Appendix 8(a)

BLACKPOOL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015–2016

BLACKPOOL SAFEGUARDING CHILDREN BOARD

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1. FOREWORD FROM THE INDEPENDENT CHAIR

I am pleased to present the Blackpool Safeguarding Children Board (BSCB) Annual Report for 2015-16. The report is an opportunity to take stock of the work of the Board during what has been a busy and challenging year and to look ahead to what we hope to achieve during 2016-17.

We entered 2015-16 under an Improvement Plan as a consequence of Ofsted's judgement that both the Local Authority's Children's Services and BSCB were inadequate in 2012. It is a tribute to all who work to safeguard children in Blackpool that the Improvement Plan was lifted in July 2015. This allowed BSCB to resume its full statutory responsibilities, although we will continue to ensure that we remain cognizant of the Improvement Plan and will ensure that changes that have been made remain embedded in practice.

I continue to be impressed at the significant commitment of the managers and practitioners of our partner agencies to the work of BSCB. This is all the more significant in a time of financial pressure and increasing demand for all of our services. I have been particularly pleased to see the increasing commitment to BSCB from our schools and I am happy to report that we now have appropriate schools' representation at our Strategic Board and all our subgroups.

As you read through the pages of this report you will gain an insight into the work of the Board, how we audit, review, learn and invest in partnerships with the ultimate aim of improving the lives of our children. There is no doubt that there is much to celebrate in our work, but much more that we can do. We are committed to continuous improvement and strive to improve the lives of children who are neglected or in need of early help, those who live with the toxic trio of parental domestic abuse, substance misuse or poor mental health and those who are at risk of child sexual exploitation. We are determined to tackle these issues from every possible angle, to improve practice, to better engage with children and communities and to build stronger partnerships.

Children should be at the centre of everything we, as a Board, do. I am therefore pleased to report the emergence of a children and young people's participation group that will enable us to seek the views of the wider population of children in secondary schools. It is vital that this work is prioritised and that an understanding of the experiences of our children is the starting point for all of our activity.

The end of the period covered by this report marks the midway point in our 2015-17 Business Plan and I am aware that much remains to be done. By the conclusion of this year I expect to report on the successful launch of a new strategy for early help in Blackpool that will ensure that all children receive help at the earliest possible opportunity, thereby reducing the potential harm that they face. I likewise expect to deliver a comprehensive assessment tool to enable practitioners in Blackpool to effectively and consistently evaluate the scale of neglect that children experience. The need to an effective response to child sexual exploitation is well-rehearsed and I am pleased to note ongoing progress in this respect. The vulnerability of children who go missing from home and the known links with child sexual exploitation is a cause for significant concern and one that will be a focus of our attention in the forthcoming year.

The work of BSCB places significant demands on all of those who attend our meetings and work to deliver our business plan. I would therefore like to thank all members of the Strategic Board and Subgroups, together with our small business unit which is responsible for the continued orderly running of the Board.

Finally, I would like to take this opportunity to thank all practitioners and volunteers who work to keep Blackpool children safe. Without you the successes reported here would not happen. For our part we will continue to work to provide you with the best possible system to keep our children safe.

David Sanders
Independent Chair
Blackpool Safeguarding Children Board

Executive summary

This is the statutory annual report of Blackpool Safeguarding Children Board in which we are required to review our work during 2015-16 and to make an assessment as to the effectiveness of services to keep children safe in Blackpool.

The report therefore provides an overview of **Blackpool demographics** which continue to be characterised by a stable child population, primarily of white British origin. Blackpool as a whole experiences long standing high levels of deprivation as a result of which nearly a third of our children live in poverty.

Chapter 3 outlines **Who we are and what we do**, including our statutory context, our local governance arrangements, how we are funded and how we manage our business plan. During 2015-16 we were able to meet our statutory requirements in terms of membership and reached a longer term funding arrangement with our contributing partners.

What our children have been telling us should be central to the work of BSCB, but is an under-developed area of our work. We are, however able to report initial steps to remedy this, together with good evidence of our partner agencies ensuring that they listen to and act on what children and young people tell them.

Each stage of **A child's journey through services** is considered to review what our data and audit activity tells us about the overall health of the child protection system. The picture during 2015-16 mirrors that of previous years, in that significantly more children are subject to each stage of child protection processes than would be expected. There is, nevertheless, some evidence of good systems performance. Two areas of concern are noted, namely the absence of data on early help provision and a significant increase of children in need of protection during the final months of the year.

Having considered the overall system, the report continues to address how we **Safeguard vulnerable children** in specific circumstances. In terms of child sexual exploitation considerable professional awareness raising activity is noted, together with the start of work to raise awareness amongst children and specific sectors of the economy.

Operational responses to children who go missing from home or care have developed significantly during the year, however improvements in how we collect and use intelligence from return home interviews continue to be needed. We are unable to obtain assurance that effective early intervention is provided to all children who are in need of help and will continue to work to provide an effective assessment framework for all practitioners, together with responsive MASH and Front Door processes to refer children to a higher tier of services. Our responses to children who are experiencing neglect, the toxic trio, private fostering and radicalisation are also considered.

The children's workforce is central in work to safeguard children in Blackpool and a particular focus for us during 2015-16 has been how we engage with schools. This has enabled us to better understand their needs and has resulted in the production of a number of template policies to assist them to safeguard children. We continue to provide quality multi-agency safeguarding training, to 1,665 practitioners in the reporting period, delivered by a pool of trainers drawn from our partner agencies.

The **Learning and Improvement Framework** is central to the work of the Board and services to collate all our review and audit activity. During the reporting period we have published two serious case reviews and continue to deliver the action plans from four others. These have enabled changes in systems, for example to substance misuse services, which should reduce the risks of further deaths in similar circumstances. The Child Death Overview Panel has likewise continued its successful Safer Sleep campaign that has now been recognised by NICE. Our Section 11 audit scrutiny programme this year has included visits to frontline practitioners which has allowed us to triangulate information provided by senior managers and provided us with information that has informed other streams of work, for example our review of the thresholds document.

Finally, the **Work of our partners** provides evidence of innovative and effective single and multi-agency work to safeguard children in Blackpool, including successful bids for significant lottery funding, together with other services that have been recognised as being effective in serious case reviews.

2. BLACKPOOL DEMOGRAPHICS

Blackpool is a seaside town in the north west of England. Its population of 142,100 people living within an area of 34.92km2 renders it one of the most densely populated areas outside London. Transience is a significant feature of the town, with 9,000 people estimated to move in and out of the town annually.

There are approximately 28,800 children and young people aged under 18 resident in Blackpool, making up 20.3% of the population. Overall, the 65+ age group is the most over-represented in Blackpool. Children and young people from minority ethnic groups form 9.1% of the school age population, compared with 28.9% nationally. Life expectancy for children born between 2012 and 2014 is estimated to be 74.7 and 79.9 for boys and girls respectively, compared with 79.5 and 83.2 nationally.

Blackpool experiences considerable levels of deprivation which have increased over recent years. The English Indices of Multiple Deprivation 2015 record that 38.3% of smaller areas within Blackpool are in the most deprived 10% nationwide, while 20.2% are in the most deprived 1%. In contrast, none are in the most affluent 20%. Amongst the adult working age population 23% of Blackpool residents are reliant on out-of-work benefits, compared with 12.7% nationally. The impact of these levels of deprivation is such that 32.9% of children live in income deprived households.

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 for substance and alcohol misuse and self-harm are amongst the highest in the country. 6.5% of 16-18 year olds are not in education, employment or training.

Within Blackpool there were 1,916 children in need as of 31st March 2016 (2015: 1,826) equating to 665.0 per 10,000 of the population (2015: 629.0). This is considerably in excess of both the national average of 337.3 and that of our statistical neighbours of 512.7 (2015 figures).

3. WHO WE ARE AND WHAT WE DO

3.1 Statutory context

Blackpool Safeguarding Children Board (BSCB) is the partnership body statutorily 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 Board Regulations (2006). During 2015/16 the work of BSCB was governed by the statutory guidance of Working Together to Safeguard Children (2015), 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 and challenging the performance of 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 the deaths of children and young people to identify how the risks of deaths in similar circumstances can be reduced.

Working Together (2015) requires each Local Safeguarding Children Board to produce and publish an annual report evaluating the effectiveness of safeguarding in the area. The report should "provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action".

3.2 Key roles

Independent Chair

David Sanders was appointed to the role of Independent Chair of BSCB in November 2014. The role of the Independent Chair is to provide an external perspective by which impartial challenge can be brought to any of our member agencies.

The Independent Chair is appointed by and accountable to the Chief Executive of Blackpool Council for the effective working of BSCB. David promotes the work of BSCB through regular attendance at other strategic boards and through meetings with senior managers in partner agencies, schools and other bodies that have a duty to safeguard and promote the welfare of children. The work of the Chair and BSCB is supported by a full time business manager and a training co-ordinator.

Blackpool Council

Whilst the Chair and Board are independent, the Local Authority 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 statutory Director of Children's Services, Delyth Curtis, has the legal responsibility for the provision of all services to children by the council, including safeguarding, and sits on BSCB. She is held to account by the Lead Member for Children's Services, Councillor Graham Cain and the Lead Member for Children's Safeguarding Councillor Debbie Coleman who sit on BSCB as participating observers, and therefore inform, but are not part of, the decision making process.

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 committed to the effective operation of BSCB.

A number of our partners have a statutory responsibility to sit on BSCB, while others have been invited to join due to the significance of their work in Blackpool. BSCB was compliant with statutory requirements in respect of partner agency membership throughout the reporting period.

Strategic 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 safeguard 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 subgroups respectively.

Lay Members

It is a statutory requirement that LSCB should take reasonable steps to appoint two lay members to make links with community groups, support stronger public engagement and improve local understanding of safeguarding children. The lay member acts as an independent voice within the Board to question decision making and to hold agencies to account. BSCB has had one lay member in post throughout the reporting period but, despite advertising the role in local media and on the BSCB website, has been unable to recruit to the second post. This will remain a priority in the forthcoming business year.

3.3 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) was put in place and BSCB became accountable to the CIB. As improvements became embedded, more functions were returned to BSCB and, in June 2015, the Department for Education signed off the Improvement Plan as complete and dissolved the CIB, thereby returning all statutory functions to BSCB.

The Director of Children's Services has subsequently established the **Continuous Improvement Board** that seeks to continue the broader development of services for children in Blackpool to a point at which they might be considered good by Ofsted. The BSCB Independent Chair is a member of this Board.

Blackpool Safeguarding Adults Board

Local Safeguarding Adults Boards were made statutory bodies by the enactment of the Care Act (2014) in April 2015, although Blackpool Safeguarding Adults Board (BSAB) had already been established for a number of years at this point. In recognition of the continuum of safeguarding need that extends through childhood into adulthood, a number of measures have been taken to more closely align the work of the two Boards during the reporting period.

David Sanders is also the Independent Chair of BSAB and a number of joint subgroups have been established to better co-ordinate and streamline the work of the Boards. A joint development session was held for Strategic Board members and a joint plan of action in respect of the Toxic Trio (parental domestic abuse, poor mental health and substance and alcohol misuse) is now in development. Finally, a commissioning review of the two Boards' business units proposed that they became a joint unit to promote greater collaboration and resilience. This has been accepted by both Strategic Boards and will be put in place in forthcoming months.

Other Strategic Boards

The Health and Wellbeing Board and Community Safety Partnership (CSP) are multi agency strategic boards with responsibility to meet overall health needs and to reduce crime respectively. There is understandably a degree of overlap between the work of these Boards and that of BSCB. For example, the CSP has a responsibility to tackle domestic abuse while BSCB seeks to ensure that children are safeguarded in homes where there are incidents of domestic abuse. The chairs of both of these Boards are therefore members of BSCB and aspects of the work of both Boards are scrutinised to ensure that adequate provision is made for the safeguarding of children. BSCB is also required to submit its annual report to the Health and Wellbeing Board.

A piece of work is currently being overseen by the Continuous Improvement Board to formalise relationships between strategic boards and other groups in Blackpool and to ensure that work is not duplicated.

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 and has funded new services for victims of child sexual exploitation in the reporting period.

Other LSCB

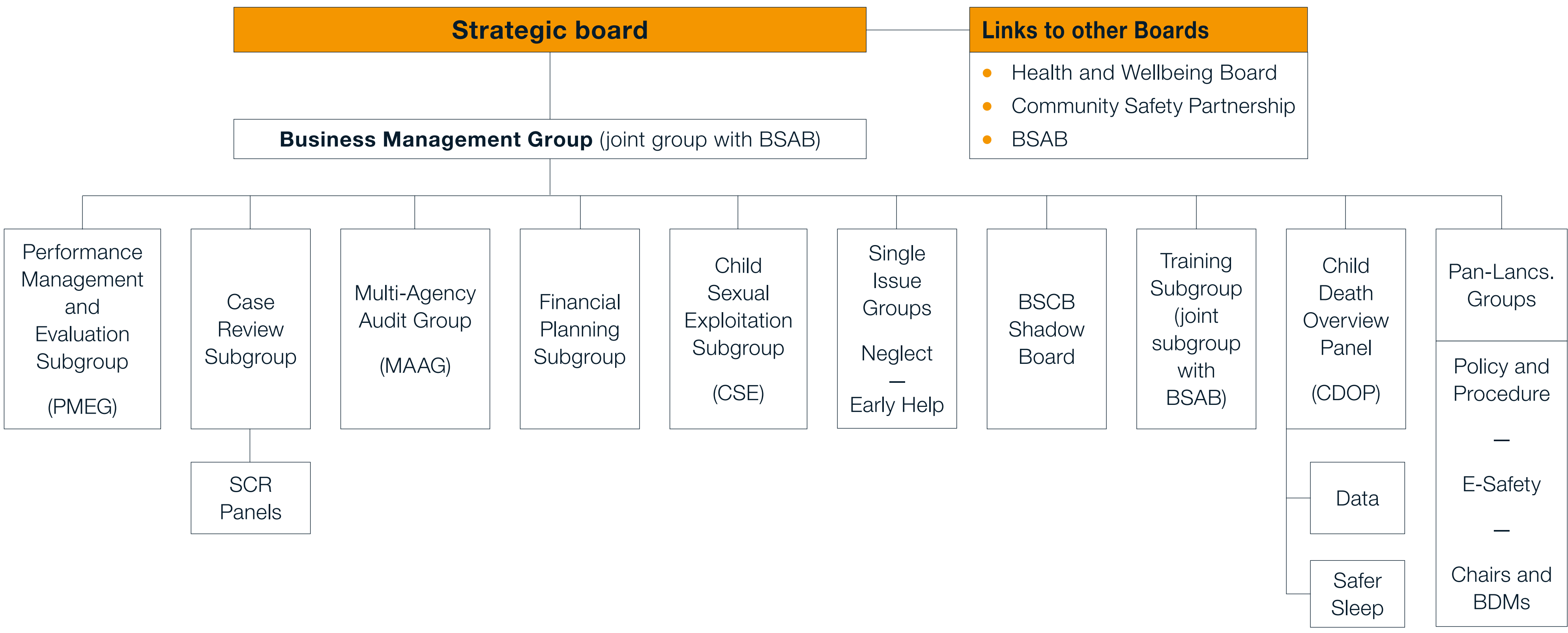
The Independent Chair regularly meets with his colleagues from Lancashire and Blackburn with Darwen to ensure that a co-ordinated approach is taken to issues that extend beyond Blackpool. This assists our partner agencies, the majority of whom operate on a wider geographical footprint. Formal arrangements are in place for the development of joint multi-agency policies and procedures, while a Pan-Lancashire Child Death Overview Panel has been in place since 2011.

3.4 How we work

The work of the BSCB is driven by the Strategic Board which meets on a bi-monthly basis. The final hour of Strategic Board meetings is set aside for a more in depth discussion of a safeguarding theme, which will typically be a Board priority area. Two development sessions were also held during the reporting period, in the first of which an external review of Board functioning was provided by Howard Cooper, Independent Chair of Liverpool LSCB.

The delivery of specific elements of the BSCB business plan and other statutory functions are delegated to a number of subgroups, some of which are held on a joint basis with BSAB or with Lancashire and Blackburn with Darwen LSCB. Subgroups are chaired by Strategic Board members with the necessary expertise to tackle the area in question, while members are drawn from the agencies considered necessary for the subgroup to meet its objectives. In June 2015 a Business Management Group (BMG) was established. This group co-ordinates the work of the subgroups and monitors business plan delivery, with a membership consisting of subgroup chairs and others co-opted to ensure that all sectors are represented. In November 2015 it became a joint group of BSCB and BSAB.

Strategic Board and subgroup members are expected to attend 80% of meetings in person and, when they are unable to do so, to send an appropriately briefed named deputy. Attendance is monitored by BMG and during the reporting period the majority of Strategic Board members did not meet the required threshold for attendance. In the event of protracted concerns in respect of the attendance of an individual or agency the Independent Chair will challenge the organisation concerned. This has been effective in securing better attendance from a number of agencies during the reporting period, although it is acknowledged that further improvement is required in this respect.



3.5 Budget

Funding for the operation of BSCB continues to be provided by a core group of partner agencies. Having remained unchanged for five years, increases in contribution were negotiated with a number of these and are gratefully acknowledged in a time of financial constraint. The contribution of other resources 'in kind' by the wider partnership is likewise acknowledged and has consisted of the time taken by staff to attend meetings, membership of the training pool and the use of buildings.

Income and Expenditure Summary

Income		Expenditure	
Blackpool Council	100,137	Staff costs	103,570
Blackpool CCG	51,867	Independent Chair	26,820
Lancashire Constabulary	22,782	Training	6,933
Cumbria and Lancashire CRC	3,304	Board support costs	14,155
National Probation Service	3,304	Council support	10,000
Blackpool Coastal Housing	2,933	Serious case reviews	2,669
CAFCASS	550		
	184,877		164,147

Board staffing costs remain the largest area of expenditure, although in year administrative vacancies and a delay in recruiting to the newly agreed analyst post were the primary contributors to the underspend. Training costs have been reduced by the development of the pool of local trainers from partner agencies and the charging of agencies for non-attendance. Serious case review costs have substantially decreased due to the majority of costs for reviews that were completed during the year having been attributed to the 2014/15 budget. It has been agreed to carry forward the underspend of £20,730, together with that brought forward of £54,042 into 2016/17. Agreement has been reached, in principle, for a three year budget to 2018/19 that will support the ongoing activity of the Board, together with the new joint business support unit with BSAB.

3.6 Business plan

This report covers the first year of a two year business plan that was agreed by the Strategic Board in March 2015 and is available on our website

The plan is split into six priority areas which include the four safeguarding themes of child sexual exploitation, early help, neglect and the toxic trio. Work toward and an assessment of BSCB performance in respect of the four safeguarding priority themes is included in Chapter 6 below.

The remaining two priority areas are:

Completion of outstanding elements of the BSCB Improvement Plan

We have:

- Improved our schools representation through the Strategic Board and subgroups and established half termly schools' twilight meetings
- Implemented a new dataset that strengthens our range of multi-agency data
- Improved our understanding of frontline practice through the establishment of the shadow board, multi-professional discussion forums and visits to the frontline

What we will do next

- Improve our use of data through the expansion of the suite of data indicators which will be facilitated by the recruitment of a board analyst
- Evaluate the impact of serious case review learning on frontline professionals

BSCB Organisational development

We have:

- Re-launched the BSCB website to develop professional and public awareness of the Board and our work
- Reviewed and expanded the training programme
- Re-modelled the BSCB governance structure
- Held two young people's participation meetings to help us understand how to develop this area of work

What we will do next

- Establish a permanent programme of children and young people's participation in the work of BSCB
- Raise public awareness of necessary actions to safeguard children through marketing campaigns
- Publish a regular newsletter for professionals

The BSCB business plan is reviewed on a bi-monthly basis by the Business Management Group which holds subgroups or partner agencies to account for the completion of their areas of responsibility. It is intended to be a fluid document and other areas of work that assume a greater national or local priority may be formally incorporated into the plan or have discreet pieces of work undertaken on them. During this reporting period BSCB has also considered radicalisation, female genital mutilation and familial child sexual abuse.

4. WHAT OUR CHILDREN HAVE BEEN TELLING US

In the development of its 2015-17 Business Plan, BSCB acknowledged that it had undertaken insufficient work to directly seek the views of children and to utilise these to inform its ongoing work. During the reporting period BSCB consequently held two consultation events with children drawn from Blackpool secondary schools and further education providers. Based on the feedback provided by children and young people at these events, we will establish a standing group of children and young people who will meet on a half termly basis to inform our ongoing work and provide a perspective of the lived experience of children in Blackpool. We intend to have two members from each secondary school who will link back to their school council and/or use surveys of their wider school community to both promote the work of BSCB and to seek the views of a wider cohort of children and young people. The 2016-17 annual report will therefore be able to reflect the views of children and young people on the success or otherwise of the work of the safeguarding partnership.

BSCB will also work to ensure that we seek the views of children and families when we evaluate practice. Multi-agency audits will therefore seek to measure the impact of interventions on children and families, while the evaluation of our training programme will seek to evaluate the impact that training has had on practice and outcomes for children.

In the course of its audit and review activities BSCB also seeks to ensure that multi-agency work to safeguard children is child focussed. Examples of partner agencies consulting with children and young people include all schools having a form of school council and using wider surveys to seek the views of pupils, while Blackpool Teaching Hospitals seeks the views of children and their parents on discharge and maintains the Victoria's Voice group that is open to any child who accesses its paediatric ward. Blackpool Council engages with the children in its care and care leavers through the Just Uz group. As a result of the feedback from its children a website has been developed to improve communications and a dedicated building, The Core, has been opened where children and young people in its care and care leavers can access a range of services in one place or simply spend time together. Representatives of the Just Uz group attend the Corporate Parenting Panel to provide feedback to elected members and senior managers, as a result of which changes have been made in how the Local Authority communicates with children and Passport to Leisure provision has been extended to care leavers up to the age of 21. The views of children as they progress through safeguarding services are routinely sought through conference packs that children are asked to complete prior to child protection conferences, while children in care are able to set the agenda for their reviews.

BSCB were concerned to note the findings of a recent Healthwatch report regarding the emotional health and wellbeing of Blackpool. This suggested that a significant proportion of children in Blackpool experience poor emotional health, to the extent that one in four of those surveyed have self-harmed. During the forthcoming year we will seek to fully understand this issue through our own consultations with children and we will be undertaking an audit to develop our understanding of the experiences of children who do self-harm and what preventative approaches should be developed.

5. A CHILD'S JOURNEY THROUGH SERVICES

Universal and Early Help

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

For the vast majority of children, there are no safeguarding concerns and they will receive a Level 1 universal service offer that will provide for their health and educational needs. When a professional is concerned that there are indications that a child is at risk of harm (or if it is suspected that a child's health and development would be impaired without statutory intervention, or the child has complex needs) they are expected to complete the continuous assessment tool provided by the Getting it Right (GIR) framework. A Level 2 approach would be likely to involve one agency providing targeted support to address a specific issue, while a Level 3 approach would necessitate multiple agencies working together to address more broadly based issues. In these circumstances one agency is expected to take the lead professional role and to assess, co-ordinate and provide early help to the child and their family.

Ensuring that effective and consistent early help is provided to children in Blackpool is a priority for BSCB and progress in this respect in assessed in Chapter 6 below. At this point BSCB is unable to fully assess the effectiveness and scale of early help provision. This is due to not knowing the number of children who receive early help at Levels 2 and 3 as a consequence of there being no central record of open continuous assessment tools. Blackpool is alone in the north-west in not collating this data and BSCB has identified the urgent need to remedy this issue.

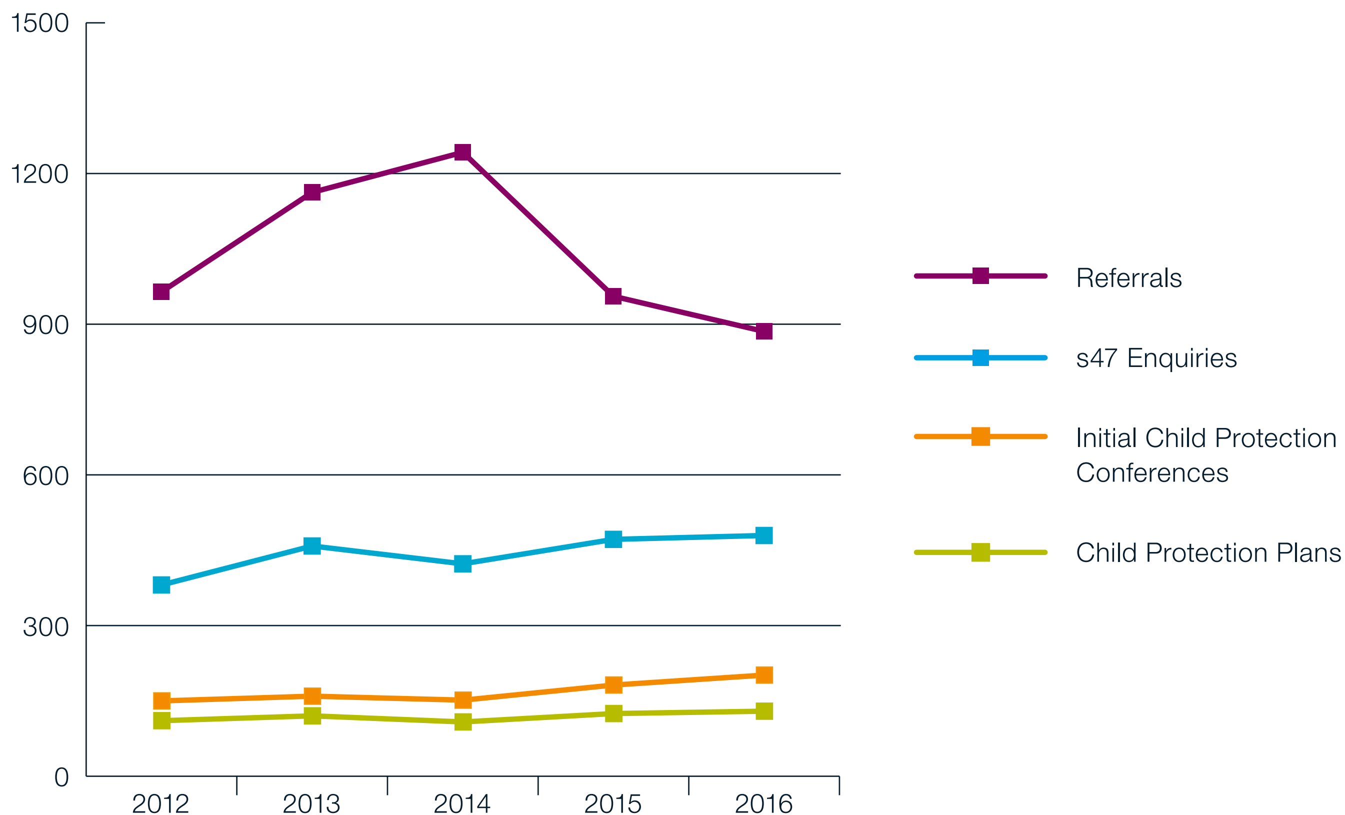
To assist BSCB's understanding of early help provision a Multi-Agency Audit Group (MAAG) audit conducted in October 2015 reviewed 15 cases that had been referred to children's services at Level 4, but had been assessed not to meet this threshold. Each case was audited to identify whether early help provision was evident prior to and after the referral. 60% of the cases were receiving early help prior to the referral and stepped back down to this level, while the remaining 40% returned to universal service provision, which was viewed as being appropriate. The audit consequently concluded that there is evidence of effective early help being provided, despite the Local Authority's lack of quantifiable data in this respect.

Child Protection

The Children's Services Front Door acts as the single point of access for all contacts to Children's Social Care. In 2015/16 the Front Door received 10,115 (2015: 10,829) contacts. A contact, in this context, can include anything from an urgent request for safeguarding action to pieces of information that require sharing, but no further action. The combination of all contacts in this category renders analysis of the conversion rate into referrals difficult, as some are clearly not intended to prompt further action and means that conclusions cannot be drawn from breakdowns of contacts by agency. Children's Services intend to address this issue by the introduction of an 'information only' category of contact that should allow more accurate data reporting.

Of the 10,115 contacts 2,937 or 29.0% (2015:28.6%) progressed to a referral to children's social care of which 24.4% were repeat referrals. The latter figure represents a reduction from 31.0% since 2015 and brings Blackpool back into line with the 24.0% figure recorded nationally (note that this, and all subsequent national and statistical neighbour comparator data, is the most recently published March 2015 figure).

Blackpool's rate of children per 10,000 of the child population at each stage of the safeguarding journey over the last five years is documented below:



It is notable that within this period the relative rate of section 47 enquiries, initial child protection conferences and children subject to child protection plans has remained stable, while the rate of referrals peaked in 2014 and has subsequently declined. This would suggest that fewer inappropriate referrals are now being made which suggests a better understanding of thresholds for intervention than has previously been evident.

National Comparisons

The rate of children at each stage of the safeguarding process in Blackpool remains well in excess of those recorded nationally and amongst our statistical neighbours (a comparator group of Local Authorities with similar demographics), as is indicated by the table below:

Rate per 10,000 child population of	Blackpool	England	Statistical Neighbours
Referrals	885.6	548.3	615.3
Section 47 enquiries	479.3	138.2	173.4
Initial child protection conferences	198.9	61.6	86.1
Children subject to child protection plans	127.0	42.9	60.9

With the exception of referrals, which remain relatively lower, there are around three times the rate of children at each stage of the child protection system in Blackpool, than nationally. This places significant strain on all agencies and is something that BSCB has yet to definitively understand, despite considerable activity in this respect. Increased child protection activity is associated with higher levels of deprivation so figures in excess of the national average are to be expected, however Blackpool continues to experience rates well in excess of its statistical neighbours. It would be fair to say that single and multi-agency audits have not suggested that there is a significant issue with children being inappropriately placed on child protection plans. Similarly, some data indicators that could account for Blackpool's high rates, for example the conversion rate from section 47 enquiry to initial child protection conference, are in line with national rates.

However, Blackpool does have a higher than national average number of child protection plans that were in place continuously for two years or more or for three months or less, which could suggest that some children are on a plan for longer than is necessary, while other plans may not have been required. This warrants further investigation, but would not account for the overall high rates. Similarly, robust early help data is required to allow meaningful judgements as to the impact of early help provision on the numbers of children in receipt of higher tier services. Without this data it might be argued that the high numbers of children in the system reflect ineffective early help services or, alternatively, that agencies effectively identify children in need of higher tier services at an early stage. BSCB audit activity would suggest that there is some effective early help provision, however the need to ensure that effective early help is provided throughout Blackpool will remain a priority area for BSCB during 2016/17.

Child Protection Plans

If professionals at an Initial Child Protection Conference (ICPC) are concerned that a child is at risk of significant harm or has suffered abuse and there is a continued risk 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 promote the safety and wellbeing of the child and to manage risk. The plan is managed through regular core group meetings and reviewed at child protection conferences.

On the 31st March 2016 there were 366 children subject to child protection plans in Blackpool (2015: 355). Of the 517 children who became subject to a child protection plan during 2015/16 99 (19.1%) were being made subject to a plan for a second or subsequent time, compared to a national average of 16.6%. While the two episodes may be entirely unrelated, this potentially indicates that some plans are being ended too early, before changes made to protect the child are sufficiently embedded.

The age profile of children subject to a child protection plan in Blackpool differs from that evident nationally, most notably in terms of the number of unborn children subject to a plan who represented 9.6% of the total number of plans in place on the 31st March 2016 and 13.0% of plans that were in place throughout the entire year. In contrast 2.1% of plans nationally are for unborn children. Children from birth to the age of four are under-represented, while children over four are broadly consistent with national trends. This may indicate a tendency in Blackpool to intervene prior to birth, thereby reducing the need for intervention in early years, however it is an area of practice that BSCB should seek to better understand in the forthcoming year. Unfortunately, a failure to consistently record ethnicity precludes an analysis as to whether the ethnic origin of children subject to a child protection plan corresponds with Blackpool's overall demographic. Recording practice in this respect must be improved.

The most common reason for a child protection plan being put in place was emotional abuse (73.2%), followed by neglect (38.1%), physical abuse (21.1%) and sexual abuse (21.1%). This represents a continuation of the recent increase of plans made in respect of emotional abuse (2014: 57.7%; 2015: 67.1%), while the number of plans made in response to neglect has declined significantly in year (2014: 51.5%; 2015: 54.5%). National comparisons are not entirely reliable due to Blackpool's practice of allowing registration in more than one category, which is not followed in all local authorities. However, the disparity between the national figures of 33.5% and 44.7% of plans being made due to emotional abuse and neglect, respectively, is worthy of note.

The BSCB 2014/15 Annual Report also noted a significant increase in child protection plans being made in respect of emotional abuse. In order to better understand this increase a MAAG audit was undertaken of 256 children subject to child protection plans for emotional abuse. 99.6% were assessed to be correctly categorised as emotional abuse and in 82% domestic abuse was noted to be a contributory factor, with parental mental health being noted in 55% of cases and parental alcohol and/ or substance use in 47%. Given the high levels of domestic abuse that are known to exist in Blackpool this audit finding was not unexpected, although it does not explain the increase in the number of plans that are made in respect of emotional abuse. This finding will, however be used to challenge commissioners to ensure that the safeguarding needs of children in families where domestic abuse is present are met.

Core groups

The effective functioning of core groups has been an ongoing concern of BSCB since Ofsted identified this as a significant area of concern during its 2012 inspection. While the 2014 inspection did find improved practice in this respect, BSCB has continued to undertake six monthly audits of core groups to ensure that improvements are embedded in practice. The audits have provided BSCB with an accurate longitudinal view as to the effectiveness of core group processes. The picture has been of overall steady improvement, but with some examples of poor practice in individual cases that have been reported back to line managers. Evidence has therefore been obtained of improvements in respect of timeliness, recording and planning being maintained, while other issues, for example contingency planning, have been addressed through the production of 'Lessons Learned' newsletters for professionals. Ongoing issues with attendance have resulted in a determination to conduct a more fundamental review of how core groups are managed, that will be undertaken by BSCB during 2016.

Children in Care

When it is no longer possible or it is not 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. Most 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 their partners to provide for children in care is scrutinised by the Corporate Parenting Panel. Children who are remanded in custody also become looked after and the Youth Justice Board (YJB) maintains oversight of their care and management, while also working to reduce the rate of re-offending by all children in care.

There were 470 children in care on the 31st March 2016 (2015: 454), which represents 163.1 per 10,000 of the child population (2015: 156.4). While this is well in excess of the national rate of 60.0 it may be expected, given the high numbers of children previously noted at each stage of the child protection process.

Over recent years, the nature of where children in care are placed has changed, with a significant increase in the use of Special Guardianship Orders, typically to place a child with a member of their extended family, that is mirrored nationally, and an increasing use of external fostering placements as a consequence of the limited capacity of internal fostering placements, especially those who are able to manage older children with challenging behaviour. As corporate parents, the local authority seeks to reduce the disruption that each child in its care experiences. The level of children placed more than twenty miles outside Blackpool has remained stable in recent years (currently 9.5%), although the number of children with three or more placements within twelve months has increased to 12.3% (2015: 9.9%) which is in excess of the national average of 10.0%. The local authority were challenged to increase the completion rate of personal education plans for looked after children by the Children's Improvement Board and have subsequently achieved an increase from 67.1% being completed in the Autumn term of 2014 to 96.7% in 2015, although further work to improve their quality has now been identified.

When it is in the best interests of a child for permanence to be achieved through adoption, it is expected that this is attained as quickly as is possible. In the reporting year 46 children were adopted, although the number of days between their entering care and being placed with their adoptive family stood at 690 (2015: 752), compared with a national average of 593. Data in this respect is subject to a significant time lag and it is expected that this will improve in forthcoming years.

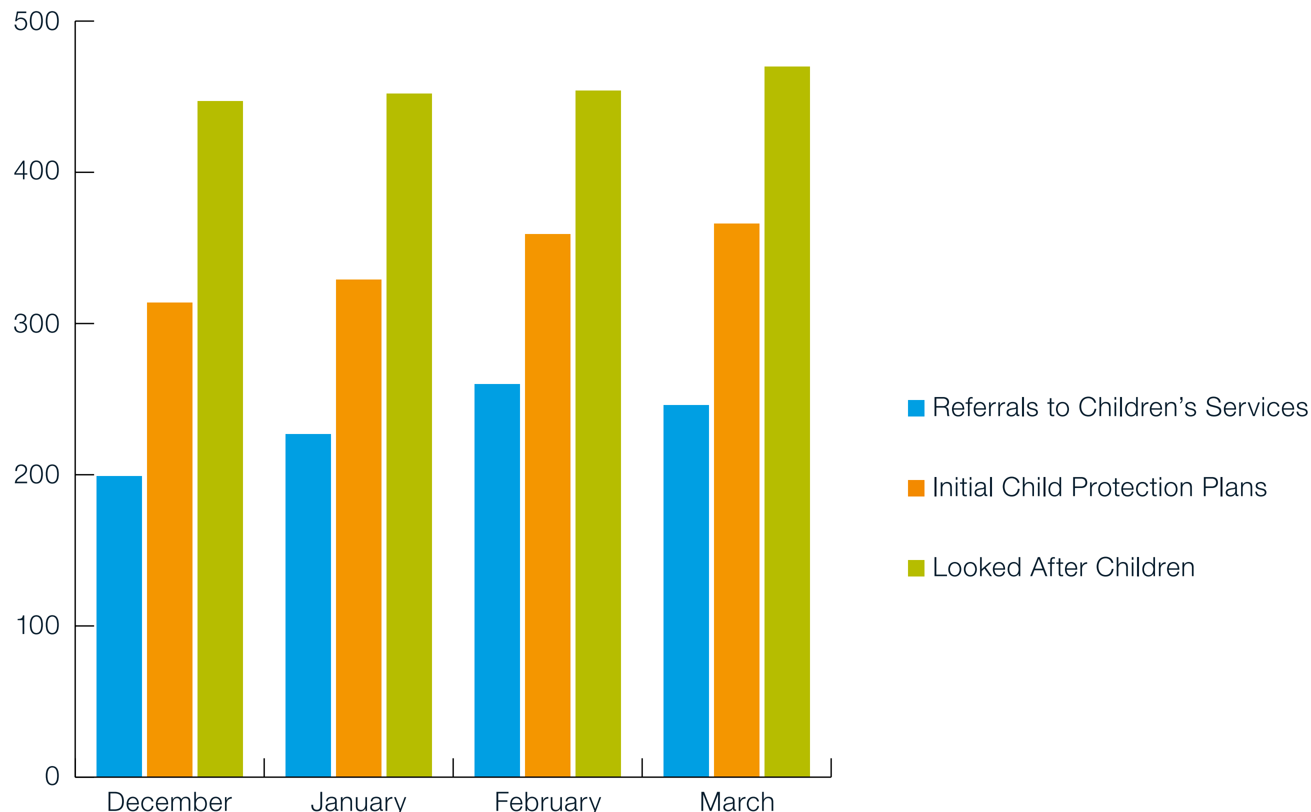
Good system performance

The high number of children that require protective action within Blackpool undoubtedly places a strain on the multi-agency system, however there remains continued evidence of good practice both in terms of individual case studies, that are included in this report, and in systems performance data that includes:

- Maintained performance in respect of the completion of child and family assessments within 45 days and in which the child was seen, despite almost 400 more being completed in the year
- 93.2% of ICPC being held within 15 days of the start of a section 47 enquiry, compared to a national average of 74.7%
- Every child protection plan review during the reporting year was within timescale, compared to a national rate of 94.0%
- 98.2% of LAC reviews were completed within timescale
- A higher percentage of children who cease to be looked after are adopted or become subject to Special Guardianship Orders than nationally
- A higher percentage of looked after children have health development checks (for under fives), up to date immunisations and annual health assessments than nationally

The challenges ahead

During the final quarter of the year a significant increase in the number of children at each stage of the child protection system was evident, as is demonstrated by the following graph:



Early indications are that this trend has continued after the year end and while some increases can be attributed to individual factors, for example a large family coming into care, no overall explanation for this increase has been identified. BSCB will therefore continue to closely monitor the number of children that require child protection action and will ensure that its audit programme and other learning activity enable it to understand trends in performance data. When changing trends in data are identified we will seek to hold partners to account to ensure that adequate arrangements are made to meet changing needs.

6. SAFEGUARDING VULNERABLE CHILDREN

6.1 Child sexual exploitation and missing from home

The need for a robust partnership response to child sexual exploitation (CSE) was recognised locally a number of years ago and has subsequently been driven by high profile national cases, including those in Rotherham, Rochdale and Oxfordshire, and a number of reports published in recent years. While Blackpool was consequently at the forefront of developing multi-agency responses to CSE, BSCB is keen to ensure that it continues to effectively respond to CSE.

What we know about CSE in Blackpool

Our understanding of CSE in Blackpool does not conform to some national stereotypes. In Blackpool perpetrators are typically white males operating alone and offending after a process of building a relationship either online, at hotspots or parties. There is no current evidence of gang or taxi related offending. While the majority of victims are girls, a higher than average number of male victims have been identified. The predominant age of victims is between 13 and 15, although this has reduced in recent years. At least 40% of perpetrators are under five years older than their victim. Key vulnerabilities identified in CSE victims are substance misuse and missing from home, with a third of victims having been reported as missing from home in the previous year. Over half of victims have had a disrupted education, including multiple school moves, being on the out of school register, known to the pupil welfare service and with a record of persistent absences. 4% of looked after children were considered to be at risk of CSE in their most recent review.

In 2015/16 290 Police Vulnerable Person (PVP) referrals with a CSE element were made to the Multi-Agency Safeguarding Hub (MASH), of which 185 were assessed as being high risk (the risk assessment is based on the perception of the officer making the referral, so is not based on a formal risk assessment). In the reporting year 174 crimes with a CSE element were recorded in Blackpool and 24 investigations were completed with either a charge or caution. (Both these data indicators are naturally subject to a degree of time lag in that crimes may only be reported some time after they were committed and investigations will take a number of months to complete).

What have we done about CSE?

BSCB has agreed an ongoing operational action plan to tackle CSE and is able to report progress against each of the seven areas:

Leadership is provided by the BSCB strategic board which reviewed progress in respect of CSE in four of its six meetings during the reporting period. The delivery of the action plan is managed by the BSCB CSE subgroup, which provides progress reports to every Business Management Group meeting. A co-ordinated pan-Lancashire approach is maintained through the pan-Lancashire Strategic CSE group. To ensure that this promotes a genuine multi-agency approach to CSE, it has been agreed that this group will be chaired by the three pan-Lancashire LSCB Independent Chairs on a rotating basis. Political leadership is provided by elected members, all of whom have received CSE briefings.

Action is taken to **Prevent** CSE through building public confidence and awareness. During the reporting period a pan-Lancashire CSE awareness week included a public media campaign using Lancashire Constabulary's successful "The more you see, the more you know" branding. Ofsted commented in their 2014 inspection of Blackpool that awareness raising with taxi drivers and the licensed trade was not as developed as would be expected. In response Blackpool Council has made it a mandatory requirement for newly registered taxi drivers to receive safeguarding (including CSE) training and BSCB has trained directors from all the taxi companies, together with approximately 700 taxi drivers by the end of the reporting period (representing over half the total). Promotional material for hoteliers and other leisure industry providers were in development at the year end, ahead of a projected day of briefings. Secondary school children in all Blackpool schools received PHSE lessons in Year 9 that include a CSE awareness element, while the Chelsea's Choice theatre production was delivered in five of Blackpool's eight secondary schools and two special schools.

Work to **Protect** children at risk of CSE is led by the Awaken team, which has now been in place for over ten years. This provides for a multi-agency response to the child's needs and will provide for one key-worker drawn from the agency most able to effectively work with the child. During the reporting period a new pan-Lancashire protocol was agreed, which will ensure that children receive a more consistent response, while a CSE risk assessment tool has been successfully piloted by children's services and will now be rolled out on a multi-agency basis. This will enable more consistent and accurate assessment of children at risk of CSE. A spotting the signs tool was also piloted in A&E and is now routinely used to ensure that children presenting in specific circumstances are asked questions to identify if they have been the victim of CSE.

BSCB seeks to ensure that the experiences of children inform the development of services. Practitioners in Awaken are now routinely seeking the views of children at the conclusion of a criminal investigation and when their case is closed to Awaken. The need to provide effective intervention for child victims of CSE was emphasised by a Children's Services study into ten children who had displayed harmful sexual behaviour (including indications of becoming a perpetrator of CSE). This identified that all had previously been victims of a form of sexual abuse. A successful bid for funding was subsequently made to the Office of the Police and Crime Commissioner for a pilot that will aim to more effectively identify young people who have been victims of sexual abuse and thereafter provide therapeutic support to address their experiences as a victim and any emerging patterns of sexually aggressive or harmful behaviour.

A multi-agency approach to share information and co-ordinate intervention underpins work to **Pursue** offenders. This is co-ordinated through fortnightly Multi-Agency Child Sexual Exploitation (MACSE) that discuss children considered to be at risk of CSE and thereby identify and collate information about perpetrators, how they operate and 'hotspots' for CSE. The meetings draw intelligence from a range of sources, including the views of the children who are open to Awaken. Lancashire Constabulary has adopted a pro-active approach to tackling potential perpetrators and will seek to disrupt their activity through a range of means including Section 2 abduction notices which may be sought against perpetrators to prevent further contact with the child. A range of approaches may be adopted when a 'hotspot' for CSE activity is identified, action may be taken in respect of its licence, covert monitoring can be used or the premises visited to provide the proprietor or resident with advice. BSCB and the Awaken team have additionally provided awareness raising sessions for a number of private organisations that were considered particularly relevant.

The complex nature of CSE demands an effective **Partnership** response, which is well embedded in Blackpool. The co-located Awaken team includes staff from Health, Police, Children's Social Care and Education, while MACSE meetings are typically attended by around 20 representatives of the wider partnership.

BSCB uses **Intelligence and Performance monitoring** to ensure that its response to CSE is effective. Throughout the reporting period it has received reports on Awaken activity, a local CSE self-assessment of the views of the wider partnership on CSE provision, a pan-Lancashire Partnership Intelligence Assessment and routinely captures CSE data within its wider dataset. It is however, acknowledged that a more systematic and multi-agency suite of data indicators is necessary. To this end an expanded dataset has been agreed and will start to be populated during the forthcoming year.

The provision of **Learning and Development** activity for professionals has formed a priority for BSCB during 2015/16. During this period 283 practitioners attended briefings and 96 half or full-day training courses. In the course of one day, three productions of Chelsea's Choice were delivered, together with a CSE briefing, which were attended by 237 practitioners and 44 further education students. A CSE e-learning package has also been developed and has been completed by 1,407 practitioners. During the reporting year BSCB has sought information from all its partner agencies as to the numbers of staff that have completed CSE training and have challenged those who are unable to provide this information. The majority of agencies have now made CSE training mandatory for all staff. While causation is difficult to prove, it may well be that the increase in Police PVP CSE referrals that was evident during the second half of 2015/16 is attributable to CSE awareness week and the ongoing single and multi-agency training programme.

What we will do next

- In conjunction with pan-Lancashire colleagues incorporate missing from home and trafficking into our action plans to ensure a co-ordinated approach to safeguarding children at risk from each issue
- Ensure that agencies assist us to develop a multi-agency CSE dataset
- Use intelligence to inform our decisions about which organisations and groups we target for awareness raising activity
- Ensure that refugees who settle in Blackpool are safeguarded from CSE
- Ensure that public awareness raising activity is available and relevant to minority groups
- Develop a CSE awareness programme for use with older primary and all secondary schools pupils and further education students
- Develop a professional directory of services available to CSE victims to ensure children are able to access appropriate interventions
- Continue to develop our training programme to address emerging needs and to ensure that the whole partnership is trained
- Continue to review the effectiveness of the multi-agency response to CSE through thematic audits

Children who are missing from home or care

Children who are missing from home (MFH) are vulnerable at that time, quite simply because those who are 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 becoming a victim of crime and involvement in substance use. The correlation between CSE and children missing from home has already been noted above. As corporate parents the Local Authority are particularly concerned to address the over-representation of the already vulnerable group of children in its care amongst those who go missing (although this over-representation may, to some extent, reflect a greater willingness of care homes, over parents, to report children as missing).

During the reporting period BSCB acknowledged that governance arrangements for MFH were insufficiently robust, as a result of which the issue will be incorporated within the revised CSE governance model, noted above. This will ensure that the Board has strategic and operational oversight of the partnership's response to MFH and is able to hold it to account. In the interim period BSCB has received a number of ad hoc reports in responses to MFH.

The multi-agency response to MFH in Blackpool is provided in accordance with a pan-Lancashire protocol that was agreed in 2014. The priority in responding to any child who goes missing is ensuring their immediate safety. Once they have returned home they should receive an immediate Police safe and well check, followed by a return home interview within 72 hours. It is the responsibility of the local authority to ensure that the return home interview is provided, in which it will seek to try to understand why the child went missing and what can be done to reduce the risk of them individually and children more general going missing again. A standard question about CSE is included within the return home interview pro-forma. For children who are known to the local authority, return home interviews are undertaken by the professional who is most likely to effectively engage the child in the process, while those not known are seen by the missing from home co-ordinator. It would be expected that a looked after child who was considered at risk of going missing would have a specific element in their care plan to address this, which was approved by their Independent Reviewing Officer.

The 2014/15 BSCB annual report concluded that the response to children who go missing from home was under-developed in Blackpool. A more coherent multi-agency response is now in place, although its longer term effectiveness has yet to be tested. The Police and Local Authority both now have missing from home co-ordinators in place who are responsible for co-ordinating their agency's operational responses to children who are reported as missing. The local authority co-ordinator is responsible for logging and collating information obtained from return home interviews. Monthly missing from home panel meetings are attended by Local Authority and Police Early Action, Awaken, Health, Education and YOT representatives, together with the missing from home and anti-social behaviour co-ordinators. These meetings review and develop action plans for high risk children, including both Blackpool and out of area Looked After Children. Links have been developed with missing from education processes, including those electing to be home educated.

Missing from home data is included within the BSCB dataset and during 2015/16 there were an average of 89.5 non-Looked After Children reported missing one or more times each quarter and 12.75 three or more times. Amongst the Looked After Child population the figures were 32.75 and 13.0, respectively. Finally, an average of 6.5 children are reported missing on nine or more occasions each quarter from the overall child population. Unfortunately a national change in Police recording practices to include a category of 'absent' has removed the possibility of longer term comparisons, although figures have remained broadly stable in the six quarters since this change. 7.7% of Looked After Children are considered to be at risk of going missing from care and it is reported that in 92% of these cases the Independent Reviewing Officer is satisfied with the plan to address this issue. Of greatest concern in terms of action to tackle missing is the data in respect of return home interview completion within 72 hours, which stands at 26.8%. We are advised that there are reporting issues that produce an artificially low rate, however this rate of completion is clearly far from satisfactory. More positively, we are advised that a review of return home interviews indicates an improvement in the quality of practice during recent months.

What we will do next

- Continue to receive regular reports in respect of return home interview completion and hold the Local Authority to account for improving this rate
- Consider trends evident in return home interview responses to develop our understanding of why children go missing and how instances can be reduced
- Review the return home interview form to ensure compliance with recognised best practice
- Pilot the submission of all MFH reports to the MASH to enable the sharing of information and the development of a better understanding of the child's overall circumstances

6.2 Early Help

The provision of early help to children and families is a key means by which longer term harm to children can be forestalled and the demand for higher tier services can be reduced. The need for effective early help provision within Blackpool is emphasised by the high numbers of children who require protection, while a lack of partnership understanding of their responsibility for early help provision was identified by Ofsted in their 2014 inspection of Blackpool. Early help was consequently identified as a priority area within the 2015-17 business plan.

In order to better understand the current position, Blackpool Council commissioned an independent review of overall early help provision and the influence that this has on referrals received by Children's Services. This was reported to BSCB in the summer of 2015 and drew the following conclusions:

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

The review recommended that a clearer partnership ownership for the provision of early help was developed, as a result of which the existing Getting It Right (GIR) and MASH steering groups were merged into the Early Help steering group and brought into the BSCB governance structure.

In view of the absence of any data in respect of the completion of continuous assessment tools and the provision of Level 2 and 3 support, the Early Help steering group has attempted to map the early help that partner agencies provide. While reporting in this respect tended to be descriptive, there was evidence of a range of early help provision by schools, health providers and the voluntary sector. This was supported by the findings of the MAAG Early Help audit noted in Chapter 5 above, which likewise noted that the continuous assessment tool was not routinely being used to assess and plan interventions at Levels 2 and 3, but as a referral form for Level 4 services. A consistent theme of this service mapping and findings from serious case reviews has also been that early help provision is not co-ordinated by one practitioner taking the lead professional role.

Both the 2014 Ofsted inspection and the Front Door Review noted that thresholds were not consistently understood across the partnership, although the Front Door Review did note that they were consistently applied by the Duty and Assessment team in 95% of cases that were reviewed. A MAAG thresholds audit of 60 referrals to the front door undertaken in July 2015 provided more positive findings in this respect though, in that it found that 82% of referrals were appropriate. (Interestingly the Multi-Agency Audit Group's own perception of thresholds was higher than those applied by the Duty and Assessment Team, which does suggest that there is a perception of there being higher thresholds than is actually the case.) Limitations in the threshold document, in terms of the amount of information provided in respect of neglect and parental substance misuse, were also identified by a multi-professional discussion forum and serious case review respectively.

The Early Help steering group is additionally responsible for the development of the Multi-Agency Safeguarding Hub (MASH). This was established in April 2013 by Lancashire Constabulary, the three pan-Lancashire local authorities, health and other agencies to handle Police vulnerable child referrals. Throughout the reporting period the MASH has continued to only handle Police referrals (although in practice some referrals may be made by other agencies and placed on the system by the Police). Information about the referrals is then shared with partner agencies to build a multi-agency chronology that ensures that the child or involved adults are referred on to the most appropriate service to meet their needs. As of March 2016 the following agencies are either physically co-located within the MASH, or are included within information sharing processes: Police, Health, Pupil Welfare, Children's Social Care, Early Help, Children's Centres, schools, YOT, Fire and Rescue, Probation, Adult Social Care and substance misuse services. It had been hoped to develop MASH to allow all agencies to make referrals, at which point it would effectively become the one front door to children's services. However, the volume of work that it currently handles is such that it does not have the capacity to make this change. BSCB, in conjunction with its pan-Lancashire counterparts, has therefore challenged Lancashire Constabulary to fully review the working of the MASH to ensure that it becomes a genuine multi-agency referral and triage process.

What we will do next

- Produce a comprehensive Early Help strategy, building on successful practice in other areas, to ensure the consistent and quantifiable provision of early help by all agencies who work with children and families in Blackpool
- Provide a means by which agencies are able to evidence the assessment of the needs of children and families at Levels 2 and 3
- Ensure that data is available in respect of the number of children receiving services at Level 2 and 3
- Revise the thresholds document to ensure that it is more fully understood and that emerging safeguarding issues are included
- Re-launch the Early Help strategy and thresholds document, as the successor to GIR, making clear that it is owned by the BSCB partnership
- Provide training for practitioners in respect of the above changes, replacing the GIR training that was previously provided by the Local Authority
- Facilitate the development of the MASH to ensure that it effectively delivers its current remit, with the aspiration that it will subsequently become the one front door to children's services

6.3 Neglect

Neglect has been a long standing priority of BSCB identified in audits, reviews and a higher than expected number of child protection plans being made in this respect (although this has declined during the reporting period).

This area of the BSCB business plan is delegated to the Neglect subgroup, the primary objective of which is to implement a shared neglect assessment tool across the partnership. Late in the last reporting year a bespoke suite of assessment tools was identified, in conjunction with the NSPCC. This provides a number of tools that can be used across the thresholds of need, ranging from a basic neglect screening tool to the in-depth Graded Care Profile 2 tool, together with a number of tools designed to assess specific areas of need e.g. parental anxiety and alcohol use. Work has subsequently been undertaken to map these tools against the Blackpool threshold documents and services that individual agencies provide. The BSCB Strategic Board agreed to pilot the use of the tools in Blackpool in November 2015. Unfortunately, the subsequent start of the pilot was delayed by a change in subgroup chair, however a first cohort of practitioners were trained in the use of the tools in the final weeks of the reporting year and have begun to pilot their use. Initial feedback suggests that the tool does provide an effective means of scaling and evidencing neglect and has resulted in one practitioner not making a referral to Children's Social Care that they would otherwise have made.

In order to better understand the needs of frontline practitioners to assess and respond to neglect, BSCB also held a Multi-Professional Discussion Forum in November 2015. Attendees highlighted the difficulties that they encountered in identifying neglect, the complex needs of families and long standing nature of neglect and the difficulties they encountered securing long term changes. They suggested that more comprehensive guidance within the thresholds document would assist and support the proposed introduction of a neglect evaluation tool.

BSCB has additionally commissioned an external trainer to deliver more general training in neglect, which will now be delivered on a quarterly basis. Since its introduction in January 2016 53 practitioners have attended this course.

What we will do next

- Produce a comprehensive neglect strategy to set out how we will enable the partnership to better identify and respond to neglect
- Prioritise the implementation of practitioner training in the suite of neglect assessment tools
- Evaluate the impact of the tool through qualitative reviews with practitioners, multi-agency audits and through the review of data
- Use the practitioner feedback from the Multi-Professional Discussion Forum to inform the review of the thresholds document
- Shortly before the year end a serious case review was commissioned in respect of a child who was subject to a child protection plan due to neglect. The findings of this review will further inform our work to address neglect

6.4 Toxic Trio

The toxic trio of parental domestic abuse, substance/alcohol misuse and poor mental health was identified as a priority safeguarding theme for BSCB during 2015-17 on the basis of the findings of a number of serious cases reviews and multi-agency audits that were conducted during the foregoing year. The need for this objective has subsequently been supported by the publication of the Child BT and Child BV serious case review reports during the reporting period, which involved parental substance misuse and alcohol use, respectively.

What we know about the toxic trio

Securing reliable data in respect of children who live in households in which one or more of the toxic trio is present is difficult due to variable definitions of each issue, however the Blackpool Joint Strategic Needs Assessment (JSNA) estimates that 4,500 – 5,500 children live in a household where an adult experiences mental ill-health and that 1,500 – 2,500 children experience parental opiate use. Public Health data likewise indicates that approximately 1,200 children live with an adult who is in receipt of alcohol or substance misuse intervention. The JSNA additionally notes that Blackpool has the highest rate of crimes committed with a qualifying factor of domestic violence in Lancashire, while the rate of cases discussed at Multi-agency risk assessment conferences (MARAC) is three times that recorded nationally. In the year to March 2015 the Police submitted 2,530 Protecting Vulnerable People domestic abuse referrals involving children, of which 320 were assessed as being high risk.

What have we done?

- During the reporting period BSCB has received presentations on domestic abuse, alcohol and substance service commissioning and has used these to hold commissioners to account to ensure that children are adequately safeguarded in services that are inevitably facing budget reductions
- The PMEG subgroup has undertaken deep dive audits into adult and children's substance misuse services. As a result of these the provider of adult services has revised its safeguarding practices and their Public Health commissioner has introduced a process of auditing their providers' compliance with Section 11 of the Children Act 2004
- Responding to the need for a DA perpetrator programme that was identified in a BSCB multi-agency audit in early 2015, the Police and Crime Commissioner has funded a pilot of the Inner Strength programme that has been successfully delivered to two cohorts of participants with ten individual completions. The programme is based on academic research and works with male perpetrators who remain in a relationship with their victim. Further programmes will be delivered during the forthcoming year and an evaluation will be undertaken to determine whether it is effective and should be continued
- BSCB training programmes are available in respect of each individual element of the Toxic Trio, together with a combined 'Hidden Harm' course
- A toxic trio combined development morning was held with Blackpool Safeguarding Adults Board in February 2016. Given the overlap between the two Boards' work in this respect, it was agreed that the Boards would work together to address the issue, although the need to involve the Health and Wellbeing Board and Community Safety Partnership was highlighted due to their responsibility for the broader management of each area of the toxic trio

What we will do next?

- The BSCB chair will meet with colleagues from the Community Safety Partnership and Health and Wellbeing Board to ensure that mechanisms are in place to jointly address each element of the toxic trio and that they are held to account to ensure that children are safeguarded
- Develop a joint business plan to address the toxic trio, in conjunction with our BSAB colleagues

6.5 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 7 private fostering arrangements that were in place in April 2015, 9 commenced and 10 ended during the year, leaving a total of 6 in place at the end of March 2016. This figure has remained broadly stable during the last five years, reflecting the national picture.

BSCB delivered a public and professional awareness raising campaign in September 2015 to promote reporting of private fostering arrangements. This did not result in an increase in reporting of private fostering arrangements suggest that the campaign itself was ineffective or that private fostering arrangements are generally reported as required.

Disappointingly, the specific Private Fostering Briefing that forms part of the BSCB suite of training was cancelled on each occasion that it was offered during the reporting year due to low numbers of applicants, which would suggest that professional awareness of the issue has yet to be fully addressed. This material has consequently been included within the broader Working Together training programme to maximise its audience.

6.6 Radicalisation

Radicalisation is the process by which people come to support extremism and terrorism and, in some cases, to participate in terrorism. In this context extremism is defined as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs" (HM Government Prevent Strategy 2011) and may include, but is not restricted to, Islamist, far right, animal rights and support for Irish terrorist groups. In March 2015 the government published the updated Prevent Duty Guidance that places duties on many BSCB partner agencies to address radicalisation. Indications of radicalisation in children should prompt a safeguarding response, in addition to which they may be referred to the pan-Lancashire Channel Panel that will co-ordinate the multi-agency response to emerging extremist views.

Overall responsibility for counter-terrorism in Blackpool sits with the Community Safety Partnership, however BSCB retains responsibility for ensuring that children are safeguarded from radicalisation and receives regular updates in this respect. Following challenge from BSCB the local authority has now established a multi-agency Prevent delivery group to oversee the partnership's response.

In order to support our schools to meet their responsibilities to prevent children from being drawn into extremism, BSCB offered to deliver Prevent awareness training within each Blackpool school. 34 schools accepted this offer and training has been delivered to approximately 1,500 staff. The more in-depth Workshop to Raise Awareness of Prevent (WRAP) training now forms part of the BSCB training programme and 48 practitioners (predominantly from schools) have attended the three courses delivered to date.

Online resources for schools to tackle extremism are provided through the Prevent4schools website which is overseen by the pan-Lancashire LSCB e-safeguarding subgroup.

7. THE CHILDREN'S WORKFORCE

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

7.1 Listening to practitioners

BSCB established a Shadow Board of frontline practitioners drawn from partner agencies in March 2015, which is chaired by the Blackpool Council Head of Safeguarding. It meets a few days prior to a Strategic Board meeting and will consider broadly the same agenda. The purpose of the group is twofold: firstly, it can provide a practitioner perspective that is fed into discussion at Strategic Board and secondly, it is able to offer a means by which information can be disseminated amongst practitioners. Shadow Board members are asked to agree with their respective Strategic Board member a means of disseminating information from the shadow board within their own organisation.

During the last year the Shadow Board members have contributed to the Board's understanding of gaps in Domestic Abuse provision and have informed decision making about the review of the children's services front door. They have received presentations on Head Start, Prevent, Female Genital Mutilation and all the reviews and audits completed by BSCB, which they have disseminated within their agencies.

BSCB has also committed to the use of Multi-Professional Discussion Forums to inform its understanding of specific issues or areas of practice and the impact that they have on frontline practitioners. During the reporting period two have been held, which have discussed child sexual exploitation and neglect. The importance of consultations of this nature is often seen in unexpected information that is obtained. For example, the discussion on neglect highlighted that significant numbers of attendees were not aware of the thresholds document and the need for better information about physical abuse within it.

7.2 Working with schools

Schools play a critical role in overall activity to keep children safe. By having contact with children and their families over a sustained period schools develop the knowledge and ability to identify when a child is at risk of harm. From a position in 2014 in which BSCB did not have schools representation on its Strategic Board, we have worked to better engage with schools at all levels of our activity.

At the end of the reporting period we have one secondary, two primary and one special school representatives on our Strategic Board, who are joined by the Schools' Safeguarding Advisor, who has been employed with funding provided by all Blackpool schools to improve their safeguarding practice. Schools are furthermore represented on all our subgroups and we have instigated a programme of half-termly Schools' Twilight meetings that are routinely attended by around thirty headteachers, designated safeguarding leads and governors. During these meetings presentations have been provided about key safeguarding topics, for example CSE, e-safeguarding and radicalisation and schools have been consulted as to how we can best support them.

Our Independent Chair has begun a programme of visiting all Blackpool schools to meet the Headteacher and raise the profile of BSCB, to date he has visited around half of all schools in the area. Overall school performance is being driven by the Blackpool Challenge Board, of which the BSCB Independent Chair and Schools' Safeguarding Advisor are members. The Schools' Safeguarding Advisor also chairs network meetings of school child protection leads, which ensures a connection between strategic and operational approaches.

The Schools' Safeguarding Advisor has visited all Blackpool maintained and academy schools to audit their safeguarding practices and to provide advice as to how these can be improved. He has additionally provided more substantive support to two secondary schools which received inadequate Ofsted inspections. This work enables a significant additional layer of scrutiny to be provided to our Section 175 audit programme, in which schools are asked to self-evaluate their safeguarding practices. In 2015 36 out of 42 schools submitted returns, which was below the expected rate of return, it is expected that this rate of return will be improved with the support of the Schools' Safeguarding Advisor.

In an increasingly fragmented educational environment, BSCB is keen to promote consistent and effective safeguarding practice in schools. Our Schools' Safeguarding Advisor is therefore developing a series of safeguarding policies and procedures that we will make available for all schools to adopt. To date policies have been developed on children who go missing from the school premises, the transfer of child protection records between schools, the letting of schools buildings, core group attendance, media reporting and the use of taxis to transport children to and from school. Policies and procedures have been developed to address issues raised by schools, to tackle BSCB priority areas and to respond to learning from reviews and audits.

What we will do next

- Provide a comprehensive programme of training specifically to meet the needs of schools
- Review and promote good practice in respect of exclusions
- Develop a resource section for schools on the BSCB website
- Triangulate Section 175 audit returns with the Schools' Safeguarding Advisors' audits to thoroughly evaluate safeguarding practice in our schools

7.3 Training and Development

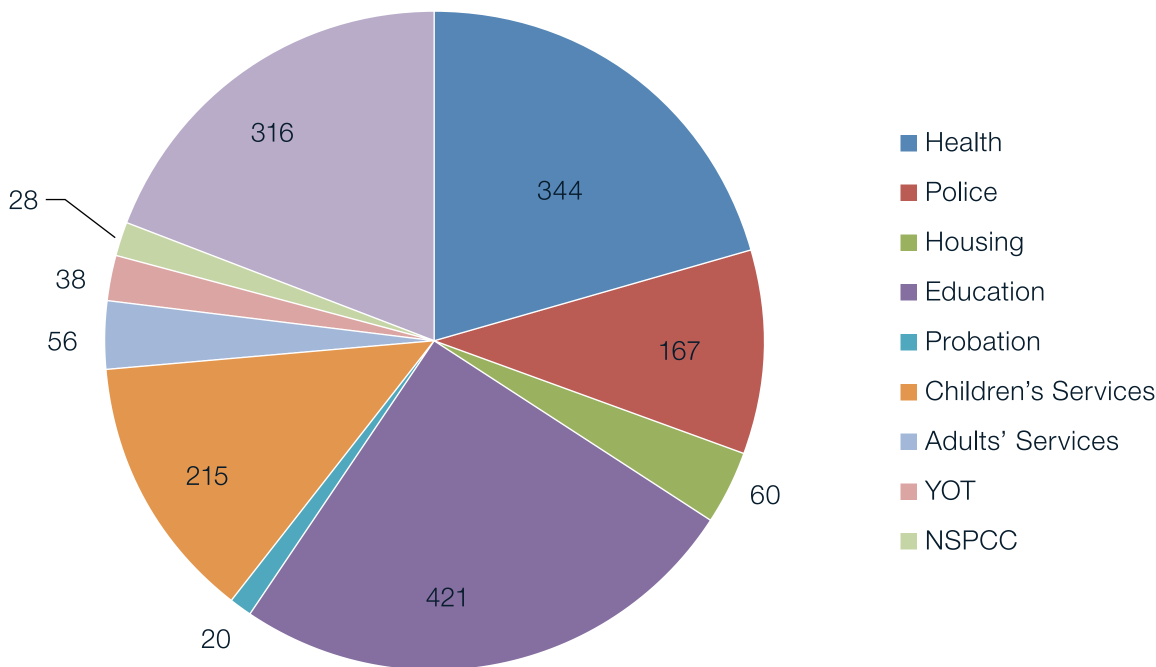
Working Together (2015) requires LSCB to monitor and evaluate the effectiveness of training. Like most other Boards, BSCB also chooses to deliver its own programme of training as a means of promoting good quality, multi-agency training. BSCB joined its training function with that of BSAB in August 2015 and is now able to offer courses that cover the full safeguarding spectrum to the adults' and children's workforce, while maintaining specific child focussed courses.

The Board's training delivery is overseen by the Training and Development subgroup, the purpose of which is to promote learning and development and to be responsible for the planning, delivery and evaluations of multi-agency training and the verification of single agency training.

What have we achieved in 2015/16?

- The BSCB training programme has been significantly revised and developed to focus on the Board's four safeguarding priorities of CSE, Early Help, Neglect and the Toxic Trio. National priorities have been responded to through the development of Female Genital Mutilation and Workshop to Raise Awareness of Prevent (WRAP) training. Core safeguarding training in Working Together, Fabricated and Induced Illness and Injuries to Non-Mobile Infants continue to be delivered
- Training courses are continually revised to include local and national learning from reviews
- All courses have been reviewed to include safeguarding adults' content and to ensure their relevance for staff in adult facing agencies
- Courses are delivered by a pool of multi-agency trainers that represent the majority of the BSCB partnership
- Training subgroup members have attended a significant number of courses to evaluate and provide feedback to trainers
- On the day evaluations, completed by participants, evidence that the courses are broadly well received and are used to inform future delivery
- CDOP and CSE e-learning package are now available
- In response to requests from our schools a training package for designated safeguarding leads is in development for the new academic year
- A comprehensive programme of CSE training was provided throughout CSE awareness week for different groups of agencies and covering topics linked to daily themes

In 2015-16 we delivered training to 1,665 practitioners



What we will do next

- We have not been able to implement the planned impact evaluation strategy, due to a lack of administrative capacity. This has now been revised and subgroup members will contact participants from their own agency for feedback a number of weeks after attendance to assess the impact of training on practice
- We will work to better understand the training needs of the multi-agency workforce
- We will work to ensure that consistent safeguarding (including CSE) training is delivered internally by partner agencies
- We will work to better understand the types and lengths of training courses that are needed to secure more full attendance – there have been too many courses that have not been full to capacity
- We will work to more fully analyse our course attendance to identify any agencies that are not accessing specific training

7.4 Policies and Procedures

Clear and comprehensive policies are the foundation of multi-agency work to safeguard children. BSCB, in conjunction with its pan-Lancashire colleagues, provides a comprehensive suite of safeguarding policies and procedures that are available to all practitioners online. The website host provides data to evidence the frequency with which the site is used and all audits and reviews consider whether practice has been in accordance with agreed multi-agency policy.

BSCB seeks to ensure that policies and guidance are available to professionals facing any safeguarding eventuality. During the reporting period policies have been updated to reflect new national guidance (radicalisation and female genital mutilation), changes in local practices (fabricated and induced illness and persons who pose a risk) and learning from serious case reviews (procedures for the recording of surnames and safeguarding in early years settings).

7.5 Management of allegations

The Local Authority Designated Officer (LADO) works with local employers and voluntary organisations to decide whether an allegation about an adult working with children is substantiated or not. By operating independently, the LADO is expected to provide a fair and timely resolution to concerns that are raised and ensure that unsuitable people are removed from the children's workforce.

During the reporting period the LADO received 106 referrals (2015: 91), 53% of which came from Children's Social Care. The remainder were submitted by education providers (28%), health agencies (3%), the Police (10%) and the voluntary sector (6%). Referrals were primarily concerned with people working in education (32%), foster carers (27%) and employees in residential settings for children and young people (13%). 31% of investigations completed within the reporting period were substantiated.

Aside from investigating allegations the LADO also works with organisations to improve their recruitment practices and to ensure that they respond appropriately when allegations are made. It is positive to report that referrals are now being received from the voluntary sector after over a year with none, which may, in part, be attributable to awareness raising work that the LADO has undertaken.

An emerging area of work for the LADO is developing her role in relation to providers of transport. Drivers of school transport services are currently included with the LADO's remit due to being contracted by education providers, however other taxi and bus drivers are not, despite the likelihood that they will, on occasion, be called on to transport unaccompanied children. The ability to investigate allegations made against drivers in these circumstances would add a further degree of protection, both for children and adults who may be subject to malicious allegations, and would support other awareness raising work of BSCB with these groups.

8. LEARNING AND IMPROVEMENT FRAMEWORK

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

This approach enables BSCB to investigate, better understand and respond to the safeguarding environment in Blackpool. For example, the audit programme for 2016 includes audits in respect of parental substance misuse and strategy meetings as a result of issues raised in serious case reviews. The enhanced understanding of the issue that the audit will provide will allow us to disseminate effective practise and to hold commissioners to account for the provision of services to safeguard children.

BSCB promotes good practice by safeguarding professionals through the publication of serious case reviews on our website and through the production of occasional 'Lessons Learned' newsletters that detail learning from audits and ways that individual practitioners can act on the learning. We recognise that a more structured and professional approach is required to communications and during 2016/17 will be working with the Local Authority marketing team to produce regular newsletters.

8.1 Serious Case Reviews and Multi-Agency Learning Reviews

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

BSCB, through the Case Review subgroup, has managed an unprecedented number of SCR in recent years and during the reporting period completed four reviews that were in progress at the beginning of the year and considered referrals for seven more, one of which proceeded to SCR and is currently in progress. Two further cases were agreed not to meet the threshold for serious case review but were considered to offer learning opportunities, so were made subject to lower level Multi-Agency Learning Reviews. Both remain in progress at the year end.

This year BSCB published two SCR.

Child BT

What happened?

Child BT was born into a family with a history of parental substance misuse and died at the age of two as a consequence of methadone ingestion. There had been considerable agency involvement with Child BT's family prior to and throughout their life. Prior to the incident, as far as agencies were aware, Dad was drug free and Mum was stable on a methadone prescription, although both had experienced periods of stability interspersed with those of more chaotic use throughout recent years. Dad had a lengthy criminal record, but had not come to the attention of authorities for a number of years. It would be fair to say that the lifestyle of both parents adversely impacted on their children.

What did it tell us?

The report identified three areas of effective practice, namely the specialist midwife provision that is available for substance misusing mothers, the safeguarding practices of the private nursery provider that was involved and the number of home visits undertaken by professionals involved with the family. It also carried five findings that were:

- Interagency information sharing and working to support the children of problematic drug users need to be strengthened
- Problematic drug use is prevalent within the borough which carries the risk of it becoming normalised for professionals working with families

- The threshold for intervention was not acted on, despite clear reference in the thresholds document to children in drug using families
- A whole family approach was lacking, the father was known but not included in assessments
- Specialist drug services have a critical role in safeguarding, there were indications that the mother was not complying with treatment, but no action was taken

What have we done?

As a result of the review, Public Health and their commissioned substance misuse service providers have reviewed expectations and practices for working with families, including where and how methadone is stored in the house. Measures are now in place for sharing information with all agencies through MASH. The findings of this review will influence the revision of the thresholds document that is underway to ensure that all professionals are able to respond appropriately to substance misuse in families. A Public Health marketing campaign later in the year will raise public awareness of the need for safe medicine storage. Following completion of the review a learning event was held for practitioners who had been involved in the case.

Child BV

What happened?

Child BV was a four week old baby who was found to be unresponsive in the family home. During the preceding twenty four hours both parents had been drinking heavily and were unable to account for the location in the home in which Child BV was found or their actions during the period. Child BV had only been known to universal services, although it emerged that the father was a consistent heavy drinker.

What did it tell us?

The report concluded that the death of Child BV could not have been predicted or prevented and that agencies could not have altered the outcome in this case. There were, nevertheless, five recommendations made:

- That BSCB undertake a professional and public awareness raising campaign as to the impact of alcohol use on the ability to provide safe care for children
- BSCB should continue to promote the need for agencies to complete early help assessments
- BSCB should promote the need to engage with and include fathers in assessments of families
- The referral pathway into substance misuse services should be reviewed to ensure that there are no unnecessary barriers with specific reference to the role of self-referrals
- BSCB should introduce a safer sleep assessment, for professionals to use in addition to providing safer sleep advice

What have we done?

A safer sleep assessment has been piloted and will be rolled out later this year to all agencies, while our provider of midwifery and health visiting services has held a vulnerable women's study day to promote the need to work with fathers. The findings of this review around the need for early help assessments will influence the development of the early help strategy reported in Chapter 5 above and an awareness raising campaign around alcohol use and safe care of children is planned for later this year. A learning event was held for practitioners involved with the family.

Other Serious Case Reviews

BSCB has completed two further reviews during the reporting period and taken the unusual step of deciding not to publish them. This is on the grounds of the impact of publication on involved children. This is not a decision that is taken easily and has been made after the receipt of professional advice and full discussion by the Strategic Board. BSCB is, nevertheless, keen that the learning from the reviews is acted upon and has formulated an action plan in respect of the first review that includes the provision of a standard safeguarding guidance and paperwork for all early years providers and developing the recording of strategy meetings in response to one review. The second review was approved at the year end and the action plan will be included in the 2016-17 annual report.

Other action plans

Two actions plans were reported in the 2014-15 annual report as being under development at the year end. The Baby Q SCR provided a significant number of actions for our provider of midwifery and health visiting services who have submitted a comprehensive action plan that includes revised information sharing and handover procedures between midwifery and health visiting services and for transfers out of area and measures to ensure effective handovers between paediatricians when there are safeguarding concerns. Multi-agency procedures have also been revised to ensure consistent practice in the recording of baby's surnames.

The Child BR SCR has resulted in a review of information sharing pathways between GPs and tertiary care providers and an enhanced employee support service being offered to Children's Services staff. The delivery of this action plan has also offered learning for BSCB in terms of the need to set effective and achievable objectives, given that a number have proved to be beyond the influence of the Board (primarily due to their relating to organisations outside Blackpool) and have therefore been removed with the agreement of the Business Management Group.

Serious case reviews inevitably offer learning that can assist individual practitioners to work more effectively. In order to disseminate the findings of reviews as widely as possible BSCB held six SCR briefings during the reporting period that were attended by in excess of 150 multi agency professionals. These provided an overview of all the recently completed reviews and how individual practice might be adapted as a result. The findings of reviews are likewise included throughout the BSCB training programme, for example, findings noted above in respect of fathers influence the content of our 'Working with Fathers' course.

Full copies of SCR reports are available for a year after their publication date on the BSCB website and on request thereafter.

8.2 Audit activity

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

The Multi-Agency Audit Group (MAAG) has undertaken five audits during the reporting period which have assessed core group working (twice), practitioner understanding and use of thresholds, early help provision for children that have not proceeded to an initial child protection conference and child protection plans for emotional abuse. The audit group has considered multi agency work with 341 children in the course of these audits, the findings of which have been included throughout this report.

As a result of MAAG audits action plans are developed that often require multi and single-agency system changes and occasional 'Lessons Learned' newsletters are produced for practitioners to promote changes in practice.

The Performance Management and Evaluation Group undertake deep dive audits into services provided by individual agencies in which managers are invited to attend meetings to discuss how their agency meets its safeguarding responsibilities. During the reporting period it has completed audits into substance misuse provision for children, school nursing, Child and Adolescent Mental Health Services (CAMHS) and early help provision.

The CAMHS audit was a follow up to an audit undertaken in October 2014 and provided evidence of successful challenge in the initial audit. This had resulted in improvements being made in respect of out of hours provision, safeguarding training, more flexible places of appointment and a more effective response to children who do not attend initial appointments.

8.3 Dataset

Working Together (2015) requires that the Local Authority and partner agencies provide the LSCB with data and performance information to allow it to assess the effectiveness of services to safeguard and promote the welfare of children.

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

In addition to enabling us to understand and assess the effectiveness of safeguarding activity in Blackpool, as summarised in Chapter 5 above, we are able to identify and challenge agencies about specific subjects. As a result of our analysis of the dataset we have undertaken more in-depth work to understand the position and recording of Looked After Children placed outside their home authority, challenged the local authority in respect of their recording of children with disabilities and maintained a focus on the completion of return home interviews for children who go missing from home.

BSCB progress in this respect has, however been hindered by an inability to secure all its expected data indicators, most notably in terms of the completion of early help assessments, and meaningful commentary about individual indicators in the dataset. In order to resolve this the partnership has agreed to the funding of a half time analyst post, although it will remain incumbent on partner agencies to supply data and commentary.

8.4 Child Death Overview Panel and SUDC rapid response

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

By its very nature the death of a child is very distressing for parents, siblings, carers and professionals involved with a family. 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 to prevent future deaths. Broader findings can be used to inform strategic planning and the commissioning of services. By sharing the function pan-Lancashire there is a greater ability to identify themes and trends.

Within Blackpool there were 12 child deaths during the reporting period and CDOP reviewed 13 (a CDOP review occurs after all other legal and review processes are exhausted, as a result of which the number of reviews will usually differ from the number of deaths).

Of the 13 deaths reviewed:

- 9 (69%) were deemed to have modifiable factors (circumstances that, if changed, would reduce the risk of future child deaths)
- 6 (46%) were expected (predictable 24 hours prior to death)
- 8 (62%) were aged under one year
- 6 (46%) were female

The weakness of CDOP is the small number of deaths considered (even pan-Lancashire only 127 were considered in year) are statistically insignificant. Consequently, while the review of an individual case may cast a light on risk factors or service provision, extreme caution has to be utilised in the drawing of general conclusions. Nevertheless, CDOP has now captured eight years' data since its inception. During the reporting period a review was undertaken of the 752 deaths that have been reviewed by CDOP between 2008 and 2014, of which 71 were of Blackpool residents. This identified that:

- The pan-Lancashire rate of deaths per 100,000 population in the most deprived quintile is 48.0, compared to 40.2 overall
- The three highest recorded categories of death are peri- or neo-natal events, chromosomal or congenital abnormalities and sudden unexpected deaths
- Within Blackpool 48% of deaths were neo-natal and still births/ peri-natal mortality was significantly higher than national and Lancashire averages
- The overall infant mortality trend is declining, although the rate remains above that of England overall
- The riskiest age is the first year and within that the riskiest period is the first four weeks of life

BSCB seeks to both act on and influence the work of CDOP, for example raising the issue of the need for safer sleep assessments as a result of the Child BV SCR and requesting further information from our acute hospital trust in respect of the high number of still births identified in Blackpool.

Safer Sleep campaign

CDOP has a well-established safer sleep campaign that produces safer sleep advice materials that are distributed by partner agencies throughout Lancashire. During this period the campaign was reviewed to include recent research and is now included on the NICE website as an example of effective practice. A specific marketing campaign was conducted in pharmacies to reach families who do not routinely access other services. During forthcoming months materials will be distributed to ensure that professionals providing safer sleep advice also make an assessment of sleeping arrangements.

Sudden Unexpected Deaths in Childhood (SUDC)

Working Together (2015) requires LSCB to ensure that a multi-agency rapid response process is in place to review the circumstances of any unexpected death of a child. Multi-agency colleagues work together to share information to ensure a thorough investigation, to ensure that the bereavement needs of the family are met and that lessons are learned from the death, where possible. The pan-Lancashire SUDC service is led by two nurses (outside office hours initial co-ordination is provided by Lancashire Constabulary), in conjunction with a range of multi-agency partners, including children's services, acute hospital trusts and North West Ambulance Service.

During the reporting period Lancashire LSCB was reviewed by Ofsted and our shared rapid response service was found to be effective. An external review of the service is being undertaken which will assess its compliance with Working Together and identify any issues with its delivery, while a separate review of all sudden unexplained deaths between 2012 and 2015 is also being completed. Both will be reported in the 2016-17 annual report.

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

8.5 Section 11 audit

BSCB requires all its partner agencies to complete an annual self-evaluation as to whether they are meeting their responsibilities under Section 11 of the Children Act (2004). In 2015 returns were received from all expected agencies, including for the first time North West Ambulance Service and British Transport Police. Returns are scrutinised by the Performance Management and Evaluation Group which decided to test the veracity of returns through visits to meet frontline practitioners in three agencies: North West Ambulance Service, Lancashire Care Foundation Trust and Lancashire Constabulary.

This approach provided evidence of good knowledge and understanding of safeguarding practice in each agency, together with evidence that the information provided about training and employee support programmes provided within the Section 11 return reflected the experience of frontline practitioners.

Specific examples of good practice were identified in ambulance staff making assessments of home conditions, in addition to their primary duties of emergency response, while Police staff had forged relations with schools and children's homes in their area and were therefore able to identify safeguarding issues at an early stage. Adult mental health staff were able to recognise the need to consider the needs of children within assessments of their parents/ carers and were able to access support when concerns were evident.

As a result of the visits, arrangements have now been made to invite ambulance staff to SUDC end of case decision meetings and Lancashire Constabulary have taken measures to improve the distribution of SCR learning. BSCB will also act on feedback provided around information sharing between schools and police colleagues and will work with BSAB to ensure effective transitions between children's and adults' mental health services. There was additionally a general lack of awareness of the work of BSCB, which will be addressed through the production of newsletters and marketing campaigns in the forthcoming year.

BSCB has tested Section 11 audit returns through a variety of means in recent years and the approach adopted during this reporting period of visits to the frontline was effective in confirming that information contained in audit returns reflects the experience of practitioners. However, the approach was time consuming and only covered a minority of practitioners in a minority of agencies. It is therefore likely that this will form part of a wider ongoing approach.

8.6 Inspection and review of partner agencies

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

During the reporting period we received an update report from Blackpool Teaching Hospitals that noted an overall improvement to 'good' and that staff were able to demonstrate a good knowledge of safeguarding. Their safeguarding team have subsequently been nominated for two national awards. Reports have been received and support provided to South Shore Academy and Highfield Humanities College, both of whom received inadequate Ofsted inspections. More positively, St Nicholas Church of England Primary School received Blackpool's first outstanding school inspection since 2009, while over 90% of early years providers have good or outstanding judgements which is amongst the best rates in the country.

9. THE WORK OF OUR PARTNERS

BSCB is keen to promote good practice within Blackpool and to a wider audience. The following examples demonstrate innovative and successful single and multi-agency work undertaken in Blackpool to safeguard our children.

Better Start

Better Start is a multi-agency project, led by the NSPCC, that has obtained £45 million of Big Lottery funding over a ten year period to improve the life chances of children aged 0-4 and their families. The project seeks to provide two outcomes of healthy gestation and birth and school readiness and is built on four cornerstones of improving public health outcomes, transforming systems, ensuring evidence based interventions are delivered to address specific needs and building and sharing learning from work undertaken.

The programme will be rolled out over a ten year period and to date public health campaigns to address alcohol exposure in pregnancy and oral health have been delivered, while Video Interaction Guidance and Parents Under Pressure courses are available. Video Interaction Guidance is a 10-12 week programme that provides parents with recorded footage of positive interactions that they have with their children, with a view to developing confidence in their ability to parent successfully. Evidenced outcomes are a reduction in children's emotional and behavioural difficulties. Parents Under Pressure is an intensive parenting programme for parents who misuse substances. It has been shown to have a positive impact on child abuse potential and to improve parent-child interactions. In forthcoming months the Safe Care programme will be implemented, this provides for intervention with families where there are concerns in respect of neglect, but not at a level to trigger child protection processes. By the conclusion of the Better Start funding period changes should have 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 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 is currently piloting a project to raise the emotional resilience of 10-14 year olds, with a particular focus on the transition from primary to secondary school. The project is based on an ecological approach that aims to provide a wider environment in which young people are able to flourish. Current interventions include walk and talk counselling, online counselling, art therapy and specific work on exam and prom stress. It has been announced, following the end of the reporting period, that a bid for funding to secure the longer term future has been successful, as a result of which all children in Blackpool will benefit from the project.

Socially Complex Needs Midwifery team

The Blackpool Teaching Hospitals (BTH) Socially Complex Needs (SCN) Midwifery team coordinate and provide care for vulnerable groups including non-English speaking families, substance misusing women, women who are victims of domestic abuse, women with mental health issues, young parents and those who have had previous children removed from their care. There is a negative lifelong impact of poor early bonding and attachment, the SCN team therefore have a vital role to play in improving health and social wellbeing for all women thus reducing health inequalities.

The SCN team work closely with the BTH Safeguarding team and Children's Social Care to ensure timely referrals, assessment, and that a robust birth plan is in place which encompasses the needs and identifies any risk to the unborn. The team also provide screening, education and awareness for women, their partners and families, co-ordinating care to improve family health and wellbeing. They work with the health visitor, who becomes involved with the Mother and unborn at 28 weeks' gestation, thus giving opportunity for joint working and sharing of information. Within 28 days of birth, the care is transferred to the health visitor who will oversee the longer term health and wellbeing of mother and baby. The work of the SCN team has been recognised by both the Baby Q and Child BT serious case reviews as providing an excellent standard of care to mothers with complex needs.

Family Nurse Partnership

The Family Nurse Partnership (FNP) work with first time mothers under 19, many of whom have the same vulnerabilities and complexities as those who are engaging with the SCN Midwifery team. The programme aims to enable young mums to have a healthy pregnancy, improve their child's health and development and plan their own futures and achieve their aspirations. The care is delivered over a 2 year period and is an evidence based approach.

The FNP is a preventative programme and has the potential to transform the life chances of the most disadvantaged children and families in Blackpool, helping to improve social mobility and aims to break the cycle of intergenerational disadvantage. The FNP works closely with the BTH Safeguarding Team, SCN midwifery team and children's social care to ensure timely referrals, planning of care and robust sharing of information.

Care leavers housing project

Blackpool Coastal Housing and Blackpool Council are working together to support care leavers into successful tenancies. The care leavers are provided with a support worker to work with them to establish their tenancy, ensure that services are in place and to provide longer term support and mentoring. By doing so the young person will have a home that they can take pride in, there will be a higher chance of them maintaining their tenancy and they will be provided with an additional layer of support as they transition into adulthood.

Child and adolescent self-harm enhanced response (CASHER)

CASHER is a pilot programme delivered in the accident and emergency department of Blackpool Teaching Hospitals. It has been funded by the Blackpool and Fylde and Wyre Clinical Commissioning Groups and was prompted by Blackpool having the highest rate of hospital admissions due to self-harm amongst 10-24 year olds in England. CASHER provides an out-of-hours multi-agency response to children who self-harm or display symptoms of mental-health problems. The programme aims to ensure that children are referred into appropriate services (including those to address contributory factors to their presentation such as substance misuse) at the earliest possible juncture and to consequently reduce the need for and length of admissions. Additional outcomes have included the development of wider multi-agency working practices to address issues that have become evident during the pilot.

Cumbria and Lancashire CRC

Cumbria and Lancashire CRC introduced a new initiative in Blackpool, delivered by PACT which is a national charity supporting people affected by the criminal justice system. PACT will provide one to one and group work for offenders, children and families in prisons and the community. This can include Relationship Courses to help build, develop and strengthen relationships within families; Parenting Courses to help develop positive relationships with children and Family Literacy workshops to support parents to help their children with reading, writing and language.

Case studies

YOT

Rob* moved to Blackpool in his mid-teens to try and make a break from negative peer associations and to tackle his drug use. He was subject to Youth Offending Team supervision and referred himself to substance misuse services.

Unfortunately, his relationship with the family member with whom he lived broke down to the extent that he became homeless, which necessitated the involvement of Children's Social Care. Supported housing was secured for Rob which provided practical support and enabled him to develop the life skills that ultimately made it possible for him to stop drug use altogether.

Throughout this period multi-agency work was co-ordinated in regular Multi-Agency Risk Management Meetings that ensured a unified plan to meet Rob's needs and address his offending behaviour. Regular meetings were also held with Rob at his accommodation to ensure that he was supported to achieve his goals for the future.

After a while it became evident that Rob had unmet mental health needs and, with his permission, a referral was made to mental health services. Rob has subsequently received a diagnosis and is being provided with medication and support. He has now been abstinent from street drugs for several months, is accessing a college course and looking to move to semi-independent accommodation.

*all names have been changed to protect the anonymity of those involved.

FIN/ BCH

The Davis* family, who were being supported by the multi-agency Families in Need (FIN) team became homeless and accessed emergency hostel accommodation. While they were resident there FIN worked with the hostel support staff to ensure that they were aware of the family's needs, that they continued to attend health appointments and that the children were able to safely travel to and from school, thereby reducing the disruption that the children experienced.

The agencies worked together to complete a GIR continuous assessment tool, after which, in view of the risks to the family from other parties, a referral to the Duty and Assessment team was made. FIN ensured that all involved were kept aware of the risks to the family and by sharing their expertise, FIN and the hostel staff were able to secure suitable move on accommodation. Support was finally provided to ensure that possessions were not lost on moving and that the family's immediate basic needs were met once they had moved.

Secondary School

Lucy* is a pupil at a mainstream secondary school in Blackpool but has a very poor attendance record, which is thought to stem from her own mental health problems and a difficult home environment. Professionals who accessed the home described it as being unliveable and residents were noted to have very poor standards of personal hygiene. This increased concerns that Lucy was being neglected, while it was noted that her mother seemed unable to fully communicate with or support her as a consequence of her own mental health difficulties.

The complexity of issues in the household was such that a significant number of agencies were needed to support the family to make changes and to reduce the risks to Lucy. Involvement was therefore secured from school pastoral and child protection staff, Children's Social Care, the Families in Need Team, CAMHS, school nursing, the Police, the housing provider and adult mental health service. By providing a co-ordinated response to address multiple needs the level of neglect that Lucy experienced has been reduced and both the family's home environment and personal hygiene have improved. By securing mental health provision for both Lucy and her mother they are able to communicate more effectively and Lucy's attendance at school has now improved and she has been able to remain in mainstream education.

LCFT

Sally* is an adult who is receiving support for her mental health needs from Anne*, a Registered Mental Health Nurse. Sally disclosed that when she was younger a care worker abused her as a result of which she experiences low moods, anxiety and thoughts of self-harm. This experience has made it difficult for her to trust professionals. Anne reflected on this case with the Safeguarding Team and was advised that there are some concerns that needed to be addressed urgently and information needed to be shared to ensure there was no current risk to other young people from the care worker who abused her, this would also demonstrate to Sally that agencies would believe her. With support Sally was able to provide further information about the care worker which was provided to the LADO.

It also emerged that during her 'welcome call' to services, Sally refused to disclose details of her children, or that they were already known to Children's Social Care. Anne was curious as to why she refused to provide her children's names but was able to establish the details of the four children by contacting other health and children's social care colleagues. Anne was then able to establish which other services were supporting the family and was able to ensure they were aware of her role in providing care and support to the family. All agencies were then able to share appropriate information to ensure the safety of the children. Conversations and plans also include Sally's needs and Anne was able to help guide her through the meetings and support plans. With co-ordinated interventions Sally's mental health improved, her Trust of services improved and the family were supported to stay together.

*all names have been changed to protect the anonymity of those involved.

10. ASSESSMENT OF BOARD EFFECTIVENESS AND CHALLENGES FOR THE YEAR AHEAD

BSCB was reviewed by Ofsted in July 2014 and found to require improvement. We are confident that we have made significant progress in respect of the majority of issues that were raised in this review. We are now compliant with statutory requirements in terms of membership and have made significant progress in engaging schools at strategic board, subgroup and operational levels. We have developed our range of performance information through a revised dataset, Section 11 audits and single agency deep dive audits which, together with our ongoing audit and review programme, form our Learning and Improvement Framework. The findings contained therein have been used to develop our audit programme and to pursue service improvements, for example the domestic abuse perpetrator programme.

Some areas raised by Ofsted remain ongoing pieces of work on our business plan. While the use of the thresholds document is embedded in all our training and one audit has provided some re-assurance about practitioner understanding, other serious case reviews and practitioner consultations suggest that the issue has yet to be resolved. BSCB is likewise not assured that consistent early help is provided across the partnership, partly due to a lack of quantitative evidence. These two areas will form key priorities for BSCB during the early parts of the 2016/17 business year. The provision of early help likewise remains the primary concern in terms of its assurance of the robustness of the overall safeguarding system.

More broadly, consistent progress has been made toward the delivery of the CSE action during 2015-16, however the evolution of the response to children missing from home has been slower and significant improvements are required in the rate of completion of return home interviews. The slow progress made in terms of delivering a neglect assessment tool remains a source of concern and will attract the scrutiny of BSCB throughout the forthcoming year. As the year has progressed other safeguarding issues have emerged nationally, namely radicalisation and familial child sexual abuse, which will come to form part of BSCB's ongoing programme of work. Locally, we have become increasingly aware of the high number of children who self-harm and will seek to ensure that agency responses are effective.

While the Learning and Improvement Framework now provides a means to collate learning and plan ongoing activity, work to evidence outcomes is less well embedded and should come to form a routine part of Board activity. One mean that this can be achieved – through consultation with children and young people – is in development, which should allow some progress to be made to better understand the impact of BSCB activity.

BSCB had an external review in October 2015 by the Independent Chair of Liverpool LSCB. On the day Board members commented that they felt there was more consistency in attendance, more debates and challenge in meetings and that the Board was more focussed and driven from the top. A consistent theme throughout the day was the need for greater co-ordination between strategic boards in Blackpool to reduce duplication and improve communication. This issue is being addressed by the Independent Chair through meetings with other strategic board chairs and through a wider review of governance arrangements in Blackpool. Board members also highlighted the lack of commentary provided within the dataset and this challenge to our partner agencies to provide meaningful data and commentary remains.

More broadly 2016-17 will be a period in which many of our partner agencies experience a reduction in resources, this comes at a time when we know that the numbers of children in need of protection is increasing. BSCB has written to all partner agencies to request assurance that risks to safeguarding provision will be mitigated when changes are made to services. This will remain an important focus of our work during the forthcoming year.

Finally, the Government's response to the Wood review of LSCB suggests that significant changes could be made to the strategic multi-agency responsibilities for safeguarding during the forthcoming year. During what may be a transitional period, BSCB will seek to continue to hold its partner agencies to account for the effectiveness of their safeguarding responses.

11. MESSAGES FOR STAKEHOLDERS

Children and Young People

Nothing is more important than making sure that you are safe and well cared for. As adults, sometimes we think that we know best… we don't… and that's why we want to hear from you. Please help us understand how we could make a difference to your lives. If you are ever scared or worried about your own safety, or that of a friend, please speak to someone that you trust or ring ChildLine on 0800 1111

The people of Blackpool

You are best placed to look out for children and young people and make sure that they are safe. Don't turn a blind eye. If you see something, say something. If you are worried about a child please call the Duty and Assessment team on 01253 477299. You will not have to leave your name if you do not want to.

Frontline staff and volunteers who work with children and families

Thank you for your unstinting work to keep children safe in Blackpool. Please ensure that you keep up to date with the changing safeguarding environment and use our shared policies for keeping children safe. If you do not agree with the actions of other agencies escalate your concerns, it may help keep a child safe. Make use of our free multi-agency training programme and get involved in other Board activities for practitioners.

Elected members

You are the leaders and representatives of our local communities. When you consider plans ask what effect they will have on our children and whether they will ensure that they are safe. You are corporate parents to children in the care of the Local Authority. Demand the best for them, ensure that they have the life chances you would want your own children to have.

Chief Executives and Directors

You set the tone and culture for your organisation. Inspire others to be interested in children and to keep them safe in everything that they do. Provide time for staff to attend our training and hold them to account for applying their learning. Ensure that you comply with your Section 11 duties and provide evidence to us of how you do this.

Commissioners

If you have control of a budget that is used to commission a service for children ensure that you listen to children when you make decisions. Hold your providers to account to meet their responsibilities to safeguard children.

The local media

Safeguarding children is everybody's responsibility. Help us communicate this to the local community. Every year hundreds of children in Blackpool are kept safe from harm. This is good news.

12. APPENDICES

Strategic Board members at the time of publication

Name	Title	Agency
David Sanders	Independent Chair	
Jenny Briscoe	Lay Member	
Cllr Graham Cain	Elected Member	Blackpool Council
Cllr Debbie Coleman	Elected Member	Blackpool Council
Delyth Curtis	Director of Children's Services	Blackpool Council
Dr Arif Rajpura	Director of Public Health	Blackpool Council
John Blackledge	Director of Community and Environment Services	Blackpool Council
Amanda Hatton	Deputy Director of People	Blackpool Council
Josephine Lee	Interim Head of Safeguarding and Principal Social Worker	Blackpool Council
Moya Foster	Senior Service Manager (Early Help)	Blackpool Council
Andrew Lowe	YOT Service Manager	Blackpool Council
Kate Barker	Lead Early Years Consultant	Blackpool Council
Paul Turner	Schools' Safeguarding Advisor	Blackpool Council
Helen Williams	Chief Nurse	Blackpool CCG
Cathie Turner	Designated Nurse	Blackpool CCG
Dr Sujata Singh	GP Representative	Blackpool CCG
Marie Thompson	Director of Nursing and Quality	Blackpool Teaching Hospitals NHS Foundation Trust
Hazel Gregory	Head of Safeguarding	Blackpool Teaching Hospitals NHS Foundation Trust
Dr Rob Wheatley	Designated Doctor	Blackpool Teaching Hospitals NHS Foundation Trust
Bridgett Welch	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	Superintendent	Lancashire Constabulary
Andrew Webster	Detective Superintendent	Lancashire Constabulary
John Donnellon	Chief Executive	Blackpool Coastal Housing
Vacant	Director 14-19	Blackpool and the Fylde College
Jane Bailey	Principal	South Shore Academy
Rosie Sycamore	Headteacher	Highfurlong Special School
Karen McCarter	Headteacher	Norbreck Primary Academy
Cara Vaughan	Deputy Principal	Waterloo Primary Academy
Jackie Couldridge	Service Manager	CAFCASS
Martin Murphy	Senior Service Manager	NSPCC
Sonia Turner	Assistant Deputy Director	NW National Probation Service
Louise Fisher	Assistant Chief Executive	Cumbria and Lancashire CRC

Glossary of acronyms

BMG	Business Management Group
BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
CAMHS	Child and Adolescent Mental Health Service
CASHER	Child and Adolescent Self-Harm Enhanced Response
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIB	Children's Improvement Board
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CSP	Community Safety Partnership
FIN	Families in Need (team)
FNP	Family Nurse Partnership
GIR	Getting it Right
ICPC	Initial Child Protection Conference
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Child
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAAG	Multi-Agency Audit Group
MACSE	Multi-Agency Child Sexual Exploitation (meeting)
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MFH	Missing From Home
NICE	National Institute for Clinical Excellence
PCC	Police and Crime Commissioner
PMEG	Performance Monitoring and Evaluation Group
PVP	Police Vulnerable Person (referral)
SCN	Socially Complex Needs (Midwifery team)
SCR	Serious Case Review
SUDC	Sudden Unexpected Deaths in Childhood
YJB	Youth Justice Board
YOT	Youth Offending Team

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