APPENDIX 10(a)

BLACKPOOL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2018–2019

BLACKPOOL SAFEGUARDING CHILDREN BOARD

CONTENTS

FOREWORD FROM THE INDEPENDENT CHAIR

Thank you for taking the time to read the annual report of the Blackpool Safeguarding Children Board.

In fact, the report has covered a period extending to the end of June 2019. This is because the Children and Social Work Act 2017 has seen the current safeguarding arrangements change. In future there will be a new safeguarding partnership that will see us join together with our colleagues in Blackburn with Darwen and Lancashire; albeit retaining structures to ensure we do not lose the local focus on child safeguarding. These new arrangements come into place on 29th September.

I would like to thank the previous Chair Nancy Palmer, who stepped down in January 2019, for her work over a number of years and all of those partners who have worked so hard to safeguard our children.

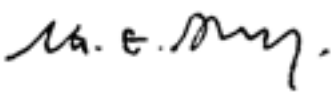
This has been a difficult year for safeguarding in Blackpool. Several of our key agencies have had adverse inspectorate reports. In particular, Children's Services in Blackpool were inspected by Ofsted at the beginning of the year and judged to be inadequate.

This is clearly a worrying position, but I am pleased to say that following intensive work and investment it has been agreed by the Department for Education that those services have already made considerable progress. Children's services will continue to get further support and will be monitored by Ofsted over the next two years. The quarterly reports by Ofsted can be viewed on their website.

It is also pleasing to be able to report that Lancashire Constabulary have also been re-inspected by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and received an outstanding result in terms of the improvement in safeguarding.

This report highlights the huge amount of good work conducted by individuals and agencies across Blackpool. The board agreed a number of priorities and again I have been impressed with the progress made.

As the new safeguarding partnership arrangements develop, the public will be kept informed of the progress agencies have made through a new website. I look forward to seeing continuous improvement in services over the coming years and would like to take this opportunity to thank all of those front-line staff who continue to work to protect and safeguard our children.



Steve Ashley
Independent Chair
Blackpool Safeguarding Children Board

WHO WE ARE AND WHAT WE DO

What is a Local Safeguarding Children Board?

Blackpool Safeguarding Children Board (BSCB) is a multi-agency body whose role is to oversee, co-ordinate, challenge and scrutinise the work of all professionals and organisations to protect children in the town from abuse and neglect, and to help all children grow up safe, happy, and with the maximum opportunity to realise their potential.

It is a statutory body, established under the Children Act 2004. Under the Act every upper-tier local authority in England is required to establish a Local Safeguarding Children Board (LSCB) with two primary purposes:

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

Subsequently published regulations and guidance expand the role of the LSCB to include developing policies and procedures, raising awareness of the need to safeguard children, participating in the planning of local services for children, reviewing child deaths and undertaking serious case reviews. LSCB do not have the power to direct other organisations, but should make it clear where improvement is needed.

What is this report?

Every LSCB is required to publish an Annual Report. The purpose of the Annual Report, as set out in Working Together to Safeguard Children (2015), is to "provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the actions being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period". The report should include information on the LSCB's assessment of the effectiveness of Board partners' response to child sexual exploitation (CSE), and appropriate data on children missing from care, and how the LSCB is addressing the issue.

Due to forthcoming changes to strategic multi-agency safeguarding arrangements, outlined below, this will be the final annual report of BSCB. It therefore covers a fifteen month period from 1st April 2018 until 30th June 2019, the point at which the handover process to successor arrangements was set in motion.

Who are we?

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

A number of our partner agencies have a statutory responsibility to sit on BSCB (for example the local authority, police, health organisations, probation and Cafcass), while others have been invited to do so due to the significance of their work in Blackpool (for example Blackpool Coastal Housing and NSPCC). BSCB was compliant with statutory requirements in respect of partner agency membership throughout the reporting period. However, it did not fulfil the statutory requirement for lay member representation, due to an earlier decision not to recruit to the posts following the resignation of the two previous lay members. This decision was taken on the basis of the forthcoming dissolution of BSCB.

BSCB is led by an Independent Chair whose external perspective, enables him to bring impartial challenge to any member agency. Nancy Palmer stepped down from the role of Independent Chair in February 2019 and was replaced by Stephen Ashley. Stephen has an operational background in policing, after which he has served as Independent Chair of the LSCB in Rotherham, Tower Hamlets and Hillingdon. He is also currently the Independent Chair of Lancashire LSCB and Blackpool Safeguarding Adults Board (BSAB). He promotes the work of BSCB through regular attendance at other strategic boards and through meetings with senior managers in partner agencies, schools and other bodies that have a duty to safeguard and promote the welfare of children.

Relationships

Stephen Ashley is accountable to Blackpool Council's chief executive, Neil Jack, for the effective functioning of BSCB. In turn, political oversight is provided by Cllr Graham Cain, who sits as a participating observer on the BSCB Strategic Board.

BSCB works in partnership with Blackpool Council's multi-agency Getting to Good Board (formerly the Children's Improvement Board), which drives the ongoing development of children's services more broadly. While this body has been in place for a number of years, it has assumed an increased importance following the Ofsted inspection of children's services, outlined in Chapter 4 below. A formal memorandum of understanding has consequently been drawn up between BSCB and the Getting to Good Board to ensure that work is delegated appropriately, while the board chairs routinely meet to co-ordinate activity.

BSCB is also part of the broader local partnership architecture that promotes the health and wellbeing of all Blackpool residents. As well as BSCB, this includes the statutory bodies of the Health and Wellbeing Board, Community Safety Partnership and Blackpool Safeguarding Adults Board. There is understandably a degree of overlap between the work (and membership) of these boards and their chairs have regular meetings to co-ordinate their work and to avoid duplication. Responsibility for the multi-agency response to domestic abuse (DA) was handed over from BSCB to the Community Safety Partnership at the start of the reporting period, however BSCB and its partner agencies continue to contribute to the DA action plan to ensure that children who live with DA are properly safeguarded.

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

How do we work?

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

Strategic Board members agreed a business plan for 2018-19 shortly before the start of the reporting period and agreed a six month addendum to the plan in March 2019 to cover the final period of the Board's operation. Progress against the business plan objectives is covered in Chapter 5 below.

The delivery of specific elements of the BSCB Business Plan and other statutory functions are delegated to subgroups, some of which are held on a joint basis with BSAB, or with Blackburn with Darwen and Lancashire LSCBs. Subgroups are chaired by Strategic Board members with the necessary expertise to tackle the area in question (with the exception of CDOP, which is independently chaired), while members are drawn from the agencies considered necessary for the subgroup to meet its objectives. Subgroup chairs (with the exception of the Child Death Overview Panel) are members of the Business Management Group (BMG), which co-ordinates their work and monitors business plan delivery. The work of the subgroups is referenced throughout this report and a structure chart is included as Appendix B.

Attendance at Board Meetings

BSCB members have agreed that the acceptable minimum attendance rate for the named representative at board and subgroup meetings is 75%. The Independent Chair and subgroup chairs challenge attendance likely to fall below the acceptable rate throughout the year. The attendance of the named representative at Strategic Board and subgroups is recorded below, although on many occasions when the named representative was unable to attend a deputy did so. For the sake of brevity, agencies that solely attend subgroups have been omitted. Attendance at all meetings has been poorer than expected during the reporting period, including two inquorate subgroup meetings. Challenge, where appropriate, has also been balanced with a recognition of the demands on partner agencies. It is expected that the successor arrangements to BSCB, outlined below, by being based on a broader geographical footprint will rationalise he overall number of meetings agencies are expected to service and enable them to properly prioritise their attendance.

Agency	Board	BMG	QAPM	Training	VMET
Blackpool Council – Elected Member	80%	n/a	n/a	n/a	n/a
Blackpool Council – Director of Children's Services	80%	n/a	n/a	n/a	n/a
Blackpool Council – Children's Services (other representatives)	100%	80%	100%	100%	100%
Blackpool Council – Targeted Intervention Service	20%	n/a	n/a	n/a	n/a
Blackpool Council – Schools Improvement	80%	20%	60%	40%	60%
Blackpool Council – Public Health	60%	n/a	40%	n/a	80%
Blackpool Council – Leisure, Catering and Illuminations	60%	n/a	n/a	n/a	n/a
Lancashire Constabulary – Western Division	20%	20%	n/a	n/a	100%
Lancashire Constabulary – HQ Public Protection Unit	80%	n/a	40%	80%	20%
Blackpool CCG – Chief Nurse/ Head of Safeguarding	20%	n/a	n/a	n/a	n/a
Blackpool CCG – (Deputy) Designated Nurse	60%	80%	80%	60%	50%
Blackpool CCG – Designated Doctor	20%	n/a	n/a	n/a	n/a
Blackpool Teaching Hospitals NHS Foundation Trust	40%	40%	60%	80%	60%
Lancashire Care NHS Foundation Trust	80%	n/a	0%	100%	n/a
NHS England	40%	n/a	n/a	n/a	n/a
Cumbria and Lancashire Community Rehabilitation Company	60%	n/a	n/a	40%	60%
HM Prison and Probation Service	80%	60%	n/a	60%	80%
Blackpool Coastal Housing	80%	100%	100%	80%	n/a
Schools	65%	n/a	n/a	n/a	80%
NSPCC	40%	n/a	n/a	n/a	n/a
Cafcass	60%	n/a	n/a	n/a	n/a
Blackpool Carers Centre (third sector representative)	80%	n/a	n/a	n/a	n/a

Budget

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

Income and Expenditure Summary (for the period from 1st April 2018 to 31st March 2019)

Income		Expenditure	
Blackpool Council	106,267	Staff costs	151,844
Blackpool CCG	51,867	Independent Chair	14,504
Lancashire Constabulary	31,595	Training	7,238
Blackpool Coastal Housing	5,000	Board support costs	14,699
Cumbria and Lancashire CRC	2,565	Serious Case Reviews	12,888
HM Prison and Probation Service	1,710		
CAFCASS	550		
Training income	1,350		
	200,904		**201,173**

Board staffing costs remain the greatest area of expenditure and have remained stable throughout the reporting period. The greatest area of variability within the Board's budget remains serious case reviews, with the three commissioned in early 2019 likely to exceed the budgeted amount for 2019/20. As in previous years, this will be met from reserves.

The LSCB team

The work of BSCB is supported by a small business unit, which is merged with that of BSAB to provide additional resilience. The staffing structure has remained the same throughout the reporting period, although there have been changes of personnel. The BSCB element of the team consists of:

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

The future

The Children and Social Work Act 2017 replaces LSCBs with Safeguarding Partnerships that are the shared responsibility of the local authority, clinical commissioning group and chief officer of police for the area. The revised version of Working Together to Safeguard Children, published in July 2018, provided the safeguarding partners with the framework and timeframe to implement these arrangements. The three safeguarding partners in Blackpool expressed an early desire to explore the potential for shared arrangements that covered the geographical footprint of Lancashire Constabulary, bringing together the three local authorities of Blackpool, Blackburn with Darwen and Lancashire, together with eight clinical commissioning groups.

The resulting Safeguarding Children Partnership arrangements were published on the 28th June 2019 and represent an ambitious step to achieve consistency of practice and scrutiny across the broader geographical footprint over which many of our partner agencies operate. Stephen Ashley has been appointed as Independent Scrutineer to the new arrangements, which is a new and distinct role to that of LSCB Independent Chair. The new arrangements, which will be known as the Children's Safeguarding Assurance Partnership (CSAP), will formally come into place on 29th September 2019, although it is envisaged that it will take until 31st March 2020 to have structures fully established. LSCBs additionally have until 29th September 2020 to conclude existing serious case reviews. The CSAP will publish an annual report in 2020 outlining the progress that they have made under these arrangements.

BLACKPOOL: THE PLACE AND ITS PEOPLE

Blackpool is a seaside town in the north-west of England. Its (mid-2017) population of 139,870 people, living within an area of just under 13.5 square miles, renders it one of the most densely populated areas outside London. Transience is a significant feature of the town, with 6.2% of the population estimated to have moved out of the area in 2017 and the equivalent of 6.1% having moved in. According to the 2011 census, 8% of the population had also moved within the town during the past year.

Blackpool experiences considerable levels of deprivation, which have increased relatively over recent years. The English Indices of Multiple Deprivation (2015) record that 38.3% of smaller areas within Blackpool are within the most deprived 10% nationwide, while 20.2% are within the most deprived 1%. In contrast, no part of the town is in the most affluent 20%. The impact of this is that 22% of children live in workless households and 32% in poverty (in a household with an income of less than 60% of the median), compared to 20.1% nationally. The one area within the Indices of Multiple Deprivation in which Blackpool ranks amongst the most favourable in England is Barriers to Housing and Services, and some of this breadth of service provision is reflected throughout this report.

There are approximately 28,760 children aged under 18 resident in Blackpool, making up 20.6% of the population. Overall, the 65+ age group is the most over-represented in Blackpool and is expected to further increase in the forthcoming decade, while the child (and overall) population declines. Life expectancy for children born in Blackpool between 2015 and 2017 is estimated to be 74.2 and 79.6 for boys and girls respectively, compared with 79.6 and 83.1 nationally. Of Blackpool's school population 12.0% are from a minority ethnic group (compared to 32.3% nationally) and 3.1% have social, emotional and mental health needs (2.4% nationally). Approximately 1,500 children moved between schools within Blackpool during the 2018/19 academic year, which reflects the previously noted internal transience.

Within Blackpool there were 2,132 children in need as of 31st March 2019 (2018: 1,807), equating to 741 per 10,000 of the population (2017: 632). This is considerably in excess of both the national average of 341 and that of our statistical neighbours of 513 (2018 figures). Put in different terms, in Blackpool, in every class of 30 children, two will have a social worker.

SAFEGUARDING IN BLACKPOOL: NEED, DEMAND, PRESSURE AND PERFORMANCE

The vast majority of children in Blackpool will grow up to be happy and healthy and make a successful transition from education into employment and adulthood. These children will only ever come into contact with universally provided health and education services. When it becomes apparent that extra intervention is needed to keep a child safe and promote their welfare, that decision is based on the pan-Lancashire CON, together with the supporting information provided in the BSCB Keeping Children Safe in Blackpool document. A guiding principle to working with children and families who do need extra help is that the minimum level of intervention necessary should be provided at the earliest possible opportunity.

BSCB seeks to monitor activity at each stage of the safeguarding system to assure itself that interventions are effective and that children are kept safe. The overall picture is, and has been for some years, one of considerably more children in the system, at every stage, than would be expected in comparison to national averages and our statistical neighbours (a comparator group of local authorities with similar demographics). Operating a system with significantly more children open to intervention than might be expected carries with it cost pressures for all partner agencies for the additional resources and staffing required, but equally raises the more fundamental question as to whether the state is intervening in the lives of families more than is necessary. Ultimately, BSCB's concern is to be assured that all children who require intervention to be kept safe receive it, at the earliest possible opportunity. To this end statistical neighbour and national comparators can be used as a guide to what might be expected, but not a target.

As tends to be the case nationally, the months following the Ofsted inspection of Children's Services saw considerable volatility within the safeguarding system and a significant increase in the number of contacts and referrals to the Front Door of Children's Services. By the end of the overall reporting period there were some indications that a degree of stability was returning to the system, following a phase of recalibration.

To enable year-on-year comparisons to be drawn, data in this chapter will relate to the 12 months ending the 31st March 2019, however narrative mention will be made of the following three months to capture emerging evidence of a more settled system.

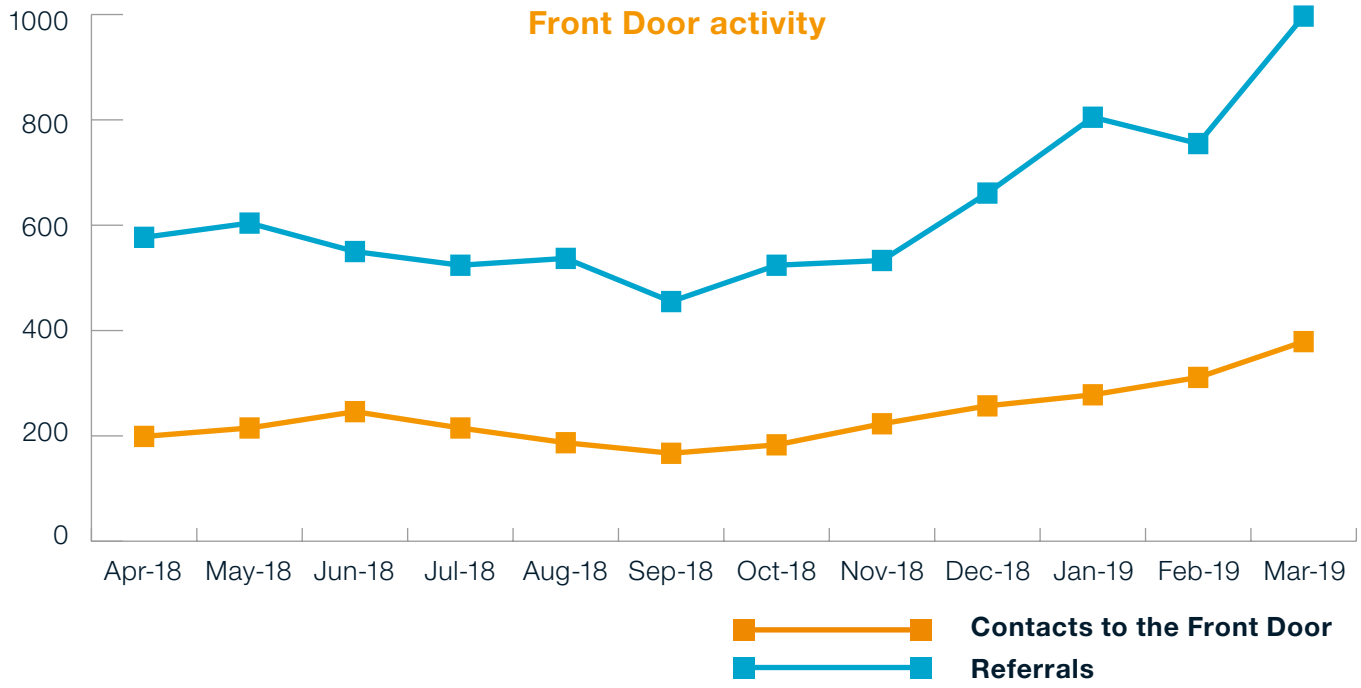
Early Help

Early Help is the level of provision between universal services and statutory provision under the Children Act. It is expected to be provided by the best-placed professional already involved with the family, in partnership with whichever other agencies are needed to support the family to make the necessary changes. BSCB plays a critical role in the co-ordination of work to support professionals to provide early help, including through the provision of assessment forms and tools. The responsibilities of agencies to provide early help are suffused throughout our training programme, while practical support is provided through the Early Help Support Network and Schools' Twilight meetings.

A lack of overall data in respect of early help provision remains a significant and longstanding gap in our understanding of unmet need in Blackpool and therefore the effectiveness of the whole system. Without knowing how many Early Help Assessments are completed or how many children and families are receiving early help, the conclusion that high demand for statutory services stems from ineffective early help provision cannot be discounted. Over recent years BSCB has attempted to collect data through request and surveys to partner agencies (most recently in the Section 175 audit of schools, reported below), however returns have been too fragmentary to build a complete picture. Until a more structured system is put in place this will remain a significant weakness in our understanding of the overall safeguarding system. At the close of the reporting period an Early Help and Neglect Task and Finish Group had been established to review the partnership's overall early help response, including how to capture data.

Referrals and assessments for statutory services

Our last annual report noted a significant reduction in the number of contacts to the Children's Services Front Door (a contact can include anything from an urgent request for child protection action to requests for information from other agencies). This was primarily due to the diversion of standard risk Police Protecting Vulnerable Person referrals to an Early Help Hub, which also provided advice and support to partners working with children and families at an early help level (this was replaced with a re-modelled advice line staffed by social workers, shortly after the end of the reporting period). This reduction in contacts was maintained until November, before picking up again in the months after the Ofsted inspection, producing an annual figure of 7,522 during the year ending 31st March 2019 (2018: 9,746; 2017: 12,494).

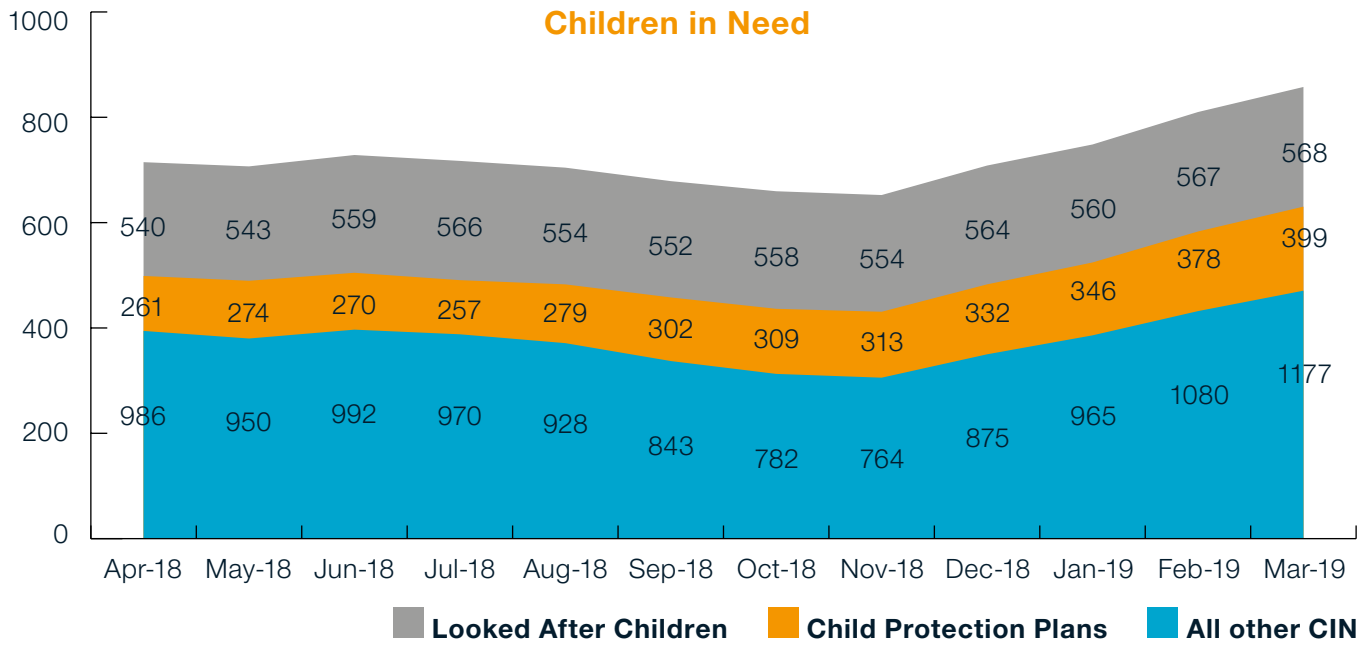


This spike in contacts peaked in March 2019 before reducing back to a level slightly higher than seen prior to the inspection, but lower than in preceding years. In contrast, taken over a year, the number of referrals for Children's Social Care intervention increased to 2,883 (2018: 2,603), with a similar spike recorded toward the end of the year. This was due to an increase in the conversion rate from contact to referral to 38.3% (2018: 27.0%). An increased conversion rate can be viewed as positive both in terms of partner agencies correctly identifying children who require a statutory response and in reducing the overall volume of work within the Front Door, thereby allowing proper focus on the cases most in need of intervention. That said, the proportion of referrals that result in no further action, following a Child and Family Assessment (CAFA), remains high at 34.9% (2018: 35.6%) compared to our statistical neighbours (22.0%) and nationally (29.0%) . This peaked at 48% during April and May 2019, indicating that a higher proportion of the referrals made during the early part of the year did not require statutory intervention, and potentially reflected an increased nervousness amongst partner agencies and Front Door practitioners that opportunities to intervene should not be missed after the inspection. Given that the number of contacts and referrals has started to settle, it is anticipated that the proportion of cases that do require intervention following assessment will start to increase over the summer period.

Where there are indicators that a child has been, or is at risk of being, significantly harmed the referral will trigger a section 47 enquiry. The rate of section 47 enquiries undertaken in Blackpool has historically been the most disproportionately high indicator. The rate (number completed per 10,000 child population) rose in 2018/19 to 507.3 (2018: 487.0) and while this remains below levels seen prior to 2017, it remains well in excess of statistical neighbour (265.0) and national (167.0) rates. Again there was evidence of a settling in the system following the year end and the rate seen in May 2019, if maintained, would equate to an annual rate of around 410. The proportion of section 47 enquiries resulting in Initial Child Protection Conferences (ICPC) slightly increased to 35.8% (2018: 33.5%), but remains below comparators (statistical neighbours: 37.7%; England 40.1%), suggesting that some section 47 enquiries are being triggered unnecessarily. At 94.6% of ICPC, a decision was made to place the child on a child protection plan (England: 87.6%), which raises questions concerning the effectiveness of conferences as a forum for multi-agency scrutiny, discussion and challenge.

Children in Need

In a continuation of the trajectory seen in 2017/18, the overall number of children in need reduced during the eight months prior to the inspection, before climbing sharply in the subsequent four months to a year end figure of 2,144 (2018: 1,807), which represents the highest ever in Blackpool. Broadly speaking, this cohort is made up of those open for assessment following referral, children subject to section 17 child in need plans, child protection plans, and looked after children. While the numbers within each category has fluctuated, the proportion of children at the 'top end' of the system on child protection plans or looked after has remained fairly constant, only increasing slightly during the 12 months to 31st March 2019 from 44.7% to 45.5%. This is somewhat out of line with what is seen in our statistical neighbours (35%) and nationally though and indicates a tendency toward escalation in Blackpool, with more families higher up the CON than would typically be the case in other similar areas.



A significant factor in this increase has been the rise in the number of children subject to child protection plans (CPP). From a starting point of 275 on the 1st April 2018 the number continued to decline to 257 in July, before increasing to 399 by the 31st March (and reaching a subsequent peak of 448 following the end of the reporting period). This pattern stands in contrast to data indicators in respect of referral activity and overall numbers of children in need that reached their low point in November, immediately prior to the inspection. Three broad factors are at play in accounting for this pattern: firstly, a high rate of CPP ending prior to July 2018, which corresponded to a period in 2016/17 with a high rate of CPP commencements; secondly, the rate of children becoming subject to a CPP increased from a low of 122 during early 2018, to 155 in November and to 190 following the inspection (all annualised rates per 10,000 child population); finally, the rate of plans ending fell from 200 in mid-2018 to 125 in October and 112 in February. This reduction in the number of children ceasing to become subject to a CPP has occurred exclusively amongst those being stepped down to lower levels of intervention, through either section 17 child in need or early help plans, with the number of children exiting a CPP to become looked after remaining steady. This is seemingly indicative of increasingly conservative decision making brought on by a lack of confidence in making judgements about thresholds and the effectiveness of interventions, following the inspection. In order to increase confidence in step down processes from CPP, from the summer of 2019 CP conference chairs will chair the first meeting under a section 17 Child in Need (CIN) or early help plan. A tapering off in the rate of children becoming subject to a CPP is also expected in light of the more recent reduction in the number of referrals, however the foregoing analysis demonstrates that the current bulge in the number of children subject to a CPP will take one to two years to stabilise.

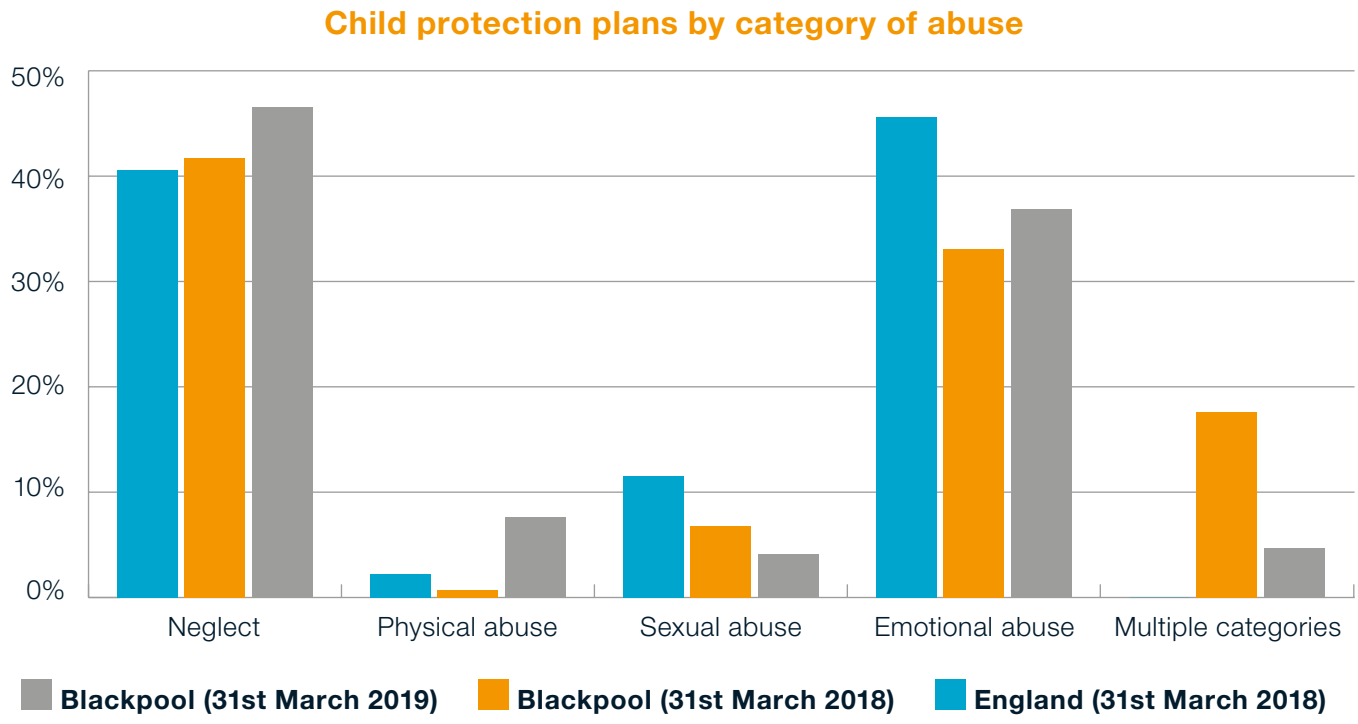
In contrast, the number of Looked After Children has remained more stable throughout the period, only increasing from 533 to 568 during the 12 months to the 31st March 2019. This increase is due to a reduction in the number of children ceasing to be looked after in the year, which fell to 167 (2018: 207). A high proportion of those leaving care did so on attaining the age of 18, with younger children leaving care for other reasons (e.g. returning to their family) showing more marked reduction than the overall figure would indicate. This reduction in children leaving care was mitigated by reducing numbers of children becoming looked after which, at 198, was the lowest number since 2014/15. There has equally been little, if any, discernible rise in the number of children becoming looked after since the inspection.

Notwithstanding the volatility in the system around the year end, it remains the case that the number of children in receipt of statutory intervention remains well in excess of those seen elsewhere in the country. While there is an accepted correlation between more deprived areas and higher numbers of children requiring safeguarding, the rates in Blackpool remain well in excess of those seen in the most comparable local authorities, and have markedly diverged from these since 2007 in the case of looked after children and 2010 for child protection plans. In order to address the high rate of children subject to CPP the Child Protection Standards Pathway, which was introduced by BSCB in the spring of 2019 after consultation with partner agencies, provides oversight from the Child Protection Chair Team Manager from the point that a Section 47 enquiry is started, to ensure that the right plan for the child is pursued. By introducing earlier oversight from a CP chair, greater scrutiny will also be provided to the timeliness and production of reports for the ICPC.

Rate per 10,000 child population of	Blackpool (2019)	England (2018)	SN (2018)
Child in Need (all)	741	341	513
Child Protection Plan	140	45	67
Looked After Child	198	64	112

Characteristics of children subject to child protection plans

It is a statutory requirement that all child protection plans record one, or more, categories of abuse which, when viewed as a whole, enable an understanding of the changing risks that children face. After a number of years of making a disproportionately high number of children subject to CPP in multiple categories, Blackpool phased out this practice completely during the course of 2018, which skews year on year comparisons:



The year on year changes evident above in Blackpool's profile would suggest that the majority of CPP plan previously made under multiple categories are now recorded as being emotional abuse. However, the year end figures serve to hide an in year reduction, then significant increase since January 2019 in the number of plans being made under the category of neglect. This may reflect the critique of Blackpool's response to neglect included within the Ofsted inspection report, together with the rising national prominence of the issue of neglect in older children. While comparisons with national data require a degree of caution due to local circumstances (for example, it is known that domestic abuse rates are higher in Blackpool than elsewhere in Lancashire, which will potentially result in more children becoming subject to a CPP on this basis), the low number of plans under the category of physical abuse does warrant further investigation. That said, BSCB's review and audit activity has not identified any significant issues in terms of decision making in respect of the category of plan.

The Ofsted inspection report raised concerns in respect of children subject to CPP experiencing drift and delay in the delivery of their plan and any necessary escalation. This issue was similarly highlighted in a multi-agency learning review in respect of a sibling group of six, the eldest of whom had been subject to a CPP for over five years, where there was little discernible evidence of either positive change or escalation. Broader data in this respect indicates that Blackpool has a lower proportion of children subject to CPP for between 1 and 2 years (9.7%, compared to 14.4% nationally), but more over two years (3.2% compared to 1.8%). The newly introduced Child Protection Standards Pathway provides for a peer reflection meeting for the core group when a CP plan is open for longer than 14 months, chaired by the CP Chairs' Team Manager. This will provide the core group with the time and space to reflect on progress and options for the family.

At the other end of the spectrum, 30.4% of CPP in 2018/19 ended at their first review after three months, compared to 20.0% nationally. Of the 113 children that this represents: 55 became looked after, 13 moved out of Blackpool, 31 were stepped down to section 17 CIN plans and 14 were stepped down to early help or universal services. This was clearly a justifiable decision for those who became looked after or moved out of Blackpool. However, the number stepping down to lower tier services suggests either that some CPP were not required in the first place, or that plans are being ended prematurely, before interventions have had time to effect long term change. The latter factor was seen to be the case in one multi-agency learning review relating to two young children who were subject to two child protection plans in an 18 month period.

The decision making to end the first plan was found to have been based on the process of delivering and completing interventions, as opposed to evidence of their outcome.

A further indication that this is a broader based issue is provided by data that 25.5% of plans are being implemented on the same child for a second or subsequent time, compared to 20.0% nationally. The Blackpool rate has consistently risen since 2014-15, when it stood at 18.5%. Of the 124 children who were made subject to a plan for a second or subsequent time, 37% had been subject to a CPP within the previous 12 months and for 27% the duration of that plan had been under three months. The predominant theme for these children was being made subject to a plan on the grounds of domestic abuse, with the previous plan having ended on the basis that the parents were no longer in a relationship. A secondary theme was for plans made due to neglect underpinned by poor parental mental health or alcohol use. The Child Protection Standards Pathway ensures that CPP will not be ended at the first review other than in specific circumstances, with the chair challenging any such proposal from the core group prior to the conference. This has already resulted in a reduction in the proportion of CPP ending in under three months to 19% during the first quarter of 2019/20.

We can say with a greater degree of certainty that the age range of children subject to CPP coincides with that expected nationally, as indicated below. However, relatively small changes in the proportion of each age range subject to a CPP plan hides the fact that the previously noted increase in the overall cohort has come almost exclusively from the 5 – 15 year old age range and is most concentrated amongst the 5 – 9 year old cohort. While this may reflect a welcome increased understanding of the impact of neglect in older children, given concerns in practice regarding unborn children, noted in Chapter 5 below, it is of concern that this cohort has reduced during the year. Over the next year the number of CPP for older children is expected to decrease as a consequence of the child exploitation pathway (Chapter 5, below), which will place children solely at risk of abuse outside the family environment in section 17 CIN plans, with a Child Missing, Exploited or Trafficked (CMET) plan.

Age of children subject to child protection plan at year end	Blackpool 2018/19	Blackpool 2017/18	Blackpool 2018/19	Blackpool 2017/18
	Number		Proportion	
Unborn	5	8	1.2%	2.1%
Under 1 year	42	31	10.5%	9.3%
1 – 4 years	109	72	27.2%	25.6%
5 – 9 years	126	73	31.4%	29.5%
10 – 15 years	108	83	26.9%	9.4%
16 – 17 years	11	11	2.7%	4.1%

There remains a slightly higher number of boys subject to child protection plans (51.4%; 2018: 53.6%), which is reflected nationally, although this has tended to fluctuate (in Blackpool) over the longer term. Just under 90% of children subject to CPP are White British, which reflects the overall population. Of the 399 children subject to a CPP on the 31st March 2019, only six were recorded to have a disability. Further work is needed to determine if this represents a failure to consistently record disabilities or a more fundamental issue.

Performance

Given the twin pressures of increasing numbers of children within the safeguarding system, together with the ongoing challenge of recruiting and retaining social workers, it is unsurprising that some performance indicators have weakened. This is an area in which Blackpool has typically compared favourably and will therefore continue to be closely monitored. That said, performance in respect of adoption remains strong.

	Blackpool 2018/19	Blackpool 2017/18	Blackpool 2018/19	Blackpool 2017/18
Child and Family Assessments completed within 45 working days	77.4%	78.1%	83.0%	78.0%
ICPC held within 15 working days of the start of the s47 enquiry	89.3%	93.6%	77.0%	79.0%
Proportion of children ceasing to be looked after who were adopted in the year	17.4%	17.4%	13.0%	19.0%
Proportion of children ceasing to be looked after who were subject to Special Guardianship Order in the year	20.4%	21.3%	11.0%	10.0%
Average number of days between Court decision and adoption placement match	432	505	486	469

Other safeguarding indicators

There is less data available in respect of the demands of safeguarding work in other agencies, although the children, at each stage of the system noted above, do require a multi-agency response to ensure that they are safe. More generally, we know that children and young adults in Blackpool are more likely to be admitted to hospital as a consequence of mental health conditions, alcohol use, substance misuse, or self-harm, and that the rate in the latter two categories is the highest nationally (although the most recently available data relates to 2017-18). This area has been subject to long standing BSCB monitoring and challenge and while we do understand that admissions practices in our acute hospital trust have played a part, it does remain an area of concern. It is therefore encouraging to note reduced admissions in respect of self-harm which is, in part, due to the success of the Child and Adolescent Support and Help Emergency Response service (CASHER).

Rate of hospital admissions per 100,000 population	Blackpool 2017/18	Blackpool 2016/17	England 2017/18
As a result of self-harm (10-24 year olds)	1009.6	1,156.8	421.2
Due to mental health conditions (0-17 year olds)	184.3	188.8	84.7
Due to substance misuse (15-24 year olds)	329.3	339.0	87.9
Due to alcohol misuse (under 18 year olds)	67.3	74.3	32.9

Managing allegations against staff

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

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

Upper tier local authorities are required to ensure that responses to allegations are co-ordinated with activity to safeguard involved children and to have in place a designated officer (colloquially known by their old title as a LADO) to be involved in the management and oversight of allegations. In Blackpool, for the majority of the reporting period, the role of the designated officer was combined with the equivalent role for allegations against practitioners who work with adults, however it has now been disaggregated and is be held by a specialist children's practitioner.

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

During the reporting period the designated officer received 121 contacts (2018: 79), of which 55 triggered a full response (2018: 60). This conversion rate of 45.5% is comparable to that of our regional peers, despite the reduction from the previous reporting period. Allegations are reported by the agency that identifies the alleged behaviour of concern and not necessarily the employer of the individual. Consequently, while the highest number of allegations were received from the social care (36) and education (32) sectors, the highest sectors of employment for the alleged perpetrator were education (42), residential (20) and foster carers (13). After a number of years in which a low number of referrals in respect of health practitioners was remarked upon, this increased from 2 to 10 in the reporting period.

The designated officer has previously been unable to report any data other than number and source of referral. During the reporting period more data points have started to be collected, which will allow further analysis of trends in subsequent annual reports. Consequently, we are now able to report that, of the 121 contacts, 48 related to physical abuse, 41 to a risk of harm or act of omission, and 17 to sexual abuse. Of the 55 allegations that triggered a full response, 50 were concluded by the year end. In 13 the allegation was found to be unsubstantiated, in 19 it was partly substantiated and in 18 it was substantiated. Substantiated or partly substantiated allegations can result in prosecution (1), dismissal (9) or disciplinary procedures (9), although the most common outcome, across all conclusions, is that a training need is identified (16).

Working Together sets target timescales for 80% of cases to be resolved in less than a month and 90% within three months. The figures of 32% and 52%, respectively, demonstrate a need for a significant improvement in the timeliness of processes in Blackpool.

INSPECTIONS

The latter part of the reporting period has been dominated by inspection activity, with the majority of statutory board partners having received some form of regulatory inspection during the reporting period. Some have carried uncomfortable messages both for single agencies and the partnership, and BSCB has continued to hold agencies to account to respond to safeguarding elements of their inspections. Equally, BSCB will ensure that issues with multi-agency working are addressed and that agencies receive the necessary support from the partnership to make expected changes.

Perhaps most significantly for BSCB, the Ofsted Inspection of Local Authority Children's Services in December 2018 returned an overall rating of inadequate. Strategic partnerships were judged not to have addressed key weaknesses, including chronic neglect, effectively. Equally, the support and commitment of some partners for Children's Services was noted to be weak, with attendance at BSCB and the Children's Improvement Board noted to be "challenging".

This judgement has resulted in the adoption of a formal memorandum of understanding between BSCB and the Children's Improvement Board (subsequently renamed the Getting to Good Board), which outlines respective areas of responsibility and provides for the delegation of partnership elements of the improvement plan to BSCB. The BSCB Independent Chair is a member of the Getting to Good Board and meets regularly with its Chair to ensure a co-ordinated response. Early changes made in response to the inspection include BSCB's adoption of a Child Protection Standards Pathway and Issues Resolution Protocol both of which are designed to support practitioners to move forward child protection plans at risk of drift and delay, and to challenge other agencies when this is not done. At the time of writing Children's Services are in the process of agreeing an internal Neglect strategy, while BSCB is in the process of reviewing its partnership neglect strategy to address concerns raised in the inspection report that neglect is not identified or addressed in a sufficiently timely manner.

Following the conclusion of the reporting period, the Department for Education appointed commissioner reported that Blackpool Council was in a position to make the expected improvements and maintain control of its Children's Services, subject to further monitoring visits. This will provide an additional layer of scrutiny to the routine Ofsted monitoring visits that commenced in August 2019.

Throughout the period under review BSCB has monitored and supported Lancashire Constabulary to make changes in light of their HMICFRS National Child Protection Inspection. This has included the provision of support for their training an audit programmes.

A Post-Inspection Review undertaken in December 2018 highlighted significant progress made in changing the culture of the organisation to one in which officers understood their responsibility to see the child in all situations. Given the success of their vulnerability training programme, opportunities are being explored to make this available on a broader basis through LSCB training units.

During the reporting period, BSCB has also reviewed the safeguarding elements of inspection reports and actions plans in respect of the multi-agency Youth Offending Team, Cumbria and Lancashire Community Rehabilitation Company (CLCRC), National Probation Service, Blackpool Teaching Hospitals, Horizon (our substance misuse service provider for adults over 25) and Highfield Leadership Academy.

During the 2018/19 academic year 9 Blackpool schools have been inspected with 1 being graded as outstanding, 5 as good, 2 requiring improvement and 1 inadequate. Only the latter received negative comments in terms of safeguarding. As of the 30th June 2019, 21 early years settings in Blackpool were graded as outstanding, 59 as good, 1 as requiring improvement to be good and 2 inadequate.

WHAT WE HAVE DONE THIS YEAR

Ensure continuity, clear governance and strategic arrangements during the transition period

BSCB has been determined not to let the forthcoming changes to multi-agency safeguarding arrangements hinder its ongoing task of ensuring that work to safeguard and promote the welfare of children is co-ordinated and effective. The following are examples of ongoing work that we have delivered during the reporting period, with an increasing emphasis on working on a joined up basis with our colleagues in Blackburn with Darwen and Lancashire.

Early Help

BSCB Strategic Board members agreed a new Early Intervention and Prevention Strategy in October 2018. The strategy seeks to ensure that children and families in Blackpool receive a consistent early help offer that is delivered by a well-equipped and confident workforce. A whole family approach is central to this offer, with co-located services provided from easily accessible locations in the community. An Early Help and Neglect task and finish group, formed toward the end of the reporting period, will be responsible for the delivery of the strategy. Its initial task will be to develop a shared early help model that underpins how all agencies work with children and families. This will be allied to an agreed model of practice for Children's Services that will ensure that children and families are supported according to the same principles, irrespective of where they sit on the CON. Further support will be provided for practitioners providing early help to children and families through the provision of an advice and support line, staffed by social workers. This was launched immediately following the end of the reporting period.

BSCB continued to support practitioners through its Early Help Support Network, which is open to professionals from any agency that delivers early help to children and families. Meetings during the reporting period were attended by a range of school, health, police, probation and third sector representatives and included presentations from services available for children and families and opportunities to share good practice and problem solve. Early Help Support Network members also act as a point of reference and expertise within their own agency to promote good practice.

Neglect

BSCB adopted a three-year neglect strategy in 2016, as part of which it launched a bespoke suite of neglect evaluation tools, including the Graded Care Profile 2 (GCP2). To date, over 400 practitioners have attended neglect evaluation tool training, which represents a significant proportion of the Blackpool children's workforce. More recently, BSCB has sought to understand the impact of this element of the strategy, with somewhat disappointing results. A number of recent reviews (the Child BY serious case review (SCR) and three multi-agency learning panels, reported below) have considered children who were neglected over sustained periods. These cases were characterised by varying levels of drift and delay and in none was there any evidence of the use of any of the neglect evaluation tools. This was disappointing given that repeated use of the tools would have enabled professionals to evidence levels of neglect and progress made under the plans (equally, this also indicated that agencies were not adhering to the agreed protocol for the use of the tools). BSCB subsequently undertook a survey of GCP2 trained professionals and a separate survey of school based professionals. Both suggested that GCP2 was only used by around half of trained professionals and that only a small minority of this group use the tool regularly (this coincides with national NSPCC research as to its use).

Concerns raised by Ofsted in their inspection of Blackpool Council Children's Services were similar to those identified in the BSCB reviews noted above, in that children were seen to live with neglect for overly long periods, while older children's behaviour was not framed in terms of the neglect that they had experienced. BSCB has subsequently undertaken consultations with both board members and a representative group of professionals to inform the development of a successor strategy. These consultations emphasised the need for an early and consistent response to neglect by all agencies, but also the need for a culture where neglect is not accepted and families and professionals have high aspirations for the children of Blackpool. Partner agencies have also requested that we explore the potential for shared assessment tools with colleagues in Blackburn with Darwen and Lancashire. Work to develop the next stage of our response to neglect is being undertaken by the previously mentioned Early Help and Neglect task and finish group and remains ongoing at the end of the review period, while Blackpool Council Children's Services are also in the process of developing an internal neglect strategy.

Sudden Unexplained Deaths in Childhood service (SUDC)

Working Together requires that LSCBs ensure that a multi-agency rapid response process is in place to review the circumstances of any unexpected death of a child. Multi-agency colleagues work together to share information to ensure a thorough investigation (of whatever type is required), that the bereavement needs of the family are met and that lessons are learned from the death wherever possible. The pan-Lancashire SUDC service is provided by Lancashire Care NHS Foundation Trust (LCFT) and consists of three dedicated nurses who work in conjunction with multi-agency partners, including children's services, acute hospital trusts, primary care providers, Lancashire Constabulary and North West Ambulance Service. The service responded to 48 deaths during the year to 31st March 2019, which is consistent with expectations.

We reported in our last annual report that an external review of the SUDC service had been undertaken, by a Public Health registrar, to assess its conformity with Working Together and the strengths and weaknesses of the current model. The review concluded that the nurse led response, within working hours, was effective and generally ran smoothly, but that the out of hours response, which disproportionately relied on the on-call acute paediatrician, was not of sufficient quality. The quality of this initial response was assessed to be critical due to the influence that it has on the ensuing process. While the demand on the service in terms of the timing of deaths fluctuates, as many as two thirds of deaths in a given period can be outside office hours and therefore receive a lower standard response. The report was endorsed by the three pan-Lancashire LSCBs and the Clinical Commissioning Groups (CCG) responsible for commissioning the service were asked to review the identified options for expansion. A seven day service, with increased hours on weekdays, was consequently introduced from the 31st December 2018 and has provided a full nurse-led response to six deaths that would have previously not received one.

November 2018 also marked the tenth anniversary of the start of the SUDC services. BSCB, together with our Blackburn with Darwen and Lancashire colleagues, expressed our appreciation to all who had been involved in the service's development and delivery at an event to mark their achievement. The successful delivery of the service over a sustained period, together with its recent expansion, has also been acknowledged by its inclusion in the NHS England Atlas of Shared Learning.

Operation Encompass

Lancashire Constabulary have provided schools and other partner agencies with feedback about domestic abuse incidents to which they are called for a number of years to date through the submission of Protecting Vulnerable Persons referrals Multi-Agency Safeguarding Hub (MASH). However, information sharing processes have been slower than would be wanted, particularly for standard and medium risk incidents. This has meant that schools could have children arriving in the morning who had experienced a domestic abuse incident the previous night of which they were unaware and are therefore unable to put in place an appropriate package of care.

In order to address this BSCB, together with our colleagues in Blackburn with Darwen and Lancashire, has worked with police and school colleagues to put in place a system by which schools will directly receive information about all domestic abuse incidents involving their children prior to 8:30am each morning. This has been made possible by the adoption of new electronic systems for police officers, while the three LSCB have provided training to all Blackpool schools in the process and their expected response. Schools have been encouraged to take a trauma-informed approach to managing children's behaviour after domestic abuse incidents to understand that their presenting behaviour might reflect their experiences and need to be managed differently. Operation Encompass went live in May 2018 and its roll out will be evaluated in forthcoming months.

Schools

Schools, by virtue of the sustained level of contact that they have with all children, are uniquely placed to safeguard and promote the welfare of children. BSCB has prioritised engagement with schools for a lengthy period now and during the reporting period continued to hold termly twilight meetings for Designated Safeguarding Leads, which provide updates on legislation and policy changes, inputs from partner agencies and more detailed consideration of specific issues. During the reporting period a new Schools' Safeguarding Advisor has been appointed by Blackpool Council. He works closely with schools to support their safeguarding practice and to ensure that they are meeting their statutory duties. BSCB supports this scrutiny through the annual section 175 audit programme. This audit, of compliance with the statutory safeguarding requirements enacted in section 175 of the Education Act, was completed by 40 of Blackpool's 46 schools and colleges. The audit is a self-evaluation, so not otherwise triangulated, and indicated that schools generally have appropriate structures, policies and training in place. By updating expectations each year, BSCB is able to ensure that schools continue to develop practice and this year's return has promoted the delivery of training on peer-on-peer abuse in schools. The audit also identified a number of schools where the Designated Safeguarding Lead is not receiving professional supervision, which the Schools' Safeguarding Advisor will address.

At a Strategic Board level, BSCB has held its counterparts in the Blackpool School Improvement Board to account throughout the year in respect of exclusions and the use of alternative provision. This has been identified as a significant safeguarding issue due to the increased vulnerability of children who are either not in school or receiving part-time provision. 50 pupils had been permanently excluded from Blackpool schools, together with a further 11 Blackpool children from schools in other local authorities, during the 2018/19 academic year, up to 30th June. This represents a slight increase on the previous year, although this increase relates to one school which is being appropriately challenged and supported. At the same date 272 children were electively home educated, representing 1.5% of the school population. This has increased from 207 (1.1%) during the reporting period and mirrors increases seen nationally. While the majority of electively home educated children will receive appropriate good quality schooling, they are of a greater concern from a safeguarding perspective due to the lack of contact that they may have with professional agencies.

Develop a joined up multi-agency learning and outcomes 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 (LIF) which allows for the identification of themes and trends that can be utilised to inform further activity.

The approach enables BSCB to investigate, better understand and respond to the safeguarding environment in Blackpool. For example, the Child CA SCR identified issues in the safeguarding of babies prior to birth and the impact of transience. The Multi-Agency Audit Group (MAAG) subsequently undertook wider scale audits of both of these issues, finding broader concerns in terms of the safeguarding of babies, but that practitioners are generally well equipped to manage transient families. This learning will lead to system changes and be disseminated to practitioners through the publication of SCR, our training offer and in written briefings. On other occasions, learning activity can arise from an identified need to understand an area of practice more fully as a consequence of local or national priorities. This was the case with the audit and subsequent multi-professional discussion forum that we undertook in respect of child exploitation that has resulted in significant system changes and the commissioning of a new training offer.

During the reporting period BSCB expanded its LIF activities to include multi-agency learning panels and multi-professional discussion forums, the outcomes of which are reported below.

Case reviews

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

BSCB continued to manage high levels of SCR activity, relative to its size, throughout the reporting period. By the end of the reporting period we had commissioned 11 SCRs in the past five years, which equates to 7.6 per 100,000 child population annually, compared to a national average of 0.97 (based on SCRs commissioned between 2011 and 2014).

The Multi-Agency Learning Panel (MALP), noted above, is a means of quick review that BSCB has introduced, for cases that fall below the SCR threshold. The agreed criteria for a MALP is “Cases [that] involve incidents where a child has been harmed or where there has been a near miss and there are concerns about multi-agency practice; or involve incidents where multi-agency practice is considered to be good (after a child has been harmed, a near miss, or a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice. A primary characteristic of all cases selected for multi-agency learning reviews will be the likelihood learning from the case that is applicable to wider practice.”

MALP consist of a one-off meeting with practitioners involved in a case to discuss the strengths and weaknesses of multi-agency interventions (based on the chronology compiled for the referral consideration process), after which a brief report with recommendations is compiled.

The period in numbers

	SCR	MALP
Reviews underway or agreed at 1st April 2018	4	3
Referrals received during the reporting period	3	6
Reviews agreed	3	5
Referrals resulting in no further action	0	1
Reviews completed during the reporting period	4	7
Reviews ongoing at 30th June 2019	3	1

During the reporting period, BSCB also provided information in respect of the involvement of Blackpool agencies with six children and families subject to SCR in other LSCB areas. The findings of these SCR will be reviewed by BSCB to ensure that any learning for Blackpool agencies is realised.

Of the outstanding reviews, the MALP will take place over the autumn of 2019, while the three SCR are projected to be finalised prior to the end of 2019, subject to the resolution of outstanding criminal investigations that may delay our ability to speak to involved practitioners and family members.

During the reporting period BSCB published four SCR:

Child CA

What happened?

Child CA was a baby who sadly died at the age of four months. The cause of death was reported to be unascertained and the police investigation found no evidence that either parent was responsible. Child CA's parents had 15 older children between them, the majority of whom had been taken into the care of the local authority due to concerns in respect of neglect, alcohol use, domestic abuse and parental mental health. Mum and dad moved to Blackpool midway through the pregnancy, despite having no obvious connection to the town.

A referral to Blackpool children's services was made by their counterparts in the originating area. Once in Blackpool mum was appropriately supported by the social and complex needs midwifery team, however there were delays in the children's services' assessment and little evidence of a co-ordinated multi-agency response prior to birth. These delays resulted in the initial child protection conference and a legal planning meeting taking place after Child CA's (premature) birth. Child CA was discharged from hospital immediately prior to Christmas and received expected midwifery and health visitor visits, including safer sleep messages. After the legal planning meeting near daily visits were undertaken by the Families in Need team. The families flat was noted to be very warm and communal areas smelt of cannabis. The Plan remained in place at review child protection conference, although the overall picture was positive and the emphasis was on monitoring to ensure that changes were maintained. Child CA died a month later.

What did it tell us?

The report concluded that the death of Child CA, from natural causes, could not have been predicted or prevented, but that the multi-agency safeguarding response should have been delivered with a greater degree of urgency. While the delays were in children's social care processes, no other agency escalated their concerns, meaning that information was not shared, or a multi-agency plan put in place, until after Child CA had been born. The child protection plan was judged to be not of a sufficient standard, although the level of intervention following management oversight at the legal planning meeting was as would be expected.

The report made recommendations that BSCB should seek assurance that agencies have systems to manage families moving into Blackpool, that the pre-birth protocol is being properly applied, that child protection assessments and plans are timely and of a good standard and that practitioners receive regular supervision.

What have we done?

BSCB has challenged partner agencies to provide evidence that they provide regular supervision to their practitioners through the Quality Assurance and Performance Monitoring process. Children's services are now able to evidence their compliance with expected levels of supervision, which was not the case at the time of the review. All children's services audits now consider the quality of the child protection plan, while the Risk Sensible training that BSCB has delivered in the reporting period has provided a framework for practitioners to develop better quality plans. Expectations of practitioners during the pre-birth period have been promoted through the publication of a seven-minute briefing, while children's services developed a more detailed internal protocol. Finally, the wider response to transience and the safeguarding of babies prior to birth was the subject of multi-agency audits and multi-professional discussion forums that are reported below.

Child BY

What happened?

Child BY was a three month old twin who received significant head injuries, but is fortunately expected to make a good recovery. The injuries, which occurred while Child BY was in mum's care, were treated as non-accidental, although criminal charges were not laid. There was a lengthy history of concerns in respect of neglect, domestic abuse and dad's wider criminality, linked to his drug and alcohol use. The domestic abuse was serious, involving assaults, threats to kill and the use of weapons. Child BY's elder two siblings had been subject to a child protection plan for over a year at the time of the incident, with the twins added in the months before their birth.

Mum lived with domestic abuse and parental alcohol use as a child and started her relationship with dad when she was 17 or 18. Domestic abuse was seemingly a feature of the relationship from the outset. They briefly separated prior to the review period, during which time dad threatened to slit mum's throat. Both parents had previously sought help for low level mental health issues. Mum had a difficult relationship with her own mum and there were allegations of domestic abuse and periods of estrangement between them. During the eighteen month period under review dad spent periods in custody and was under probation supervision throughout his time in the community.

What did it tell us?

Professionals in this case were dealing with a sibling group who were subject to numerous risks, as was their mum. This, in turn, compromised her ability to parent them effectively and safely. However, assessments of the children tended to focus solely on the domestic abuse and failed to make a cumulative assessment of the impact of years of abuse on the children, or of mum's own experiences as a child an adult. Despite ample evidence that mum wanted to continue her relationship with dad (evidence was cited of the increased risk of harm to victims of domestic abuse who attempt to separate), plans were predicated on mum ending the relationship and policing dad's contact with his children. Framing dad's actions as coercive and controlling behaviour, as opposed to taking an incident by incident approach, would have enabled professionals to better understand and respond to the experiences of the children and mum, and to provide interventions for dad. Equally, the focus on domestic abuse perpetrated by dad, reduced the emphasis on the risk presented to the children by mum. Professionals reported knowing that dad was breaching contact restrictions but feeling stuck in their approach to the case. They should have received more effective management oversight to break this cycle. Finally, a review of literature was found to support the thesis that twins and young sibling groups with short spacing between births were at an increased risk of abuse.

What have we done?

BSCB has challenged local commissioners to ensure that there is adequate domestic abuse provision for perpetrators and victims who want to remain in a relationship with the perpetrator. This has resulted in short term funding to enhance the provision of the Inner Strength programme, prior to its formal evaluation in 2020. This is a voluntary perpetrator programme that also provides support to victims. BSCB has revised its own domestic abuse training for practitioners to include specific courses covering the impact of domestic abuse on children and on coercive and controlling behaviour, in addition to the existing overview course. Blackpool Teaching Hospitals has provided an additional midwife to the existing clinic for multiple births to link with the social and complex needs midwifery team, thereby providing an additional means by which safeguarding needs can be identified. Given broader concerns about drift and delay in child protection plans found in this review, other reviews and in the recent Ofsted inspection, BSCB has agreed a Child Protection Standards Pathway that provides for increased oversight by the conference chair and means for escalation.

Child BZ

What happened?

Child BZ was a 13 week old baby who sustained, and subsequently died as a consequence of, a catastrophic brain injury. Dad was held responsible for causing these injuries and has been convicted of murder. Child BZ was the only child of mum and dad. Mum has long-standing and fluctuating mental health problems and a diagnosis of schizoaffective disorder, together with learning difficulties. She has required periods of in-patient care and has a history of aggressive behaviour when unwell. Dad has a history of perpetrating domestic abuse in previous relationships and there were also some indications of earlier alcohol problems. He was the only adult present when Child BZ's older half-sibling sustained suspected non-accidental injuries at a young age in 2004. Dad experienced lower level mental health problems and was described by his family as a recluse, with a nocturnal lifestyle.

Mum had been an in-patient in the months prior to her pregnancy and there was evidence of health professionals effectively working together to manage her pregnancy and mental health conditions in early weeks, with a children's social care referral made at the expected point in the pregnancy. There was limited activity in the weeks following referral, with no multi-agency meeting to share information until the child protection conference held three weeks later than is required in the pre-birth protocol. At the time of birth expected parenting assessments had not been completed. The conference rightly identified risks associated with mum's mental health and the suspected non-accidental injury, but missed dad's coercive and controlling behaviour, substance use and mental health. The agreed plan was for Child BZ to live with mum and dad, with dad as the primary carer for both. However, mum's mental health declined post-birth, resulting in her being detained and Child BZ being placed in dad's sole care. While intensive services were put in place, there were indications that dad was starting to disengage in the weeks prior to the murder.

What did it tell us?

The review identified five broad areas of learning. Firstly, the need to secure and attach credence to historical information when completing assessments, in this case in terms of the non-accidental injury to Child BZ's half-sibling. Secondly, the need for greater urgency to be attached to pre-birth safeguarding processes. In this case there was no multi-agency assessment or planning until well after the expected point in the pregnancy, which resulted in assessments not being complete at the time of birth and then needing to take place on the mother and baby unit. Ultimately, the decision to place Child BZ at home with dad was made before full information had been obtained about the injury to the half-sibling and was overly-optimistic. Thirdly, that significant changes to a child protection plan, in this case to place Child BZ at home in dad's sole care, should not be made without core group members' knowledge. Fourthly, that decisions should be made on a full assessment of all risks. While the primary risk of physical harm presented by mum, when she was unwell, was rightly identified, other risks presented by dad were overlooked. A cumulative assessment of all risks should have been completed. Finally, there was insufficient evidence of management oversight and escalation, particularly within children's social care given the delays in assessment.

What have we done?

The findings of this review echoed that of Child CA in terms of safeguarding babies prior to birth and the actions taken are therefore covered under that review. The safeguarding unit has amended processes to ensure that health visitors are invited to pre-birth child protection conferences and has introduced additional checks to ensure the quality of reports being provided to conference. Children's services' internal care planning protocol would now result in weekly discussion of cases of a similar nature, providing the management oversight that was lacking at the time. Finally, the risk sensible approach in child protection conferences should ensure that all risks are identified and addressed both in decision making and on the subsequent plan.

Child CB

What happened?

Child CB was a 17 year old looked after child who committed suicide. Child CB and a younger sibling had been taken into the care of the local authority and adopted at the age of three. Child CB's behaviour became increasingly difficult to manage and gradually more intensive interventions were provided, but could not forestall the breakdown of the adoption in 2014, after which Child CB lived in five foster and two residential placements. Throughout this period there was considerable multi-agency intervention to support Child CB, although provision was disrupted by moves between local authority areas. Incidences of self-harm were known from 2013 and a significant deterioration in mental health and increase in substance misuse was seen in months prior to the suicide. This was seemingly triggered by anxiety about a projected move into independent living. The review highlighted the overall difficulty of dealing with older children who can increasingly make their own decisions but who may make bad ones.

What did it tell us?

Adolescence is a time when children ask the fundamental question, "Who am I?" However, adopted children will often have an incomplete picture of their life which makes this harder. There had been insufficient early 'life-story' work done with Child CB, or the adoptive parents, and it was well known that Child CB became easily upset when there was the potential for others to find out about his adoption and past. Child CB's experience was that every trusted relationship that had been formed, be it with adoptive parents, carers or professionals would break down. Behavioural difficulties including self-harm were sometimes considered as symptoms of underlying attachment issues, but at other times, e.g. breakdown of foster placements, the underlying causes were not addressed. The case therefore highlights the complex and often considerable post-adoption needs of the whole family.

Child CB was offered and intermittently attended Child and Adolescent Mental Health Services (CAMHS) appointments from 2009. It was obvious that more formal appointments were less effective and that there was a need for more flexible and creative approaches to engagement, however this was not consistently seen. Due to not being open to CAMHS on turning 16, Child CB could not be re-referred in for support at a time of significantly increased pressures brought on by an impending transition to semi-independent accommodation, while therapeutic support to address attachment disorder was similarly unavailable.

Child CB was known to be using cannabis for a number of years and this was effectively tolerated by professionals, partially due to perception that the police would not act. This resulted in information about cannabis use not being shared amongst professionals and the potential interaction with prescribed medications not being explored. The review report therefore posed the fundamental question as to whether expectations for looked after children are lower than for those raised by their biological parents.

Finally, the review emphasised the need for a specific response to the increased risk of suicide amongst looked after children and the need for physical measures to prevent suicides.

What have we done?

In response to a request from BSCB the Lancashire Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan board has provided assurance that CAMHS services will now be open to referrals for all children up to their 18th birthday, while work remains ongoing to re-design the broader service model. This model will be based on an early intervention principle to prevent escalation to higher tier services. BSCB has also received assurance from the relevant board that looked after children will be considered as a specific group within local suicide prevention strategies, while the findings of the review have been shared with public health colleagues who are responsible for physical measures to reduce the risk of suicide. Finally, training and materials will be made available to professionals working with children at risk of suicide.

Undertaking four serious case reviews within a relatively short timeframe has been a significant undertaking and BSCB would like to express its gratitude to panel members and particularly family members and practitioners who have made valuable contributions to the review processes.

Multi-agency learning panels

In order to preserve the anonymity of the children involved, MALP reports are not published, although action plans are agreed and delivered in the same manner as for SCR. Learning is disseminated to professionals through the publication of practitioner briefings and the inclusion of findings within the programmes of Serious Case Review Workshops. MALP during the review period were used to support the challenge to commissioners in respect of CAMHS provision noted under the Child CB SCR, resulted in the provision of guidance for schools dealing with sexting and were used to inform the development of the MASH.

Child Death Overview Panel

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

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

There were 7 deaths of children ordinarily resident in Blackpool during year to 31st March 2019 (2018: 11). CDOP reviewed 13 deaths, with 7 completed within a year of the death and the remainder taking longer than a year (a CDOP review occurs after all other legal and review processes are completed, so can be subject to lengthy delays).

Of the 13 deaths reviewed:

- 8 were male and 5 female
- 9 were aged under one year of which 5 were under four weeks old
- 5 were expected (predictable 24 hours prior to death)
- 5 were recorded as peri-natal/neo-natal events, the most commonly recorded category (in 2017/18 it had been chromosomal, genetic and congenital anomalies)
- 8 were deemed to have modifiable factors (circumstances that, if changed, would reduce the risk of future child deaths in similar circumstances), of which substance misuse and domestic abuse were the most common

The weakness of data derived from CDOP is that the number of deaths considered (even pan-Lancashire only 111 (2018: 128) were considered in year) is statistically insignificant. Consequently, while a review of an individual case may cast a light on risk factors or service provision, extreme caution has to be utilised in the drawing of general conclusions. This can be overcome by larger scale analysis and thematic reviews. During the reporting period research was completed into the prevalence of Adverse Childhood Experiences (ACEs) amongst the cohort of 489 children reviewed by CDOP between 2012 and 2016. Of this cohort 20% were found to have four or more ACEs, which is a higher proportion than amongst the general population. Amongst the older group of children (12-17 years) this proportion was higher still. This research consequently raises the challenge to consider the role that ACEs might play in a child's life, how awareness of the issue can be raised and how ACEs can be prevented and mitigated against. In order to continue to develop our understanding of this issue CDOP now routinely collects data in respect of ACEs for all deaths that it reviews. During the reporting period CDOP has also completed thematic reviews of all deaths from 2008 categorised as either being the result of trauma and other external factors, and infection.

The Children and Social Work Act 2017 disaggregated the Child Death Overview Panel from future multi-agency safeguarding arrangements. It is now the responsibility of the local authority and clinical commissioning group, under the overview of the Department of Health, to make child death review arrangements. In addition to the CDOP process, these also include the initial response, investigation and review of a child's death. The current pan-Lancashire CDOP arrangements will remain in place for 2019-20 as part of the new safeguarding partnership. The longer term aspiration is for CDOP to come under the governance of the Health and Wellbeing Board, with appropriate links maintained to the safeguarding partnership to ensure that relevant learning is shared.

Audit activity

When a specific issue is identified by review, data analysis or inspection regimes and it is agreed that further information is needed to fully understand its implications, BSCB will undertake an audit of practice to inform its next steps. These are undertaken by our Multi-Agency Audit Group which meets on a quarterly basis, with one additional audit during the reporting period having been completed by the BSCB Business Manager. In recent years our audit processes have been influenced by the requirement of Joint Targeted Area Inspections for partnerships to evaluate a small number of cases within a five day period. We have consequently implemented a standard process and audit tool by which we aim to focus on the outcomes for children of multi-agency interventions.

Domestic Abuse

This was a follow up audit to one undertaken on the same topic in 2016, to assess whether practice and service provision had improved in the intervening period. The audit considered five children who were subject to child protection plans on the grounds of domestic abuse and found good practice in terms of timely referrals, multi-agency information sharing and participation in child protection conferences. There was additionally evidence of the provision of a wide ranging service offer for victims, perpetrators and children living with domestic abuse. Areas for improvement were noted to be the involvement of adult facing organisations (in this case probation and mental health providers) in child protection processes from the outset, the need for child protection plans to meet specific risks to individual children, including specific contingency plans, the need to engage General Practitioners in child protection processes and for safeguarding supervision to be available to school based professionals. Since this audit the CCG have started a General Practitioners' safeguarding forum to develop their practice and the Blackpool Council schools' safeguarding advisor has put arrangements in place to ensure that supervision is available to school based professionals.

Child Exploitation

This audit was commissioned to provide a baseline position in respect of child criminal exploitation, as BSCB partner agencies developed their response to an increasingly prominent issue. The audit sample, of five children subject to child protection plan, was taken from the Awaken team's caseload, however the first point of learning identified was that there were no cases of child criminal exploitation being held (this was in August 2018). The audit consequently considered four cases of child sexual exploitation and one child involved in card-tricking, which was agreed by the audit group not to amount to criminal exploitation. Good practice was noted in terms of joined up multi-agency working, the long term involvement of one key professional with whom the child had a trusted relationship, a school's 'handle with care' process for vulnerable pupils and the use of disruption activity. The audit however, identified significant areas for improvement in terms of attendance at multi-agency meetings (five out of eleven strategy meetings were not compliant with expectations and two out of ten child protection conferences were inquorate), the quality of child protection plans, responses to children missing from home and the use of the CSE screening tool. More broadly the audit raised the issue as to whether child protection plans are the most appropriate vehicle to address risks to older children outside the family home. Broader changes made to practice and service provision in respect of child exploitation, which address many of these issues, are recorded below.

Transience

The response to children moving into Blackpool in need of safeguarding was raised by the Child CA SCR, noted above, and this audit was commissioned to provide a broader window on practice in this respect. The audit reviewed the effectiveness of the transfer process for the child protection plans of ten children who moved to Blackpool. Overall practice in this area was stronger than in other recent audits, with nine of the ten cases judged to have been transferred safely. Good practice was identified in the use of strategy meetings to share information with multi-agency partners following receipt of a transfer request (this is not required by Working Together) and pro-active work by the health visiting service to work with families who were not registered with a GP. The average length of time from transfer request to child protection conference was 23 days, against a statutory expectation of 15, although it was noted that conferences were often delayed to allow external social workers to attend. The greatest area of concern arising from this audit was the provision of services to children in Blackpool who remain subject to a child protection plan in the originating area (which can be for a period of up to three months, if they are living in temporary accommodation). The Safeguarding, Quality and Review service have consequently undertaken to review practices in this respect.

Unborn children

The safeguarding of unborn children has been an area of concern for BSCB since the completion of the Child BW SCR in early 2017. This prompted a MAAG audit in June 2017 that identified significant areas for improvement, while the Child CA and Child BZ SCR, reported above, reflect practice in early 2017 and also identified significant shortcomings in this area. In the intervening period, the Pan-Lancashire Pre-Birth Protocol was updated and children's social care introduced a more detailed internal protocol. This audit, in March 2019, therefore aimed to identify if practice in this area had improved. The audit considered five cases of unborn children who had been made subject to child protection plans in the autumn of 2018 and the findings, on the whole, were disappointing with many issues from the previous audit remaining. That said, improvements were noted in terms of the timeliness of referrals, multi-agency involvement in strategy meetings, completion of birth plans and the use of discharge planning meetings. Concerns remain in terms of full adherence to the pre-birth protocol particularly in terms of the timeliness of both pre-birth and review child protection conferences, and in the home visit by the named social worker following discharge.

The area of greatest concern was the quality of children's social care assessments, which was not assisted by the use of a generic assessment form. These were not seen to be timely or multi-agency (to the extent that specialist parenting assessments were often not completed at the time of birth) and lacked cumulative assessments of historical factors, often resulting in overly optimistic conclusions. The cases reviewed were of children facing significant risks but none contained twin track plans for permanence with alternative carers or had contingencies, which is particularly important given that births will typically be out of hours. Finally, the audit also raised a broader question as to how universally available provision, such as the NSPCC's Baby Steps programme and the Family Nurse Partnership should be utilised as part of child protection plans.

Multi-agency referral forms

MAAG members audited 25 Multi-Agency Referral Forms submitted to children's social care for a statutory safeguarding response in May 2019. All except one of the referrals was found to have been appropriate and all bar three were timely. This provides some confidence that the multi-agency practitioners are able to make appropriate judgements based on the CON. The quality of referrals was, however found to be variable. Demographic information was missing in around half of cases and forms tended to lack historical information and a cumulative assessment of the risk of significant harm and needs. Some referrals tended to hand over responsibility for safety planning actions that should have been put in place prior to referral. MAAG members concluded that some of the identified weaknesses stemmed from the structure of the form, which contains limited prompts to provide this level of information and analysis. At the time of writing, the BSCB response to this audit has yet to be finalised.

Child Protection Conference and Core Group functioning

This audit was requested by the BSCB in January 2018, as a follow up to a review of the Safeguarding, Quality and Review service's annual report and was completed as a paper exercise by the BSCB Business Manager. The audit reviewed attendance at conferences and found that this tended to tail off between initial and review conferences. The greatest gap in attendance was found to be from General Practice, which the Clinical Commissioning Group is working to address. Understanding the views of the involved children is crucial to the effective operation of conferences and, in Blackpool, this is achieved through asking them to complete conference packs beforehand. This was only done in 13% of expected conferences, which is significantly below what we would want to see. The overall average attendance at core groups was 67%, which is considerably below expectations and Board members were asked to review their agency's practice in this respect. Child protection plans were not seen to be sufficiently dynamic, with many not being updated during the nine month period reviewed on each case, despite obvious changes in circumstances being recorded in the minutes.

Multi-professional discussion forums

In order to test whether the findings of multi-agency audits are representative of wider practice, BSCB has introduced multi-professional discussion forums (MPDF) as a means of bringing together groups of frontline practitioners to discuss their experience of the topic. During the reporting period MPDF were held in respect of domestic abuse, child exploitation, transience and safeguarding unborn children.

The first two MPDF, in respect of domestic abuse and child exploitation, highlighted differences in the maturity of the multi-agency response to the two issues. While practitioners were well versed and confident in their ability to identify and respond to domestic abuse and child sexual exploitation, they were aware of gaps in their knowledge about child criminal exploitation. Similarly, there was a well recognised service offer for the former two issues, but none known for the latter. This MPDF pre-dated the work outlined below to develop the Blackpool response to child criminal exploitation, which has addressed the identified lack of pathways and training.

A MPDF on the topic of transience confirmed the audit findings that professionals are well used to dealing with children moving to Blackpool, but also emphasised the amount of time that this takes to request information and, equally, when a child leaves Blackpool to find where they have gone. A particular issue for schools was raised in that they cannot request information from the transferring school until a child is on roll, by which time they may have missed a child protection conference. The Pupil Welfare Service have consequently agreed to attend conferences for children who have moved to Blackpool, but who are not on a school roll.

The MPDF on safeguarding unborn children, revealed a considerable degree of frustration at the delays in safeguarding processes evident in the audit. These were reported to cause practical difficulties for health practitioners who needed to plan for births and equally placed parents under unnecessary pressure when they have concerns as to whether they would be able to keep their baby. Recently introduced monthly meetings between children's social care and midwifery to review risky cases were welcomed, and the suggestion made that they should be expanded to become genuinely multi-agency.

Training

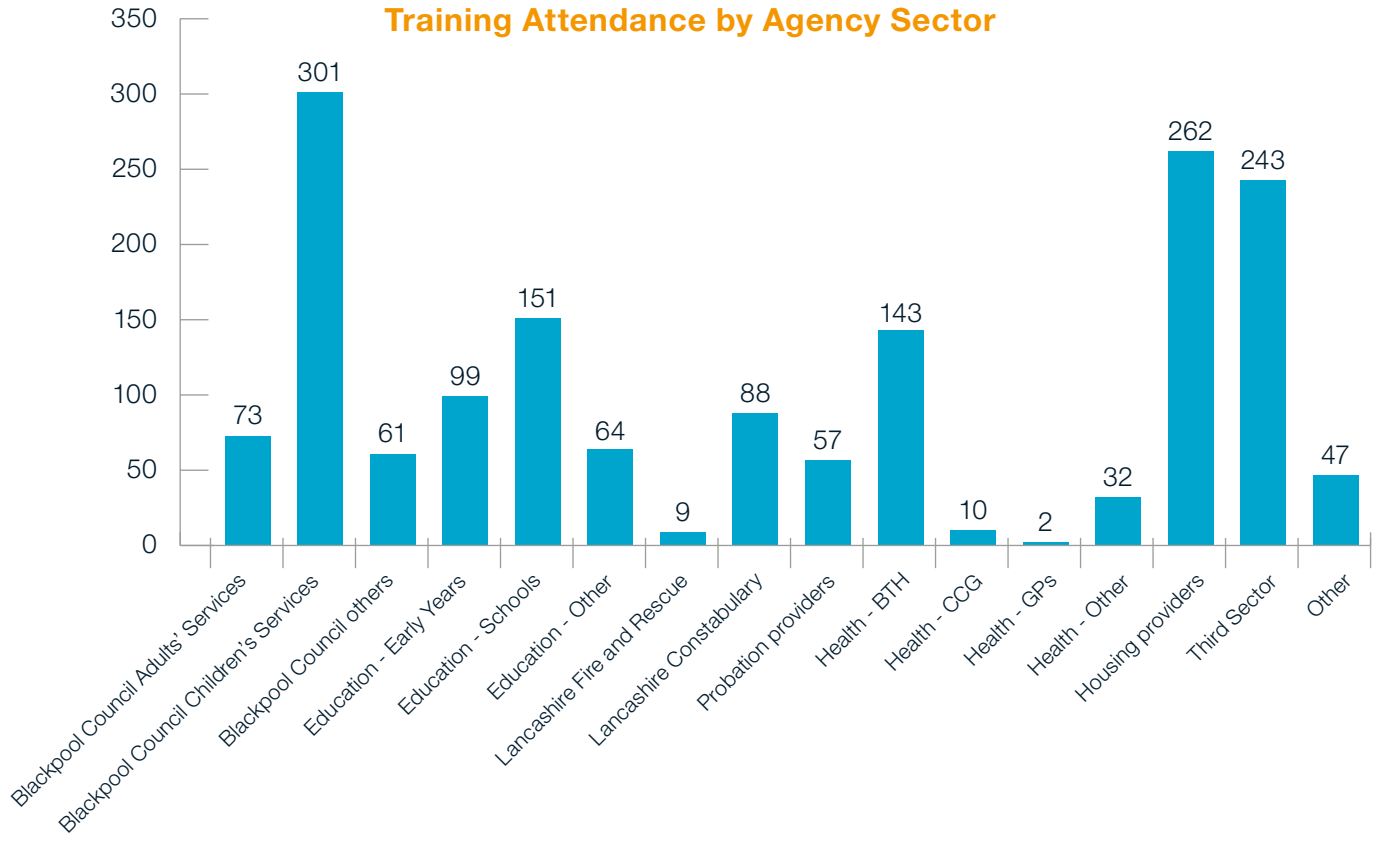
Working Together requires LSCBs to monitor and evaluate the effectiveness of training. Like most other Boards, BSCB also chooses to deliver its own training as a means of ensuring the availability of good quality, multi-agency training. This training offer forms the crucial final link in the Learning and Improvement Framework, by which improvement in practice is promoted.

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

Our overall training programme continues to evolve to reflect changing local and national priorities, emerging safeguarding issues and learning from review activity. Review activity has resulted in our reshaping our domestic abuse training, to include courses on the impact of domestic abuse on children, coercive and controlling behaviour and 'hidden men', while the more general findings of reviews are covered in Serious Case Review Workshops.

We have delivered a range of new courses covering intra-familial child sexual abuse and child criminal exploitation to reflect issues that have gained national prominence, together with more specialist topics such as harmful sexual behaviour and teenagers and pornography. Finally, we introduced 'The Blackpool Way', which is an overarching course covering our early help processes, and the resilient therapy and risk sensible models. By bringing together these fundamental ways of working in one course professionals, who are either new to role or new to Blackpool, are provided with the building blocks of how agencies in Blackpool work together to safeguard children.

During the 12 months to 31st March we delivered training to 1,642 professionals on 96 courses (this omits attendance at courses with solely safeguarding adults content). This represents slight decrease from 1,805 attendees at 105 courses in 2017-18, which largely reflects a period during the autumn of 2018 when attendance was markedly down. Training and Communications subgroup members were asked to review attendance within their individual agencies and improvements were noted over the final months of the period. A breakdown of training attendance by sector is provided below. Direct year on year comparisons are not included due to changes in our recording processes, although it can be said that the greatest increase in attendance came from Blackpool Council Children's and Adults' Services, while the greatest decrease came from the health sector.



Our training programme does continue to operate some way below capacity. The vast majority of courses have a notional capacity of 25 attendees. During the year to 31st March 2019 they were attended by an average of 17.1 delegates (2018: 17.2). This shortfall in attendance tends to occur between booking and attendance: courses have an average of 25.2 places booked on them, however 23.9% (2018: 16.3%) cancelled prior to the day and 2.2% (2018: 6.2%) failed to attend on the day. Delegates who failed to attend on the day are charged in accordance with our agreed policy. This clearly represents a significant under use of resources and will need to be considered under future partnership arrangements.

This reporting period was the first full year in which we used our electronic training evaluations process. This enables us to collect pre- and post-course feedback from attendees, which is then used to provide feedback to our trainers and to inform the delivery and development of future training. By asking attendees to rate their skills and confidence prior to and after a training course we are able to capture whether a course is likely to impact on an attendees' practice and to review those that are less successful. We have also attempted to evidence the impact of our training on practice and ultimately children and families in Blackpool through telephone interviews with attendees and their managers a number of weeks after attendance at selected courses, although this work remains in development.

The successor arrangements to BSCB, outlined in Chapter 1 above, provide an opportunity for a fundamental review of our training offer. By bringing together the training resources from three areas, it will be possible to share expertise and reduce duplication to develop a programme that will be fundamentally the same across the area, allowing for a small number of courses that reflect local needs and practices where necessary. It will be critical to the success of this offer that we start by fully understanding the training needs of our partner agencies across the area and ultimately that we are able to evidence the impact of our training on practice and, more importantly, the children and families with whom practitioners work.

Awareness raising

In addition to our training offer, BSCB seeks to develop public and practitioner awareness of safeguarding topics. We base awareness raising activities on evidenced needs from our learning activities and, wherever possible, work in conjunction with our colleagues in Blackburn with Darwen and Lancashire. During the reporting period we have:

- Started to regularly publish seven minute briefings on specific topics, including on child sexual abuse in the family environment and the pre-birth protocol
- Published practitioner briefings for all our serious case reviews and the majority of our multi-agency learning panels
- Delivered a safer sleep campaign aimed at grandparents, launched in the local media and with materials available in libraries and other public buildings
- Provided safer sleep materials to 376 pharmacies
- Supported Blackpool and the Fylde College to deliver the Bystander programme that provides participants with the skills to intervene in situations of domestic or sexual violence
- Continued to support with White Ribbon campaign to tackle violence against women and girls
- In response to a number of SCR across the three LSCB in which babies have been shaken, launched the I-CON campaign aimed at providing parents with the means to manage crying
- Held a domestic abuse conference to promote findings of serious case reviews, domestic homicide reviews and serious adult reviews and to support the launch of Operation Encompass

Understand the impact of multi-agency safeguarding activity on children and families

Understanding whether the work of BSCB and our multi-agency partners makes any difference to the lives of children and families in Blackpool is both the most important and most challenging aspect of our work. To develop this work BSCB has established links with the Head Start Young People's Engagement Group (YPEG). Head Start is a Big Lottery funded project to improve the resilience of 11 to 16 year olds in Blackpool and is based on the principle of co-production with children. YPEG is therefore a forum for ideas to be tested and developed alongside the children for whom they are intended. During the reporting period BSCB members have attended YPEG and YPEG members have attended BSCB to develop our understanding of the experiences of children growing up in Blackpool, whether and where they feel safe. While the majority of areas that gave YPEG members cause for concern, e.g. public transport and large scale events, fall outside BSCB's formal remit this did provide the opportunity to feedback to the responsible bodies. There is clearly much more work that could and should be done to understand the experiences of the wider child population and specifically those who need help and protection. To this end, the published arrangements for the safeguarding partnership include strengthened arrangements to ensure that children are consulted with both in the development of these arrangements and in the ongoing work.

Children in the care of the local authority have their own forum, Just Uz. This provides a means for our children to spend time together, for peer support and to have a collective voice to their corporate parents. During the reporting period Just Uz has provided a language guide for practitioners, which BSCB has promoted amongst its multi-agency partners. Most significantly, this has led to a move away from the use of the term "Looked After Children" to "our children", thereby emphasising the responsibility of all professionals for their care. Other changes reflect a move away from the formal language of "placement" to "home", "siblings" to "brothers" or "sisters", and "contact" to "going to see mum". These changes are supported in all our documents and throughout our training offer.

Develop the multi-agency response to all forms of exploitation

Child exploitation has been a significant area of activity for BSCB, with a decision taken by the Strategic Board shortly before the start of the reporting period to deliver a consistent strategic and operational response to all forms of exploitation, building on existing CSE work. The CSE subgroup was consequently rebranded the Vulnerable Missing, Exploited and Trafficked (VMET) subgroup and a new operational action plan for 2018-2020 agreed to deliver the new agenda.

The operational response to child exploitation in Blackpool continues to be provided by the multi-agency Awaken team. During the autumn period the team's remit was formally expanded to encompass all forms of exploitation, together with trafficking, modern day slavery, honour based violence, forced marriage, female genital mutilation and radicalisation. As a consequence of these changes, the team's caseload increased from 40 in November 2018 to 91 on the 31st March 2019. The widened remit may be responsible for a change in the profile of children open to the team with the proportion of boys having increased from 33% to 48%, although the most common age range remains 13-15. At the year end the Awaken team was constituted of 8 practitioners from Children's Services, 12 Police officers, 1.5 FTE health practitioners, an education worker and licensing officer (representing an in year increase of 8 professionals to manage the team's expanded remit). All children have a key worker who is the practitioner most able to effectively engage with them (with those requiring a statutory intervention always having a named social worker as well). The Awaken team also acts as a resource for Children's Services more widely and is able to co-work cases and provide advice to practitioners from other teams.

Our understanding of child criminal exploitation is developing and will be enhanced by the completion of a full problem profile by Lancashire Constabulary later this year. In the meantime, our knowledge is derived from the Awaken team who continue to report that there is no evidence of organised or group CSE in Blackpool, with the only evident links being through victims' own associations. Police colleagues advise that there is evidence of county lines type drug supply in Blackpool in which drug suppliers from metropolitan areas use children to supply drugs in smaller towns. Similarly, a significant number of children have been identified as victims of criminal exploitation within Blackpool, including being found in cannabis farms. Referrals as a consequence of town centre anti-social behaviour, including involvement in card tricking, have decreased, although links to criminal exploitation remain uncertain. The effectiveness of our response to child exploitation is monitored by the VMET subgroup, which receives a quarterly performance dataset, while the Multi-Agency Audit Group audit, reported above, provided a qualitative analysis of our response.

The primary means by which the partnership response to criminal exploitation has been developed is through the agreement of a multi-agency Child Exploitation pathway, protocol and screening tool, which is underpinned by a specialist assessment tool used by the Awaken team. The screening tool is embedded within the Multi-Agency Referral Form used for referrals to the Children's Services front door. The pathway has introduced Children, Missing, Exploited and Trafficked (CMET) meetings that are held in the Awaken team on a monthly basis and used to collate multi-agency information to complete the specialist assessment tool and to put in place a plan around the child. Where the risks to the child are entirely outside the home environment, with no evidence of compromised parenting, the CMET plan will forestall the need for a child protection plan. At the end of the reporting period work was underway to agree shared principles, screening and assessment tools with colleagues in Blackburn with Darwen and Lancashire to ensure that children receive a consistent approach across a wider area.

The new Child Exploitation Pathway was launched by the BSCB Independent Chair and senior managers from the Awaken team to a multi-agency audience of approximately 250 practitioners in March 2019. A separate event was held for residential settings in Blackpool, while its ongoing roll out is supported through a re-written child exploitation training package.

Broader awareness raising work has continued throughout the year and included a three day campaign by Awaken and BSCB practitioners centred on the promenade in July 2018. As well as raising awareness of exploitation amongst the public and local businesses, the campaign provided a means of gathering intelligence about risks to children in the area. Having provided CSE awareness training to all taxi drivers three years ago and to those obtaining a new licence since, a general safeguarding refresher, including criminal exploitation was in the process of being delivered to all drivers at the end of the reporting period. The Awaken education worker continues to provide assemblies and other input to primary and secondary schools on an annual basis, meaning that all children will receive age appropriate interventions on online safety, sexting and CSE prior to leaving secondary school. Finally, to support the expansion of the Awaken team's remit, BSCB held four child criminal exploitation briefings and supported a pan-Lancashire child exploitation conference hosted by the Office of the Police and Crime Commissioner.

Children missing from home, care and education

Children missing from home, care or education are vulnerable at that time, quite simply because those responsible for their care are unable to ensure that they are safe. A correlation between missing children and CSE has been a feature of previously reported audits and case reviews, and might be reasonably expected to extend to criminal exploitation. As corporate parents, Blackpool Council are particularly anxious to address the over-representation of the already vulnerable group of children in its care amongst those who go missing (although this may, in part, reflect a greater willingness on the part of residential homes and foster carers, over parents to report children as missing).

The multi-agency response to children missing from home and care (MFH) has been incorporated within the local and pan-Lancashire structure for CSE for a number of years. Operationally, children who are considered particularly vulnerable as a consequence of repeated MFH episodes are discussed at CMET meetings. Children who are missing from education are reviewed by the Blackpool Education Registration and Admissions (BERA) panel, although further work is required to ensure that information is shared between these forums, particularly in light of the high proportion of Awaken cases who are either not in mainstream education, or not in education, training or employment.

During the year ended 31st March 2019 an average of 67 children, not currently open to children's social care (CSC), were reported as missing from home each quarter, while an average of 76 children open to CSC were reported as missing. Given the small proportion of the overall population open to CSC, this reflects the increased vulnerability of this cohort, but also the previously cited greater willingness of foster carers and residential settings to report as child as missing. Each individual child may have one or more missing episodes within a quarter and there were an average of 94 individual missing episodes for children not currently open to CSC each quarter and 240 for children open to CSC. This equates to an average of 1.4 episodes for children not open to CSC and 3.2 for those who are, which would be expected given the greater vulnerability of the cohort open to CSC and the increasing likelihood that a child who is repeatedly missing will become open to CSC. Similarly, there were an average of seven children open to CSC who were reported missing on nine or more occasions each quarter, while only one child not open to CSC was reported missing on nine or more occasions in a quarter throughout the entire year. There are no obvious longer term trends in either the number of children going missing or missing episodes, which can fluctuate widely on a quarterly basis.

Operationally, understanding why children go missing is critical to protecting them individually and responding to broader threats. All children who go missing are expected to be offered an independent return home interview within 72 hours of their return. In Blackpool these are undertaken by the relevant social work teams for children open to CSC, or by Awaken for those who are not. Over the summer of 2019, all will be brought within the Awaken team to concentrate expertise and allow intelligence from interviews to be pooled. The completion rate for return home interviews has been a longstanding concern for BSCB and continues to remain well below expected levels, averaging 41% for children open to CSC and 37% for those who were not during the year to 31st March 2019 (a further 23% and 29%, respectively, were completed outside the 72 hour window). Similarly, Lancashire Constabulary remain unable to provide evidence as to whether the safe and well checks, which are expected on a child's immediate return, are completed. The Ofsted inspection report also noted that weaknesses in this process limit the ability of the partnership to respond to emerging patterns and trends. It is critical that the successor arrangements to BSCB hold partners to account for improvements in this critical area.

The overall response to missing children has been complicated by a College of Policing recommendation that the absent category should be scrapped, which has not been followed by a Department for Education guidance for local authorities. Currently, a child may be classed as absent when they are not where they are expected to be, but there is insufficient evidence that they are actually missing. There is no requirement for a return home interview, in these circumstances. Consequently, any decision to remove the absent category would carry with it an increased workload for the Awaken team. In the continued absence of statutory guidance for local authorities, Lancashire Constabulary, with the agreement of multi-agency partners has determined to move toward the removal of the absent category and, over the summer of 2019, is piloting a revised response in its call centres to children reported missing, to ensure that they are correctly categorised. Once agreed, these changes will be incorporated in a revised missing from home protocol that will be published by the safeguarding partners

OUR PARTNERS' ACTIVITIES

After a number of years in which the BSCB Business Unit collated performance information and maintained its own multi-agency dataset (albeit heavily skewed toward local authority data), our Strategic Board took a decision in early 2018 to introduce a Quality Assurance and Performance Monitoring (QAPM) framework. This requires our partner agencies to submit a six monthly return in which they are asked:

- to provide the data and performance indicators by which they measure their work to safeguard and promote the welfare of children
- to provide a narrative explanation of this with particular reference to demand and business continuity risks
- to summarise quality assurance activity and how learning, including from SCR, has been implemented
- to evidence how the above activities have improved outcomes for children

QAPM returns are scrutinised by our QAPM subgroup, who will typically raise a number of queries that can either be immediately addressed, or result in changes to how future returns are completed. It would be fair to say that the introduction of the process, for which two returns have now been requested, has proved a challenge for some agencies, particularly those whose core business is not safeguarding and who have not previously routinely collected safeguarding data. It was therefore encouraging to see a marked improvement in the level of data submitted in the latter returns by some agencies. It is envisaged that, in the longer, term these returns will be able to provide a picture of system-wide demand and pressures, together with evidence of the effectiveness of work to safeguard and promote the welfare of children. The following provides an overview of returns received during the reporting period:

Blackpool Coastal Housing

In addition to managing the former local authority housing stock, Blackpool Coastal Housing (BCH) also provide emergency hostel accommodation for families and single 16 to 18 year olds, together with the Positive Transitions service for looked after children and care leavers. They have trained all their repair operatives to recognise and report safeguarding concerns, while their Neighbourhood Teams ensure that families receive early help, with a focus on enabling families to maintain their tenancies. Typically, there will be around 20 children of families receiving emergency hostel accommodation at Level 2 or above on the CON, while most or all of the six, or so, single 16-18 year olds will be open to CSC. Approximately 38 looked after children and care leavers receive support from the Positive Transitions service, some of whom have their own children. This service supports children to obtain and manage a tenancy, providing practical support for as long as they request it. Having started to record data about early help and safeguarding interventions, BCH are now able to recognise increasing demand on their teams. They have also recorded increasing demand for their emergency accommodation for families, with the hostel occupancy rate having increased from 65.9% in 2016/17 to 87.2% in 2018/19.

BCH require all their staff who enter residents' homes to complete safeguarding training, while those in specialist roles regularly access BSCB training.

Blackpool Clinical Commissioning Group

Blackpool Clinical Commissioning Group is responsible for assuring the safeguarding arrangements for the services that it commissions, including those provided by Blackpool Teaching Hospitals NHS Foundation Trust (BTH), and primary care. Safeguarding audits of all services are required, while BTH submits a number of safeguarding performance indicators on a quarterly basis (see below). General themes from providers' safeguarding audits are access to safeguarding training required to meet changes to Intercollegiate Competencies, and continued compliance with Policy and Procedure updates. In turn, providers are supported to address these issues, including through referring them to the BSCB training programme. Blackpool CCG also employs designated safeguarding professionals who are available as a source of expertise to providers and to ensure the quality of practice. External scrutiny to Blackpool CCG is provided by NHS England and an independent external audit of safeguarding requirements has been commissioned. While Blackpool CCG currently commissions specialist safeguarding posts, for example Child Looked After and Youth Offending Team (YOT) nurses, these are moving to be commissioned on a Lancashire and south Cumbria Integrated Care System basis.

Blackpool CCG supports primary care providers through a quarterly safeguarding leads' forum, led by the Deputy Designated Nurse for Safeguarding. These provide a means of sharing good practice, raising awareness of specific topics and sharing learning from SCR. While its own staff group is small and not patient facing, all are required to complete safeguarding training, with compliance levels at the year end meeting expected requirements.

Blackpool Council Children's Services

The Director of Children's Services has statutory responsibility for the safety and education of all children resident in Blackpool. While the response to the Ofsted inspection outcome has dominated the final months of the reporting period, Blackpool Council has become increasingly able to evidence demand for and quality of services through its data and audit reporting (Children's Services data was included throughout Chapter 3, so will not be further covered here). During the reporting period Children's Services appointed a team of auditors who systematically audit both individual children's cases, together with overarching themes or areas of practice. From January 2019 all audits have been based on ten domains of practice: risk, being child centred, decision making, assessments, partnerships, plans, permanency, reviews, where the child lives, and whether help has been provided. Between January and June 2019, 428 full case audits were completed. Judgements are made against the Ofsted grade descriptors for each domain of practice and summarised findings reported to the Getting to Good Board, with partnership issues referred to BSCB. Recent findings have included the need for more timely completion of Early Help Assessments and subsequent interventions; greater partnership involvement in assessments, plans and reviews; together with a need for partners to share information with families, work with them and ensure that this is done with their full consent.

More generally, additional resources have been provided to Children's Services and these will be used to support a re-modelled Front Door that will support partner agencies to work with children and families at an early help level, while ensuring that those in need of statutory intervention receive it promptly and at an appropriate level. At the time of writing work remains ongoing to develop an overall model of practice that will be agreed by the partnership. This is being co-produced with children and families, both within and outside Children's Services to ensure that practitioners work alongside children and families to enable them to make sustainable changes that they own.

Blackpool Teaching Hospitals NHS Foundation Trust

BTH are the largest health provider in Blackpool and provide acute and community services, including midwifery, health visiting and Child and Adolescent Mental Health services. The BTH safeguarding team, in addition to providing representation to BSCB meetings, provide safeguarding advice and support to professionals throughout the organisation and to primary care providers. They identified neglect and child exploitation as their most significant themes in the latter two quarters of 2018/19. The safeguarding team also provide training and ensure that the findings of SCR are disseminated to the relevant departments. BTH are required to submit a number of safeguarding performance indicators to Blackpool CCG, which indicate both the scale of health safeguarding work, e.g. an average of 52 health assessments undertaken by the Awaken team practitioner per month, and compliance, e.g. all YOT health assessments have been completed. The primary performance issue noted by BTH is in the completion of initial and review health assessments for looked after children, which has dipped in the last year under expectations. This is subject on ongoing joint work with CSC, with identified reasons being no or late notification, children not being brought to appointments, changes of placement and practitioner capacity. This is an area in which BTH has previously performed well and BSCB will seek assurance that this issue is addressed.

As an employer of over 6,000 staff, maintaining compliance with expected safeguarding training is an ongoing task and one that has been identified within recent inspection reports as requiring improvement. At the 31st March 2019 compliance with all except Level 3 training was above 80%, while BTH practitioners regularly access and deliver training on the BSCB training programme.

Cumbria and Lancashire Community Rehabilitation Company

As a provider of adult probation services, CLCRC manages adults who may provide a direct risk to children, or who live with children who require safeguarding. Of their caseload in Blackpool 5.6% live, or have regular contact with, children subject to child protection plans (compared to 4.9% across their operating footprint), while 5.5% have been identified as presenting a direct risk to children. CLCRC deliver individual and group domestic abuse programmes to both their own supervisees and those under the supervision of the National Probation Service. During the six months to 31st March 2019 there were 8 completions of group based programmes and 18 of individual work. CLCRC require that cases with child safeguarding concerns are held by qualified probation officers. The greatest risk to their business delivery, identified in their recent inspection report, is the lack of qualified officers, which is being addressed through a newly introduced training programme. Routine case auditing includes a safeguarding element, which has found a need to improve the gathering of multi-agency information when completing the safeguarding element of their assessments, but that the delivery of safeguarding work was sufficiently co-ordinated.

Lancashire Care NHS Foundation Trust

Lancashire Care NHS Foundation Trust provides community and acute mental health services to adults in Blackpool, together with in-patient mental health beds for children (which are located outside Blackpool). The LCFT safeguarding team visit their adult in-patient facility in Blackpool, the Harbour, on a weekly basis to raise practitioner awareness of their safeguarding responsibilities. This targeted work may have influenced the slight increase in contacts that the team has received. LCFT are keen to increase the awareness of practitioners who work with adults of their responsibilities to safeguard children and representatives from the Harbour attended the BSCB Neglect consultation. As of June 2019 LCFT will attend Blackpool MARAC (Multi-Agency Risk Assessment Conference) meetings, thereby ensuring that they are sighted on safeguarding concerns in respect of the children of adults they work with. LCFT also provide the SUDC service which has been covered in Chapter 5, above.

LCFT's large staff group are all required to complete safeguarding children training and the compliance rate, at each level, was at over 80% at the end of March 2019. Having identified a need to improve supervision during their last section 11 audit, LCFT commissioned external training covering safeguarding, clinical and management supervision. A centralised recording system for supervision has also been introduced, addressing a long standing area of challenge by BSCB. LCFT produce internal briefings for their staff in respect of SCR, which ensure that areas of learning specific to their areas of work are highlighted.

Lancashire Constabulary

Lancashire Constabulary has fundamentally overhauled its approach to safeguarding children following an inspection in late 2017. This has involved an internal "Think Child" campaign to encourage all staff to consider children in every contact that they have with the public. They have provided child protection training, specific to local areas, to all operational uniform staff and introduced vulnerability coaches to act as a source of expertise for officers in their day to day work. As a consequence of the inspection they have undertaken a significant number of internal audits including of domestic abuse, missing from home, children in custody, neglect and physical abuse. Over time, these have demonstrated improved recording of the voice of the child, better quality investigations and more evidence of management oversight. Multi-agency findings have included the need to share MARAC information with primary care providers and to ensure that attendance at strategy meetings is compliant with expectations.

In response to the Child BZ SCR and HMICFRS findings, Lancashire Constabulary introduced a new system for recording strategy meetings and produced a good practice guide. A follow up audit found that strategy meetings were better recorded and being held as formal meetings, as opposed to informal conversations. The follow up HMICFRS inspection in December 2018 found cultural change at all levels that resulted in a prioritisation of child protection. It concluded that "Lancashire Constabulary has made good progress in implementing our previous recommendations and is now performing to a high level when it comes to protecting children from harm". A remaining area of challenge made by BSCB is the introduction of the new Connect computer system by Lancashire Constabulary. This has meant that no safeguarding data was available for this QAPM return. While assurance was provided that this will be resolved, in the meantime evidence of changes in demand cannot be provided or responded to.

Blackpool Council Public Health

The Blackpool Council Public Health team are responsible for commissioning public health services, including the health visiting offer (provided by BTH) and drug treatment services (provided by Blackpool Young People's Service for children and adults up to 25 and Horizon for those older). Providers are required to report specified safeguarding indicators as part of their routine contract monitoring. As has been the case with Horizon, the Public Health team will hold providers who have adverse inspection findings to account to ensure improvement. The safeguarding element of this report has also been afforded additional scrutiny through BSCB. A preventative approach has been taken in the forthcoming drug strategy for 2019-22, which will see universal drug and alcohol education, together with targeted provision for children at greater risk.

Public Health, in conjunction with Better Start, has commissioned an enhanced health visiting offer that provides eight visits to all children, together with more intensive support for those most in need. The new model provides a trauma informed approach, with routine enquiry about adverse childhood experiences built into early visits. While this model has been built with public health outcomes in mind, the increased contact with young families will also increase the ability of professionals to provide early help and prevent children from being harmed.

CONCLUSIONS

This is the 13th and final BSCB annual report and comes at the end of a 15 month period of considerable activity and challenge for the partnership. The foregoing report has highlighted the development of the partnership response to child exploitation; the adoption of a Child Protection Standards Pathway, to provide challenge prior to and throughout the duration of a child protection plan; the agreement of an Early Intervention Strategy and the early responses to this; and new and ongoing campaigns aimed at practitioners and the public. This work has been underpinned by our learning activity, with the existing programme of serious case reviews and audits expanded during the year to include multi-agency learning panels and multi-professional discussion forums.

These positives have, however to be balanced against the shortcomings found in the elements of the partnership's work to safeguard and promote the welfare of children both in BSCB's own audit and review activity and surfaced by a number of inspections that have been published during the reporting period. It is therefore critical that BSCB ensures a smooth transfer to its successor arrangements in the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership, and ensures that areas of challenge highlighted in this report remain to the forefront of the Partnership's activity.

APPENDIX A

Strategic Board members at the time of publication

BSCB	
Stephen Ashley	Independent Chair

Blackpool Council	
Cllr Graham Cain	Elected Member
Diane Booth	Director of Children's Services
Dr Arif Rajpura	Director of Public Health
Jeanette Richards	Assistant Director of Children's Services
Kara Haskayne	Head of Safeguarding and Principal Social Worker
Paul Turner	Head of School Improvement
Kate Barker	Early Years Improvement Officer

Blackpool Clinical Commissioning Group	
Lesley Anderson-Hadley	Chief Nurse
Diane Kinsella	Designated Nurse
Dr Nigel Laycock	Designated Doctor

NHS England	
Alison Cole	Deputy Director of Nursing

Blackpool Teaching Hospitals NHS Foundation Trust	
Peter Murphy	Interim Director of Nursing and Quality
Hazel Gregory	Head of Safeguarding

Lancashire Care NHS Foundation Trust	
Bridgett Welch	Associate Director of Nursing

Schools	
Amanda Wooldridge	Deputy Headteacher St John Vianney
Neill Oldham	Headteacher Highfurlong Special School
Wendy Casson	Headteacher Educational Diversity

Lancashire Constabulary	
Ian Whitehead	Detective Superintendent
Sheena Tattum	Superintendent Western Division

Blackpool Coastal Housing	
Stephen Dunstan	Director of Resources

Cafcass	
Jackie Couldridge	Service Manager

NSPCC	
Amanda Quirke	Service Manager

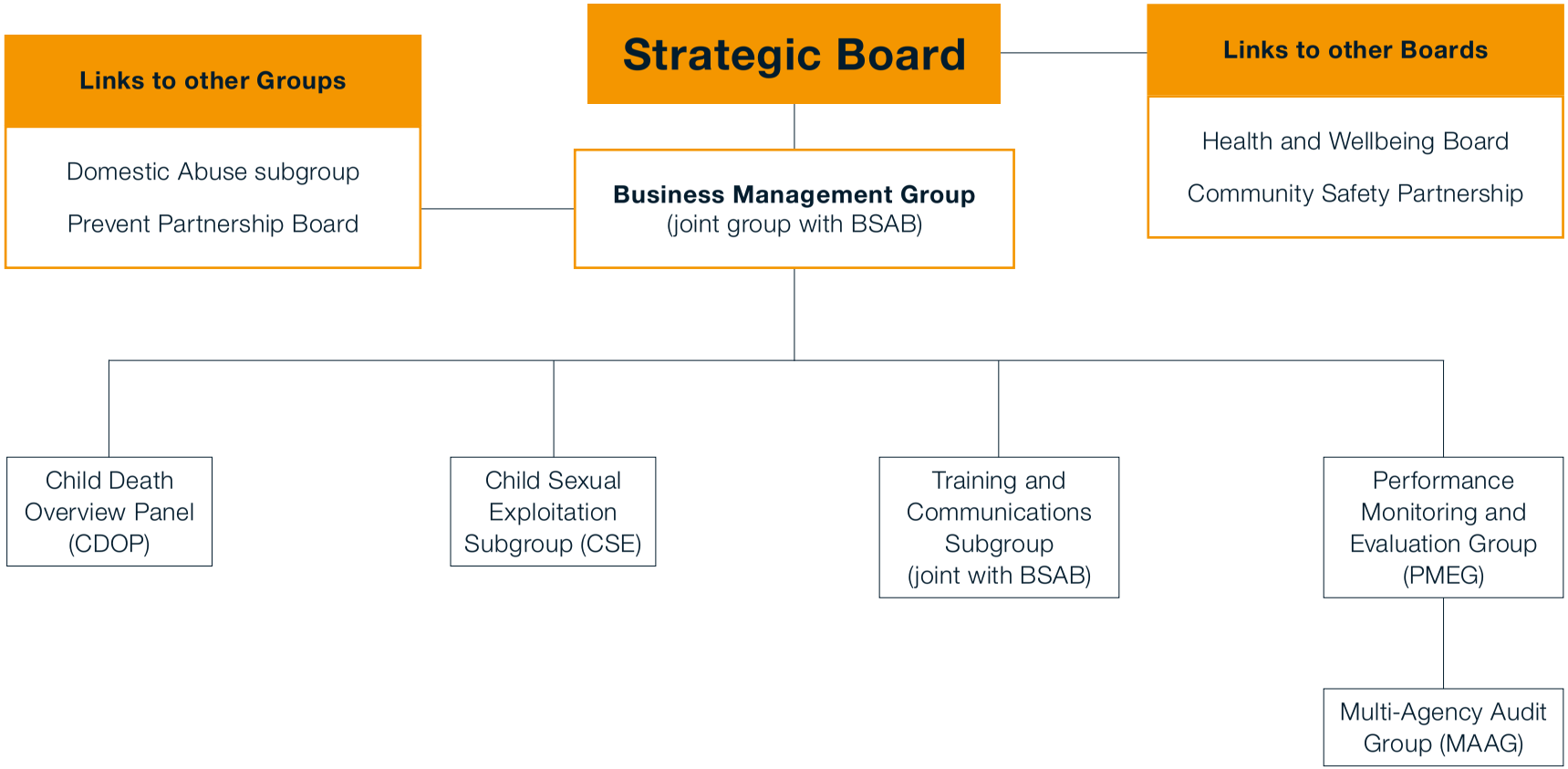
Cumbria and Lancashire Community Rehabilitation Company	
Elaine Seed	Deputy Director

National Probation Service	
Sonia Turner	Head of North West Lancashire

Third Sector representative	
Faye Atherton	Blackpool Carers Centre

APPENDIX B

BSCB Structure Chart



Glossary of acronyms

ACE	Adverse Childhood Experiences
BCH	Blackpool Coastal Housing
BMG	Business Management Group
BSAB	Blackpool Safeguarding Adults Board
BSCB	Blackpool Safeguarding Children Board
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
CAFA	Child and Family Assessment
CAMHS	Child and Adolescent Mental Health Service
CASHER	Child and Adolescent Support and Help Enhanced Response service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIN	Child in Need
CLCRC	Cumbria and Lancashire Community Rehabilitation Company
CMET	Child Missing, Exploited and Trafficked (meeting)
CON	Continuum of Need
CPP	Child Protection Plan
CSAP	Children's Safeguarding Assurance Partnership
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DA	Domestic Abuse
FTE	Full Time Equivalent
GCP2	Graded Care Profile 2
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
ICPC	Initial Child Protection Conference
LADO	Local Authority Designated Officer
LCFT	Lancashire Care NHS Foundation Trust
LIF	Learning and Improvement Framework
LSCB	Local Safeguarding Children Board
MAAG	Multi-Agency Audit Group

MALP	Multi-Agency Learning Panel
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MFH	Missing From Home
MPDF	Multi-Professional Discussion Forum
QAPM	Quality Assurance and Performance Management
SCR	Serious Case Review
SUDC	Sudden Unexpected Deaths in Childhood
VMET	Vulnerable, Missing, Exploited and Trafficked (subgroup)
YOT	Youth Offending Team
YPEG	Young People's Engagement Group

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