police and Crime Commissioner
PMEG	Performance Monitoring and Evaluation Group
SB	Shadow Board
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SUDC	Sudden Unexplained Deaths in Childhood
YOT	Youth Offending Team

For more information on the

BLACKPOOL SAFEGUARDING CHILDREN BOARD

visit **www.blackpoolsafeguarding.org**

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