Liverpool Local Safeguarding Children Board

Annual Report 2013 – 2014

together we make a difference

Contents

Headlines: How Safe Are Children in Liverpool?

Most children in Liverpool grow up happily and safely in secure families and communities. Some, however, face significant challenges and risks. This report identifies some of the key issues.

There is a high and growing demand for child protection services

We see high levels of contact from professionals working with children and others who are concerned about their welfare. A high proportion of contacts do not lead to active social work intervention. This is not good. It shows that we need to get better in supporting families earlier, involving professionals from schools, health and social care to support children and families. An Early Help Service has been established to provide expert support and workers have also been placed in schools. This is a very positive development.

There is much excellent work done by professionals from different backgrounds working together to protect children. Very occasionally this does not happen well enough

The work of the LSCB in reviewing tragic incidents as well as our audit of cases shows the impact that neglect can have and what a difference effective action by public authorities in Liverpool makes. This is even more so when there is abuse. Where things went right there was clear, active, joined up action particularly between health, police and social care professionals. There was decisive support for families and intervention where necessary. Agencies have worked hard to learn lessons from this, by developing new guidance and running joint training. They audit the work with children. This provides the LSCB with re-assurance that practice is improving and that children are kept safer. In rare cases information is not shared effectively and action is not taken quickly enough. There have been significant changes and improvements made over the last year; in 2015 a Multi-Agency Safeguarding Hub will be established to help tackle this issue in relation to our most vulnerable children. This is a positive development which should lead to better coordinated support for children and families and therefore lower levels of risk. There now needs to be further development with full involvement from all services: health, police, education, the voluntary sector and social care. There are plans in place to do this.

Neglect of children is a very important issue in Liverpool

Neglect is a complex issue with many aspects. It may be associated with the use of alcohol in the family, with domestic violence or with mental health issues for both adults and children. Our evidence is that this is a problem in our community as around 40% of referrals to child protection services concern neglect. The council and other partners have several services in place to support families and children suffering neglect and to tackle underlying causes. There is a common Neglect Strategy which now needs to be fully implemented. It will need a concerted approach from health, housing, social care and other services to make an impact. The full involvement of, and contribution from the voluntary sector is vital. A good start has been made this year by the Council establishing an Early Help Service for families and a coordinated approach involving a wide range of professionals is now needed. We will work with Adult Services to make sure that there is joined up support for children where there is domestic abuse, metal health difficulty and substance misuse.

Children who have experienced the highest levels of risk of harm are protected effectively

The council takes into care a larger proportion of children at risk than many other areas and we see few instances of these children suffering further harm. A significant number of children are supported by a Child Protection Plan and here the picture is more mixed.

Support for children's mental health needs to be improved in Liverpool and this is being addressed

We have seen an increase in self-harm and some very tragic incidents of actual and attempted suicide. We also know that emotional abuse is the second highest cause of referral after neglect. More needs to be done to make sure that help is easily and quickly available.

Child Sexual Abuse is a national concern and is receiving increased attention locally

As with other parts of the country, increasing attention has been paid to child sexual exploitation. The understanding of partners about the extent and nature of this problem has increased but there is some way to go before we can be confident that we have a full picture. Work to raise awareness has been effective and this likely to lead to more reports. Working with other areas, we are implementing a Pan Merseyside Strategy for CSE. Agencies have put in place extra services both to support victims and to pursue offenders. It is likely that more may be needed as the scale of the issue becomes apparent. We are starting to work across the whole community, for example with hotels, taxis and other businesses to tackle the issue and there is much more to be done.

Some children are affected by criminal activity in their community

Most children in Liverpool are not directly affected by crime and fewer Liverpool children become offenders than in most similar areas. When they do come into contact with crime, however, we know that it leads to great vulnerability. Young people are the group in the community who are most likely to be victims and criminal behaviour around them can have a profound effect on their lives. Nationally, Barnardos have highlighted the risks to children where a parent is in custody. We will work with the Citysafe Partnership to address this issue.

This analysis has led the LSCB to identify the following six priorities for the work of the LSCB in the coming year:

- Neglect, especially linked to domestic abuse, use of drugs and alcohol and adult mental health issues
- Early help to families under stress
- Child sexual exploitation, especially linked to children who go missing
- Children's mental health
- Children affected by criminality
- The "front door" to child protection services and access to intensive support for children
- Understanding the full extent and nature of risks to children in Liverpool

Actions that will be taken to address these priorities are detailed in the Board's Annual Report and Business Plan.

Key Indicators

Referrals:
The level of referrals in Liverpool was high in the past year; significantly higher than the average for major cities. The proportion of these that, after assessment, needed action by social care services was low at 26%; the proportion leading to “no further action” was high at 30%. This issue led to concern amongst partners and has resulted in several very major changes. These include new Thresholds with Responding to Need Guidance and Levels of Need Framework. The LSCB will monitor the impact of these changes very carefully.

Child Protection Plans:
The use of Child Protection Plans is comparable with the England average and lower than most big cities. The number of Plans lasting more than 2 years has fallen significantly from 6% to 2%. This may be positive but we need to monitor carefully what happened to these children and whether further action was necessary later.

Children Looked After:
The number of children looked after has remained fairly stable at just over 1000. Very few are accommodated outside Merseyside and the outcomes for them are generally positive as compared with other, similar areas.

Youth Justice:
Liverpool continues to perform better than other major cities in relation to youth crime. The proportion of our young people becoming offenders is lower, as is the proportion offending repeatedly.

The great majority of children grow up in Liverpool leading happy, safe lives. Our concern is with the most vulnerable who do not. The key to making them safer is for the council, the health service, housing providers, schools, police and the voluntary sector to work together effectively. There are excellent examples of this being done, including by pooling resources. More will be put in place in the coming year.

Howard Cooper CBE
Independent Chair Liverpool Safeguarding Children Board

1. Independent Chair's Introduction

I am pleased to present the Annual Report of the Liverpool Safeguarding Children Board for 2013/14. Our report has adopted a new style this year which we hope is clearer, easier to read and makes the state of safeguarding in the city explicit. I would be very interested to hear your reaction to this report and to receive any suggestions as to how we might improve it further.

In last year's report my predecessor drew attention to the considerable amount of work that needed to be done to improve the Board's capacity to make sure that children are kept safe. She highlighted also several areas that partners needed to address. I agree fully with her comments. There is much still to be done but I believe that very significant progress has been made. This view was supported by OFSTED who reviewed the Board's effectiveness in June 2014. They found many areas of development where changes had been put in place which would lead to improvement but judged that it was too early to see the results of these changes. Inspectors found therefore that the work of the LSCB "Requires Improvement". Our Board accepts and shares this view. A number of recommendations were made, many building on the work that was under way, and these have been put in hand. They form part of our Business Plan for the coming year.

This year has seen some very significant developments in safeguarding in Liverpool which I believe will make a positive impact on children's lives. Partners have adopted a new framework to assess risk and to ensure that children receive the right support from the right agency at the right time. This will underpin the work of a new Multi-Agency Safeguarding Hub which will be launched in early 2015. There is a new strategy for providing early help to vulnerable children and families and a new approach to tackling neglect. Liverpool LSCB has agreed with other Boards across Merseyside a joint strategy to address child sexual exploitation and this is currently being implemented as a high priority. Few of these initiatives are yet complete and none is embedded in work across the city. All will feature as priorities in our work in 2015.

A key task for the Board will be to monitor the effectiveness with which partners implement the changes and to highlight any risks that might arise. We will do this through our improved approach to the scrutiny of the evidence of the impact of changes. We draw evidence most importantly from the testimony of children, young people and frontline professionals but also from performance data, from the audit of cases, from national studies and from detailed inquiry into serious incidents. We have initiated three Serious Case Reviews this year together with a thematic study where several young people were involved in serious criminality. In all these, our focus is to identify underlying causes and to make sure that changes are made to prevent recurrence. These lessons are incorporated into this report.

In 2003 Lord Laming wrote in his report into the tragic death of Victoria Climbie that safeguarding cannot be done by one profession acting alone; it is a task for all of us who live and work in the city, from all professions and from all agencies. This is embodied in the work of the Liverpool Safeguarding Children Board and I am enormously grateful to everyone who has contributed. Sadly we know that all our efforts can never be enough; there are still those whose acts or neglect will cause children harm. There is no more worthwhile enterprise than working together to keep our children safe

Howard Cooper CBE
Independent Chair Liverpool Safeguarding Children Board

2. Our Population and Services

Liverpool has a total population of 470,780. Approximately 88,911 children and young people under the age of 18 years live in the city. This is 19% of the total population in the area. Around 33% of the local authority's children are living in poverty whilst the national average is 20%. The proportion of children entitled to free school meals in primary schools is 29% against a national average of 18%. Within secondary schools the figure is 27% and can be compared to a national average of 15%.

Children and young people from minority ethnic groups account for 16% of all children living in the area, compared with 21% in the country as a whole. The largest minority ethnic groups of children and young people in the area are 'Asian or Asian British', 'Black or Black British' and 'Mixed'. The proportion of children and young people with English as an additional language in primary schools is 11% (national average 18%) and in secondary schools is 7% (national average14%).

Levels of deprivation in Liverpool are particularly high and many wards are ranked as being in the most deprived 1% to 10% nationally. Household income during 2012 was the second lowest of the eight core cities in England and fell by over £700 between 2011 and 2012. Almost 40% of households are living at or close to the poverty line. Child poverty is significantly higher than the national average, with approximately one in three children living in poverty, whereas the national figure is one in five.

82% of Liverpool Schools have been judged by OFSTED to be good or outstanding and attainment at the end of the Key Stage Four is above the national average. In school inspections, pupil safety and safeguarding are judged as at least good in the majority of cases.

3. The Work of Liverpool Safeguarding Children Board (LSCB)

The Liverpool Safeguarding Children Board (LSCB) is a statutory body that leads on keeping children safe in Liverpool. The LSCB is not a service but a collection of agencies that work together to put things in place to keep children safe. We help people who work with children to protect them. The LSCB must also continually check that what we do works. For example, we try to make sure that the procedures we publish are clear and help staff and volunteers know what to do when they are worried about a child, or that staff and volunteers receive the training they need to undertake their roles. We focused our attention and efforts on a range of agreed priorities and some of our achievements are detailed below.

OFSTED reviewed the work of the LSCB this year. They found that we are effective at focusing on the right areas. They saw evidence of many positive changes which should lead to improved safeguarding for children. They judged that it was too early, last June, to see the impact of these changes and so said that overall the LSCB requires further improvement to become good. This judgment matches the LSCBs own assessment of its stage of development. The Board is confident that it will make these improvements in the coming year.

PROGRESS AGAINST OUR STRATEGIC PRIORITIES

Priority 1: Strengthening Frontline Practice through Audit, Information Sharing and Earlier Intervention

- The Board has undertaken audits to examine the quality of the help that families received. This helped us to find areas that needed attention. We developed a better understanding of front line practice and identified the action needed to help families.

There is more work to be done to make audits focussed on those factors that make children particularly vulnerable. Our thematic audits this year will be designed to inform the new priorities that we have identified in our Business Plan. The first will be on Child Sexual Exploitation; this will be done in partnership with other LSCBs across Merseyside so that we get a full picture.

- We challenged organisations which work with children to improve their safeguarding arrangements. They did this through a self-assessment which we then scrutinised. We looked closely at the quality of practice in a number of areas. Each agency assessed themselves against an agreed set of standards and all achieved over 80% of the expected standards.

The LSCB will monitor the progress of each agency towards achieving 100% of the standards. Where organisations think that they already achieve 100%, we will challenge this to make sure that there is no complacency.

- Important data was examined that told the LSCB the story of safeguarding children in Liverpool. It helped LSCB members to understand which areas it needed to focus on and improve. These included child vulnerability, the impact of neglect on children and persistent absence from education. We also identified that more work was needed in order to reduce the numbers of children requiring a child protection plan for a second or subsequent time.

Our data still shows a significant number of children needing several protection plans. This is an urgent matter for attention. We also note that there is a high level of referral to child protection services from other professionals. This should reduce during the coming year as the Early Help Strategy is implemented and our new thresholds become widely understood. We will monitor this carefully to check if this happens and act if it does not. We will pay particular attention to children referred more than once.

- When a member of the public or a professional is concerned about a child, they contact Careline and decisions are made on whether a child needs help and protection. An external audit of the decisions made following this contact, highlighted that children and families were not always being responded to in the right way. Children's Services worked to improve this and we have seen a difference being made. A second audit showed that there were no cases of children left in unsafe circumstances. In May and June 2014, Ofsted inspected services for children in need of help and protection, children looked after and care leavers and were complimentary of Careline's practice. They commented that no decisions had left children unsafe.

These achievements are to be built on by the development of a Multi-Agency Safeguarding Hub (MASH) which we expect to be launched in January 2015. The Board will monitor these changes carefully to make sure that improvements follow. We should see the number of contacts reduce as Early Help becomes more effective. Merseyside Police will introduce a new screening system for referrals relating to domestic violence and we will monitor the impact of this change.

Priority 2: Strengthen the Voice of the Child and the Family in the Delivery of Services

- We looked at evidence on how to gather children and young people's perspectives about the help they need and the services that work with them. Training was then delivered to staff working with children to help them focus more on hear the voice of the child in their work.

We now need to co-ordinate these perspectives better to make sure that they influence all services.

Priority 3: Monitor the Effectiveness of Early Help Provision to ensure Early Identification of Children in Need

- The LSCB developed a multi-agency strategy to help all agencies give help to children and families earlier. We know that lots of families face problems and most of the parents and carers in these families only want what is best for their children. If we provide help sooner we can often prevent a problem from becoming a crisis. A lot of the work we are doing will help families ask for help when they need it and enable professionals to provide that help.

We now need to make sure that this strategy is implemented effectively and makes a difference. In particular, we need to be sure that all professions are involved in giving this help and, where appropriate, taking the lead.

Priority 4: Tackling Identified Safeguarding Issues: Child Sexual Exploitation / Neglect and Domestic Violence and Abuse

Child Sexual Exploitation

- The LSCB implemented a local action plan to tackle Child Sexual Exploitation (CSE) in line with a joint strategy agreed by nine LSCBs across Merseyside and Cheshire. This strategy was the first nationally, that brought two constabularies together to work more closely in this area and was commended by the Office for the Children's Commissioner. Liverpool Council invested in a new post to co-ordinate its strategic work to tackle CSE and children who go missing from home and care. This has already led to a range of initiatives and we can evidence that these have helped us to find children at risk of CSE and provide the right help to keep them safe.

- 'Chelsea's Choice', a drama production to highlight CSE, was seen by around 3000 staff who work with children and young people so that they are better equipped to recognise this type of abuse. A further 300 (approx.) who need a deeper understanding received CSE training. Social Care and Education told us that they were previously aware of a level of CSE but that recent LSCB training has lead them to recognise the significance and scale of the problem. This led directly to these staff reporting concerns about specific children.

Much work has been done in raising awareness amongst children and adults working with them. Significant progress has also been made in supporting victims and bringing offenders to justice. We have as a result seen an increase in the numbers of instances reported. More services will need to be commissioned to support these young people. As a matter of urgency, we will map the occurrence of CSE across Merseyside and use a common data set to make sure that we have a full picture of the situation. We will work together to make sure that offenders are brought to justice.

Neglect

- A strategy to tackle Neglect at all levels was developed and launched. We will monitor the impact of this during the forthcoming year. During the last year we embarked upon a large project to train staff right across the City to work with families where there is child neglect. The aim of this training is to give staff and volunteers the skills and the tools to recognise neglect, provide the right level of support and reduce the impact upon children in these households. A range of staff across a number of organisations have been trained as trainers in this area. They are training staff to use the neglect resources from the Department of Education.

Neglect remains a very big issue for Liverpool; it is by far the most common reason that people contact Careline, accounting for over 40% of contacts. We need to make sure that the strategy is implemented and is effective.

Domestic Violence and Abuse

- Domestic violence together with the use of alcohol and drugs adult metal health issues, are frequently associated with child neglect. To help front-line staff working with those who have experienced or may be experiencing domestic abuse, we developed guidance to help them understand the problem and how to help these families. For example, we promoted the introduction of Operation Encompass that brings together police and schools to support children who witness domestic abuse.

We need to make sure that we understand how this association operates and make sure that the impact on children is prominent in all professional's minds. We need to make sure that there are well co-ordinated services across all three issues where child protection is a high priority.

Priority 5: Making Sure that the Structure and Work of the Board is Fitted to Keep Children Safe

- The structure of the LSCB and membership of the sub-groups were reviewed and revised to enable the Board to carry out its responsibilities. As a result, the Board was better able to do the work it had decided was most important. Our focus was sharpened and the right people were involved; those who can make the right decisions and lead on the necessary changes. The LSCB worked with other groups to agree how they would work together and monitor each other's work. Our priorities are now better co-ordinated.

We now need to make sure that children's safety is at the heart of decisions on how money is spent in the city. We will do this through our links to those bodies who commission work, particularly the Children's Trust, the Citysafe Partnership and the Health and Wellbeing Board.

- A key issue during this year has been to make sure that we have the right policies in place to support children whatever their level of need. Government guidance, "Working Together to Safeguard Children", changed in 2013 and a major task for the Board was to revise our procedures in the light of this and of our understanding of the needs of Liverpool children. We have done this in a careful sequence:

Our first priority was to refresh our **Guidance on Need and Thresholds of Concern**. For most children, their families and the services they receive day to day, such as school and their GP, are enough to keep them safe and well but professionals must be alert to additional needs and risks. The LSCB developed clear guidance for professionals to help them identify the level of need for children who need help or protection. These levels of need and the guidance help professionals know how to apply them, were promoted across the entire children's workforce

and to those who work with parents and carers. Professionals are better able to recognise the level of support required by a child and their family. They have reported that they are more able to apply the appropriate threshold.

The **Responding to Need Guidance and Levels of Need Framework** document provides professionals with a common understanding of what the needs of vulnerable children might be and of what they should do when they see the signs. In order to help them, we developed,

- **The Single Assessment Protocol** to cut out duplication and confusion,
- **The Multi-Agency Referral Protocol** to make sure that all professionals act consistently,
- **Managing Individual Cases Guidance** to help professionals support our most vulnerable children.

We backed these up with a very large training programme.

There is more work to do to make sure that all those who work with children understand the thresholds and how to respond. We need to provide greater clarity for local practitioners of the differences between early help and children who need support because they are Children in Need. We need to make sure that colleagues from the voluntary sector are fully involved in this.

Our second priority was to provide other guidance linked to this and focussed on areas where we know that there are particular concerns in Liverpool. These included,

- **The Early Help Strategy** targeted at support for families where needs are emerging, at Level 2 and Level 3 in the Threshold document,
- **The Neglect Strategy** aimed at the most common cause of referrals in Liverpool, at Levels 2, 3 and 4 in the Threshold document,
- **The Pan-Merseyside CSE Strategy** focussed on this issue of key national concern at Level 4 in the Threshold document
- **The Missing Children Strategy** recognises that children who go missing from home, from care or from education are particularly vulnerable.

Making sure that this work is completed in 2015 is a major priority for the LSCB. It is linked to the project to establish a Multi-Agency Safeguarding Hub (MASH) which is described elsewhere in this report.

OUR NEW STRATEGIC PRIORITIES FOR 2015

We make our business planning process focused on outcomes for children. The evidence base underpinning the Priorities comes from six primary sources. These are,

- **Evidence from Data** relating to our context and performance
- **Evidence from the Audit of children's cases**, particularly in areas of critical risk
- **Evidence from** the experience of particular children subject to Serious Case Reviews and other Reviews
- **Evidence from children and young people** about their lived experience, priorities, worries and aspirations
- **Evidence from our frontline staff** across agencies about their observations of children's lives
- **Evidence of national and local priorities** derived from a strategic analysis of need

Priority 1: Neglect linked to:

- Domestic Abuse,
- Alcohol and Drug Use
- Low level adult mental health issues

Our Priority is to reduce the incidence of neglect in families and, where we discover it, to reduce the impact on children's lives. We know that over 40% of all referrals to child protection services relate to neglect and that these are often linked to the three factors listed. This has been illustrated by case reviews that we have conducted and by our audit of cases involving neglect. There are many responses to neglect and the LSCB believes that they need to be better coordinated. Health services have a key part to play and the extension of the Health Visiting Service gives an opportunity to develop this.

Key Actions

We will:

- Monitor the roll out of the Neglect Strategy and in particular the level of multi-agency engagement
- Scrutinise the indicators of neglect to determine whether it is having an impact
- Audit the cases of a sample of children experiencing neglect to inform development
- Assist and evaluate the introduction and impact of Operation Encompass and other Domestic Violence initiatives such as MARAC
- Engage with the Safeguarding Adults Board in relation to substance misuse and adult mental health issues
- Advise on whether additional services need to be commissioned

Priority 2: Early Help and Support for Families

Our Priority is to work across partners to provide help early, reducing the impact on children of compromised family circumstances and making it more likely that families thrive. Where this is not possible, we will intervene quickly and robustly in support of children. Our analysis of data shows that the numbers of referrals received by services in Liverpool is high. Also, we know that a high proportion of contacts do not lead to active intervention. This may indicate that there has been insufficient focus on early help. The council has responded to this in the last year and the next task is to establish and roll out this work with full involvement from health, schools, police and voluntary organisations. We will pay particular attention to children assessed as Level 2 and Level 3 in our Continuum of Need.

Key Actions

We will:

- Monitor the roll out and level of multi-agency engagement of the Early Help Strategy, including EHAT
- Scrutinise the indicators for Children in Need and around the Level ¾ borderline to determine whether it is having an impact
- Audit the cases of a sample of children experiencing the new services and engage with those young people to inform development
- Help to develop and evaluate the “step up” and “step down” arrangements from Early Help
- Advise on whether additional services need to be commissioned

Priority 3: Child Sexual Exploitation linked in part to:

- Children Missing from Care
- Children Missing from Home
- Children Missing from Education

Our Priority is to identify the extent and profile of CSE and to tackle it across all agencies in order to protect children. This will extend from preventative and protective work across the whole child population to support for child victims and prosecution of perpetrators. Conscious of the risks to children who are alone, we will pay particular attention to work with those who go missing from care, home, education or health provision. National evidence suggests that CSE exists in all parts of the country and that children who go missing are particularly vulnerable. There has been extensive work by the Board and the Council in raising awareness and extra Police resource has been put in place. We now need to make absolutely sure that we know the full extent of the problem in Liverpool and that we target the work of all agencies to make a difference.

Key Actions

We will:

- Continue to provide focused, multi-agency training on CSE and evaluate its impact
- Study the pattern and profile of CSE in Liverpool to target interventions more effectively
- Ensure that there are good return and support services commissioned for children who go missing
- Work with other Boards to roll out the Merseyside and Cheshire CSE Protocol and monitor its application
- Develop further the multi-agency arrangements to target perpetrators
- Investigate the commissioning of services to better support victims
- Seek to develop ways of following up children who miss primary and community health care provision

- Deepen our collaboration across Merseyside
- Use young people's testimonies to improve our prevention and support services

Priority 4: Child Mental and Emotional Health including:

- Children who do not have a diagnosis of mental illness but who need extra help and support
- Children who self-harm or attempt suicide

Our Priority is to ensure that partners commission a more comprehensive and accessible set of services for children with low to moderate mental and emotional health needs so that these issues do not impact on their future lives. National evidence tells us that the number of children experiencing these difficulties is increasing. Very sadly, there are cases where young people attempt. or commit suicide. We think that there is much more to do.

Key Actions

We will:

- Review the effectiveness of current CAMHS provision at Tier 2/3 against evidence
- Draw on evidence from case audit, data on incidence, referrals and outcomes
- Seek the views of universal service professionals and the views of young people
- Benchmark Liverpool practice against other areas
- Advise the Children's Trust and the Health and Wellbeing Board on the future commissioning of services across all four Tiers of Need

Priority 5: The Impact of Crime on Children and Young People, including:

- Children involved in gang crime or serious organised crime, or impacted by it
- Children in families with known adult criminal behaviour
- Young victims of crime

Our Priority is to reduce the impact of criminality on children's present and future lives, whether perpetrators, direct or indirect victims of the criminality. This is a new area of priority for the LSCB which we have identified because such children are particularly vulnerable. Young people are the most likely group in the community to be the victims of crime. Barnardos have reported nationally on the impact on children of having a parent imprisoned. We are conscious of the effect that criminal behaviour can have on children in the community and of the risks of them being drawn in. We will work with the Citysafe Partnership to help to understand and tackle this issue.

Key Actions

We will:

- Ensure that the Government's guidelines on serious and organised crime are implemented in Liverpool as they affect children and monitor the impact of these changes
- Assess the impact of living in families with adult criminality on the safety of children and make appropriate recommendations for commissioning
- Support the extension of multi-agency work, led by the Citysafe Partnership, from the initial four wards to other areas of the city and monitor its impact on the safety of children
- Engage with partners, including the voluntary sector, to assess the adequacy of support to young victims of crime and to make recommendations for improvement
- In all the above work, engage with the young people concerned

Priority 6: The "Front Door" and "Pathway" to Child Protection Services, including:

- The Multi-Agency Safeguarding Hub ("MASH")
- Referral Pathways for children brought to the attention of child protection services
- Thresholds for Intervention and Support and Assessments of Risk and Need

Our Priority is to make sure that the new arrangements are well understood and consistently applied in Liverpool, particularly as the new Multi-Agency Safeguarding Hub begins its work. We need to make sure that arrangements are fit for purpose and properly protect children without any falling through the net. Our evidence about the previous arrangements shows that we have a higher level of contacts to child protection than some other, similar areas. There could be several factors leading to this. There may be higher levels of need, there may be an uneven understanding of thresholds by professionals or there may be a need for more early help and support for families. We need to monitor the outcomes for children subject to a Child Protection Plan, particularly where this is not the first time. We need to study the effectiveness of multi-agency involvement in these Plans. All of these possible factors are addressed in these Priorities.

Key Actions

We will:

- Continue to provide extensive, multi-agency training on our "Responding to Need Guidance and Levels of Need Framework" and the Single Assessment
- Monitor and advise on single agency training in this area
- Monitor the implementation of MASH and scrutinise evidence concerning its developing effectiveness
- Engage with partners concerning the future governance of MASH
- Audit the experience of key groups of children referred to services; this will pay particular attention to the following groups:

- Children not progressing from contact to services, whether Early Help or Child Protection
- Children not progressing from initial assessment to core assessment
- Children not progressing from core assessment to child protection investigation
- Children on the CIN borderline
- Children previously supported at other service levels, such as Early Help or Child Protection Plan

- Draw evidence from the views of frontline professionals across the partnership

Priority 7: Our Performance Monitoring and Management Processes including:

- Data collection, information sharing, analysis of underlying factors and testing out hypotheses
- Audit of the experiences of children, including work by each agency, across agencies and for particular themes
- Learning from specific cases and follow up from these lessons
- Embedding the Voice of the Child at all Levels
- Governance and Compliance

Our Priority is to make sure that we have a complete understanding of the position regarding children's safety in Liverpool by developing our expertise. We have made considerable progress this year to improve the quality of the evidence we use to guide our planning and action. We are better at drawing out lessons from the audit of children's experiences and from the study of specific serious incidents. We have also developed strongly our understanding from the testimony of children and young people who live in the area. We believe that there is still more to do. In particular, we can improve the way that we scrutinise data across health police, education and social care to gain a full picture of the effectiveness of services.

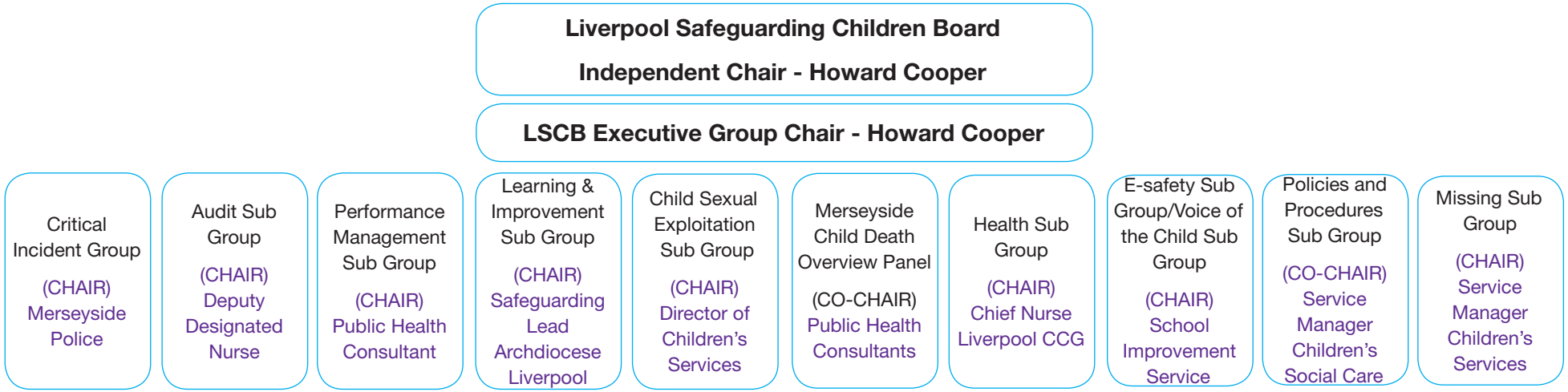
Key Actions

We will:

- Develop a single, multi-agency data set which is both comprehensive and comprehensible
- Develop our expertise in scrutinising, hypothesising, testing and acting in response to this data
- Develop our use of the systems approach to learning from Serious Case and other reviews and apply this to the cases currently in progress
- Develop our systems for monitoring the impact of actions following SCRs
- Develop our Audit Plan to focus on multi-agency work in support of these Priorities and also to oversee single agency audit
- Develop our methodology for scrutiny and challenge of partners using "Section 11 and Section 175" audits
- Ensure that the voice of children is built in at all levels from individual care and health planning to the improvement strategies of partners

STRUCTURE AND WORK OF THE LSCB

The LSCB has several sub-groups to undertake work against the agreed priorities. The work of the sub-groups is monitored by the Executive group and any issues or delays in undertaking the work are reported to the main Board.



The LSCB works alongside other strategic partnerships in Liverpool. Each has different responsibilities in relation to the same population. The Health and Wellbeing Board is responsible for producing a Joint Strategic Needs Assessment. This is to help a number of agencies plan how to best improve the health and wellbeing of people in Liverpool and reduce health inequalities.

The role of the Children's Trust Board is to understand the specific needs of children in the city; and subsequently design, develop and buy services to best meet those needs. The LSCB is the lead strategic decision making body to help people work together to keep children safe. This ranges from putting things in place, such as policies or training, to help frontline staff understand their roles and work together to keep children safe; right through to conducting Serious Case Reviews if children are seriously harmed and abuse was a factor. The LSCB uses these insights to recommend to the Children's Trust what services need to be commissioned. It is important for these partnerships to work together and inform each other. In Liverpool, there is an agreement as to how they will do just that. This is known as a Memorandum of Understanding and it describes the activities each Board undertakes to support the others in their work.

Liverpool LSCB has an Independent Chair. This helps to bring challenge to the work of the Board. The Independent Chair reports to the Chief Executive of the Council and regular meetings take place between the Chief Executive, Lead Member for Children's Services, Director of Children's Services and the LSCB Chair.

The Work of the LSCB Sub-Groups

1. Critical Incident Sub-Group

LSCBs are required to conduct a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death, life threatening injury or serious sexual abuse, and there are concerns about how professionals may have worked together. This group assists the LSCB to consider the evidence and decide if a SCR is required. Sometimes, another type of review is undertaken when a SCR is not required but the LSCB wants to learn from the case. The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; and As a consequence, improve multi-agency working when it comes to protecting children.

If the criteria for holding a Serious Case Review has not been met but the LSCB feels that the case may provide an opportunity to learn about and improve practice, a different type of review will be initiated. During the previous year, 2 SCR's and 1 Learning Review and 1 Thematic Review were initiated and improvement work commences each time we undertake a review. Learning from these reviews is outlined in a later section of this report.

2. Performance Management Sub-Group

The role of this group is to gather and examine data and other information that helps the LSCB to know if children are safe and the safeguarding system is effective. The group looked at a wide range of information and had a priority piece of work:

- To produce an effective multi-agency data set that illustrates the story of safeguarding children and allows agencies to challenge each other and identify risks and opportunities

The group examined data from partner agencies including Children's Social Care, Police and Health providers. A dataset was produced and distilled further to focus on key areas. We have looked at it closely as it tells us important facts about safeguarding. Some key messages from these data are described in a later section of this report.

3. Audit Sub-group

For the LSCB to know where practice is working and where it needs to be improved, we need to examine case files and make judgments on the quality of practice and decision making. Multi-agency audit is a good way of doing this. As it brings professionals together to learn lessons and helps us understand what barriers may be in the way and preventing people from working well together.

Audit is another way that the LSCB learns. Combining what we learn from Serious Case Reviews and other reviews, feedback from local practitioners, scrutiny of local agencies' arrangements and the analysis of child deaths, gives us a wealth of knowledge from a range of learning methods. Some of these methods also help us check that our improvement work has had the desired effect. Learning from this work is also outlined in a later section of this report.

4. E-Safety Sub-group

The primary objectives of this group are to promote safe internet use and behaviours, amongst children, young people and families, whilst educating the workforce on how to encourage this further and also respond appropriately to issues when they arise. The group also keeps abreast of emerging risks and trends, both nationally and locally; using this to inform their work and the messages provided to staff, children and families.

The Chair of the group acts as an adviser to Liverpool schools on matters relating to online safety and other members undertake this role within their own agency. A Head Teacher on the group is also a member of the National CEOP forum and this enables the group to be up to date on emerging issues and best practice.

This year the group:

- Promoted an exemplar 'acceptable use' policy across schools in the city
- Developed a suite of materials to form an e-safety resource for local schools and other agencies. This includes resources from EE, Vodafone, NSPCC amongst others, including video clips suitable for particular age ranges
- Engaged the CSE co-ordinator in their work to better understand internet behaviours and the potential for sexual exploitation
- Safeguarding training delivered to all school Designated Safeguarding Leads, included a dedicated section on e-safety
- Delivered e-safety sessions to around 400 parents within 20 local schools
- Delivered e-safety sessions to the pupils of 12 secondary schools
- Delivered awareness raising sessions to the staff within 55 local schools
- Via the Chair, considered information from other LSCB areas to inform the local response and understand emerging issues to be alert to
- Arranged an externally facilitated event for schools to enable them to better understand how to use social media safely as a way of engaging with children and parents. Professor Andy Phippen from Plymouth University helped the LSCB with this work.
- Via the Chair, provided termly e-safety updates for all Liverpool schools

Key areas of impact

- Head teacher representatives on the group regularly attend the primary, secondary and special schools forums. They have each reported that the knowledge and understanding of e-safety within schools has increased; particularly in relation to potential e-safety issues when using social media, responding to sexting amongst young people, the risks associated with online gaming and harm from adult content in games.
- By maintaining links nationally and with e-safety chairs in the region, the group has been able to quickly respond to issues arising in Liverpool.
- A school with a particular e-safety issue requested an educational session on 'sexting' for their pupils. Since this session, no further issues have been reported.

5. Child Death Overview Panel

Child Death Overview Panels became a mandatory requirement in April 2008. They are responsible for reviewing information on all child deaths, from birth to 18 years, analysing the circumstances pertaining to the death and concluding whether modifiable factors were in existence. Having done so, recommendations are made to achieve the necessary changes where possible. The ultimate aims are to identify patterns and trends with a view to reducing the number of child deaths where modifiable factors have been identified.

Development of a Merseyside wide CDOP

Four of the five Merseyside LSCBs merged their CDOP functions in 2011 and the fifth LSCB Knowsley, joined this pan-Merseyside arrangement on 1 April 2014. Analysing more child deaths enables themes and trends to be more readily recognised. Having a broader pool of professionals in this area of work is helping to get the most knowledgeable and relevant people involved in examining the some

of the complex cases we look at, eg. Neonatologists are helping us to review the deaths of very young babies. During 2013-14, the panel:

- Reviewed all deaths of children during the previous year
- Evaluated data on the deaths of all children and identified lessons to be learnt
- Worked with Merseyside LSCB colleagues to analyse trends and modifiable factors across a broader footprint.
- Developed a calendar of thematic panel meetings, enabling specialist expertise to be sourced for particular themes

Learning from Child Deaths – How Could We Change Things to Reduce Mortality?

It is a statutory responsibility for LSCBs to establish a panel to review all child deaths in the area. This process is different to that which is undertaken when abuse or neglect was a factor in the child's life. The learning to be gained from reviewing the cases with CDOP is to highlight modifiable factors that may help to prevent child deaths. Liverpool LSCB is part of a pan-Merseyside arrangement; 4 of the Merseyside LSCBs work together within one CDOP. This helps us gather learning across a broader footprint, with more cases to analyse for themes and trends. The modifiable factors identified in the 12 cases included:

- Potential misdiagnosis with significant medical history;
- Poor service provision and delay in progressing required medical intervention;
- Appropriate warning signage and public awareness of hazards required;
- Recommendations for changes in practice identified in a root cause analysis report;
- Recommendations for changes in practice identified in a Serious Case Review;
- Delay in diagnosis;
- Co-sleeping and substance misuse;
- IVF x 2: exceeding NICE guidelines re number of eggs implanted;
- Smoking and alcohol;
- Securing of a heavy item and appropriate adult supervision.

On occasions panel members have not felt able to conclude that there were modifiable factors identified but felt the situation warranted issues being identified. Below is a summary of the issues raised:

- Delay in bereavement support;
- Admission/observation policy desirable for vulnerable patients;
- Auditing of practice requested with a resource when a child death in similar circumstances occurred despite a previous
- Root Cause Analysis report recommending changes to address;
- Dietary input for patients with low BMI;
- Difficulties obtaining post mortem reports;
- Care pathway for cardiac babies;
- Alcohol and parental responsibility;
- Medical record transfer;
- Risk taking behaviour

6. Health Sub-group

The Health Sub Group for Liverpool was formed in October 2013. The initial priorities of this group were to:

- Develop a health data set. This has been drafted; further work is needed.
- Provide Serious Case Review and Management review updates and review progression of action plans. Lessons from local Learning Reviews have been circulated and discussed. This has enabled learning to be shared with health providers that may not have been

involved in a specific review but where learning can be transferred and applied within their organisation.

- Contribute to the development of Multi-Agency Safeguarding Hubs. This has been done and continues
- Respond and act in accordance with the key priorities from the Boards, for example in relation to looked after children. Data in respect of medicals for Looked After Children has been scrutinised and performance has been improved

Our priority work areas will include:

- Contributing to a reduction in Neglect and Child Sexual Exploitation
- The health needs of Looked After Children
- Improving Child Mental & Emotional Health
- Contributing to MASH
- Auditing the effectiveness of health support to vulnerable children
- Developing our Performance Information and the health data set
- Improving safeguarding training for health professionals
- Spreading the understanding of thresholds in the health community

7. Learning and Improvement Group

LSCBs have a number of responsibilities in relation to training. First we must know the needs of the workforce, then we must monitor those needs are being met. Lastly, we must understand if the training we deliver is having the desired impact upon practice.

This year, the group:

- Examined the training that had been delivered to frontline staff within several LSCB member agencies. This helped the LSCB to know which staff were being trained and which agencies need to attend in the future.
- Gathered evidence that training had helped staff to understand their role and how to keep children safe from different forms of abuse.
- Established a training pool of professionals from across the partnership to help deliver the LSCB raining programme.
- Developed a process to ensure that the messages from Serious Case Reviews and other reviews reached hundreds of frontline practitioners in our partner agencies
- Helped to co-ordinate **41 training courses** that were delivered to more than **800 local staff and volunteers**, covering 7 different safeguarding topics:

  Basic Awareness
  Working Together Introductory course and Update
  Multi-agency Public Protection Arrangements
  Neglect and Neglect; train the trainer
  The Role of the Designated Safeguarding Officer
  Child Sexual Exploitation
  Harmful Practices
  Learning from Reviews

8. Policies and Procedures Sub-group

Our Group is drawn from a broad range of professions so we can make sure we get it right - to make LSCB guidance documents clear for all frontline staff. People working with children and families need to have access to information that helps them to understand what to do and how to respond to a range of issues that they may come across in their work. This is particularly important when professionals from a number of agencies are all working together, each depending on the other to do what is best for a child. We have reviewed and revised the multi-agency procedures put in place by the LSCB. A major piece of work undertaken by the group was to revise a large chapter of the LSCB

procedures **"Managing Individual Cases"**. This includes a range of separate policies including:

- Single Assessment Protocol, Multi-agency Referral Form and Escalation of Concerns Policy
- LSCB Missing Children Protocol
- Forced Marriage Protocol, Honour Based Violence Protocol and Female Genital Mutilation Guidance
- Sudden Unexpected Death in Infancy and Sudden Unexpected Death in Childhood protocols
- Bullying Policy and Begging Policy
- Safeguarding disabled children
- Working with children who abuse others
- Licensed Premises
- Children whose behaviour indicates lack of parental control

The priorities for our future work are:

- Further development of the Single Assessment
- Neglect Strategy and Domestic Abuse Strategy
- Further development of the Child Sexual Exploitation Protocol
- Links with other Sub Groups around Audit, Training and compliance with emerging national guidance.

9. Child Sexual Exploitation Sub-group

Child sexual exploitation (CSE) is a form of sexual abuse that often involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things such as money, food, drugs, gifts, accommodation, affection or status. CSE does not always involve 'giving' something to a young person; it can be exploiting a young person through making them feel scared of the consequences if they don't do what another person wants them to do.

During 2013-14 we made tackling CSE a high priority and worked on five areas, in line with the Pan Merseyside and Cheshire strategy and National Action Plan. These are: Governance; Self-Assessment; Prevention; Safeguarding and Bringing Offenders to Justice. Liverpool's Director of Children's Services chairs the CSE sub-group. This has helped us to keep the profile of this area high on everyone's agenda, including within local schools. In addition, Liverpool City Council has made in employing a dedicated CSE Co-ordinator. This is helping to maintain a fast pace with our work and assist in the direction of travel and the pans to get there being clear for a range of local agencies.

Our work this years has included the following:

- Over 3000 multi-agency professionals attended a drama production to raise awareness of CSE
- 21 Liverpool schools hosted a performance of the CSE awareness raising drama to year 9/10 pupils – around 4500 pupils in total
- 5000 CSE trigger cards were given out to front line professionals from a range of agencies
- Referral pathway has reviewed and implemented
- CSE protocol was revised and launched
- CSE strategy was revised and is being implemented
- System was put in place to assist in identifying patterns and trends in this form of abuse which helps to target police resource

The impact of our efforts

- As a result of a vast amount of prevention and awareness raising work, local agencies received a number of disclosures from young people in relation to CSE and the numbers of referrals to the MACSE meeting increased. This shows us our awareness raising work is having an impact. We are finding children who are at risk of CSE.
- We reviewed case files to check that professionals are recognising CSE and responding in the right way. Because of the training they have received and the raised profile of this form of abuse, they are seeing it and responding in the right. This is helping children to be supported and protected.
- Other areas have approached Liverpool to find out about our approach because it is effective.
- A system was put in place to assist in identifying patterns and trends in this form of abuse. This is helping Merseyside Police to target resources and focus their attention on the right areas.
- OFSTED said we have effective arrangements in place for ensuring the looked after children at risk of CSE or who are missing from care, receive a coordinated multi-agency response.

Next Steps

The sub group priorities for 2014 /15 fall under the same headings as the priorities for 2013/14 however there are some specific areas we plan to concentrate on:

- Raising awareness with health providers and voluntary sector
- Continue to work with education to embed CSE awareness in the curriculum
- Awareness raising for parents and carers
- Awareness raising with local businesses and members of the public
- Identify gaps and look at commissioning of CSE services
- Hold police to account in relation to bringing offenders to justice - work with NWG to identify good practice

We will monitor the impact of our CSE activities through the following:

- Increased referrals to MACSE from health providers and voluntary sector. Increased confidence of professionals in identifying CSE concerns, increased numbers from these agencies attending LSCB CSE training
- S11 and S175 audits in schools to ensure CSE is included in curriculum
- Increase in referrals of cases not known to Children's Social Care, increased confidence of parents identifying CSE concerns, evidence of use of Parents against Child Exploitation (PACE – a CSE training tool for parents and carers
- Referrals and information from local businesses and members of the public
- Commission a service for young people at risk of CSE and those subject to CSE
- Increased conviction rates for CSE related crimes

10. Children Missing Sub-group

This is a new sub-group of the LSCB. It has been put in place to ensure that agencies work well together to respond to children who go missing and receive the right help from the right people following a missing episode.

The group has agreed its key work for the following year as:

- Review multi-agency procedures and protocols to ensure they are in line with the January 2014 Statutory Guidance. The group will present its findings and any amendments to the LSCB Executive group later in the year.
- Re-launch the Multi Agency procedures and protocols across the local children's workforce.
- Identify a Missing Coordinator who will monitor and identify trends, ensure compliance, develop a reporting system, keep updated on emerging practice and help to embed best practice within Liverpool.
- Work with commissioners to ensure that any commissioned service is fit for purpose and achieves the agreed outcomes in relation to the missing children agenda and the expectations of the LSCB.
- Monitor and review the effectiveness of the return interview process and establish if current service provision is sufficient and effective
- Provide quarterly reports to the LSCB Strategic Board

4. Performance Information

PERFORMANCE DATA

The Liverpool Safeguarding Children Board (LSCB) is a statutory body that leads on keeping children safe in Liverpool. The LSCB is not a service but a collection of agencies that work together to put things in place to keep children safe. We help people who work with children to protect them. The LSCB must also continually check that what we do works. For example, we try to make sure that the procedures we publish are clear and help staff and volunteers know what to do when they are worried about a child, or that staff and volunteers receive the training they need to undertake their roles. We focused our attention and efforts on a range of agreed priorities and some of our achievements are detailed below.

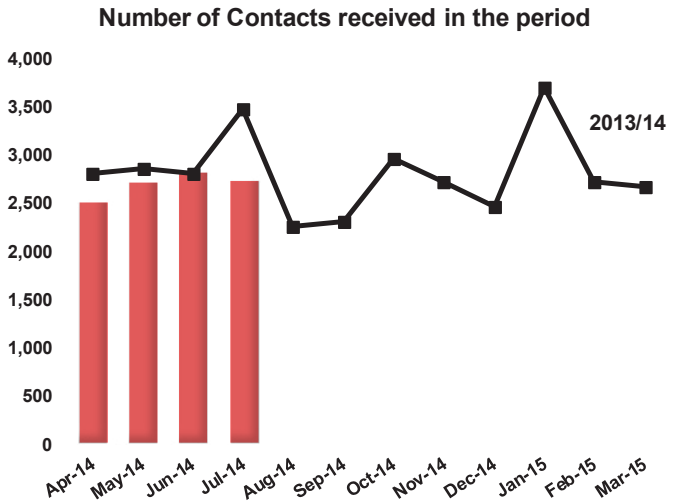
The LSCB analyses and monitors a wide range of data concerning the safety, health, education and care of children. It uses this to provide evidence on what our priorities should be and to challenge partners on their performance. The Board works with the Children's Trust and Health and Well Being Board to make sure that better services are commissioned for children and families. The data extracted for this section are those that we believe are particularly important for children in Liverpool in the light of the needs we have identified.

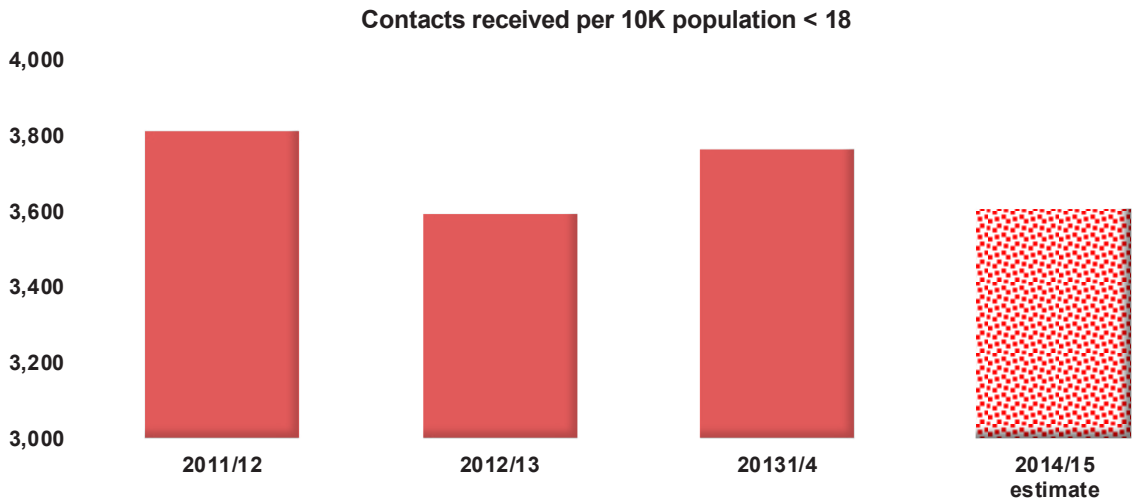
1. Contacts with Careline

'Contacts' are received by Careline when local staff, volunteers or members of the public are concerned about a child. 33,633 contacts were received during 2013-14. This equates to 3,764 contacts per 10,000 of the population. The table shows the trend in contacts made to Careline over a three year period and the estimated figure for the forthcoming year

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No Contacts in the period	33,633	2,496	2,705	2,813	2,729								
No Contacts cumulative	---	2,496	5,201	8,014	10,743								

Contacts received per 10K population < 18	2011/12	2012/13	20131/4	2014/15 estimate
Liverpool	3,813	3,594	3,764	3,605





2. Referrals from Careline to Child Protection Services

- The overall level of referrals is high – higher than the Core City average. Of the 33,633 contacts, only 8,602 became referrals to Social Care, 25.6%. These are both matters of concern. It indicates that professionals are referring inappropriately and may have a poor understanding of thresholds.
- 29.6% required no further action. This is also a matter of concern. If accurate, it indicates that even after a referral is accepted no action needs to be taken in a significant number of cases. Audit of cases suggests that the right children are taken forward into child protection procedures and therefore initial consideration of cases may be faulty.
- 44.8% resulted in information and advice to the person making the contact. This is positive if it led to a good outcome for the child.
- Repeat referrals are also part of the high referral rate. This is also of concern. An important aspect of the Early Help Strategy is to reduce re-referrals by providing support to families when cases are stepped down from social care; and to further develop the early help offer. Some children experiencing neglect require long term support from several agencies and not necessarily social care intervention.

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No referrals in the period	8,602	712	734	754	696								
No referrals cumulative	---	712	1,446	2,200	2,896								

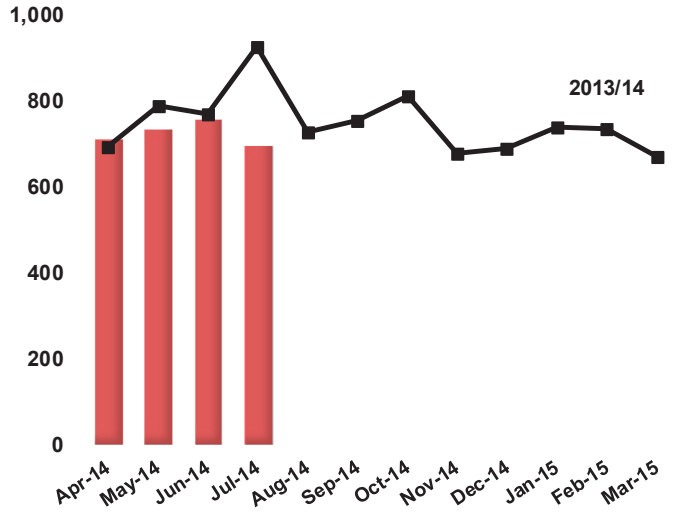
Referrals received per 10K population < 18	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 estimate
Liverpool	**1,025.9**	**789.0**	**853.6**	**767.7**	**962.2**	**971.8**
England	548.2	556.8	533.5	520.7		
Core City Avg	749.7	865.1	748.2	691.2		
Core City Min / Max	524.4	549.9	566.9	457.3		
Core City Max	1038.2	1116.9	924.9	1040.8		
Stat N'bour Avg	621.3	675.0	697.0	644.8		
Stat N'bour Min	412.4	353.7	401.6	341.1		
Stat N'bour Max	1,068.1	1,255.8	940.6	892.3		

Data Concern:

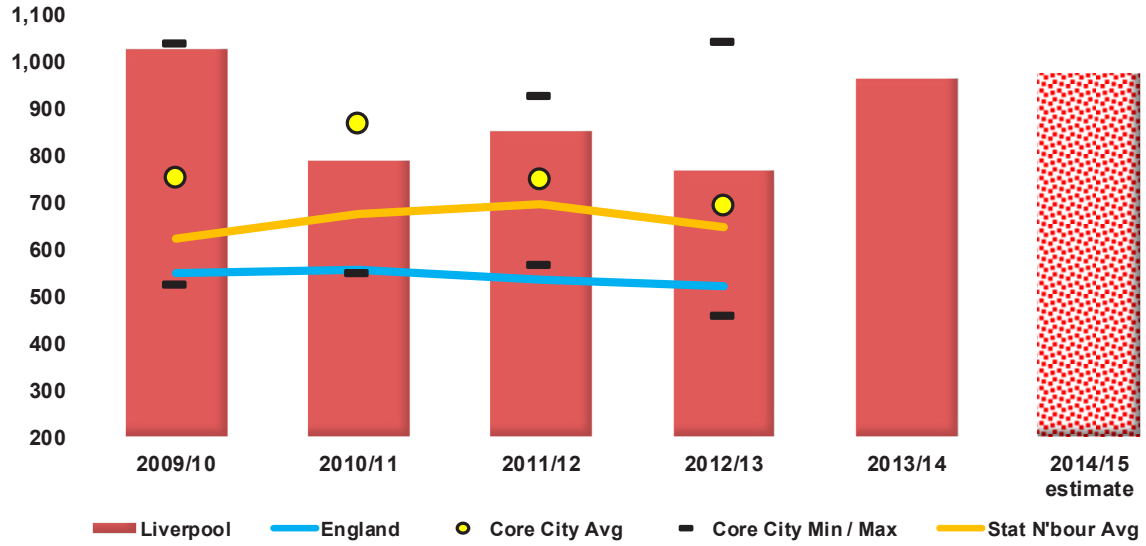
Event date of when the exemplar was created (ie. Referral and Information Record) has been used in some cases. This is because there are multiple errors owing to prepopulated dates for the actual referral start date.

There are also duplicate dates (which will not be an issue with Liquid Logic).

Number of referrals in the period



Referrals received per 10K population < 18



3. Children made subject of a Child Protection Plan (CPP) after assessment and Multi-Agency consideration

- Children considered to be or at risk of, or already suffering significant harm have reached a threshold that requires a Child Protection Plan; 642 were considered at an Initial Child Protection Conference and 546 (85%) were subsequently made the subject of a Plan. The table shows that Liverpool has 43.7 per 10,000 subject to a Plan. During previous years Liverpool has had a lower rate than statistical neighbours and we will consider national data for 2013-14 when it is available.
- 13% of children who were made the subject of a Plan, had been so on one or more occasions previously. It is important for LSCBs to monitor this figure to understand the effectiveness of the child protection system. This is a key issue for the Board and the LSCB will examine comparative data when available later this year. The figures below detail percentages of those made the subject of a child protection plan for a second or subsequent time by the time between each child protection plan.
- Plans should be implemented as soon as Thresholds are reached in a child's life and should be effective quickly. There should be no "drift". The duration of Plans in Liverpool was as follows and shows a high proportion of Plans lasting more than 3 years. The next section shows that there is an improving picture and his will be monitored.

0 to 499 days	**= 33.8%**
500 to 999 days	**= 22.5%**
1,000 to 1,499 days	**= 31.0%**
1,500 to 1,999 days	**= 2.8%**
2,000+ days	**= 9.9%**

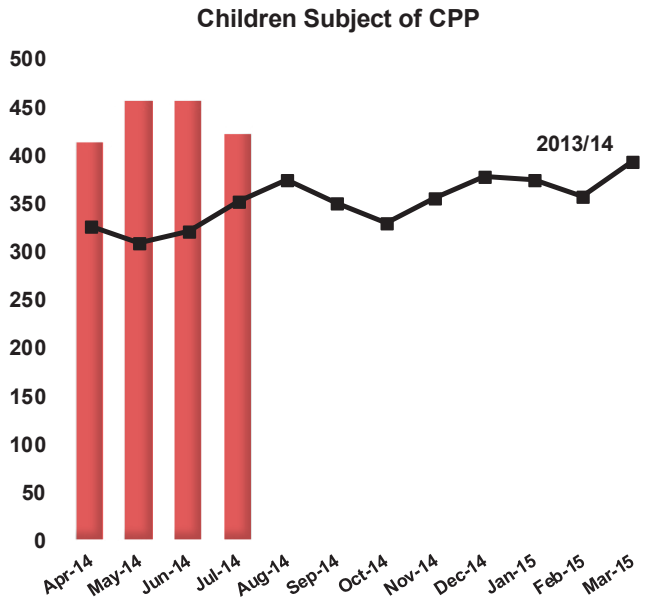
- A breakdown of age at the time of the child being made the subject of a CP plan shows that most were under 9 years old:

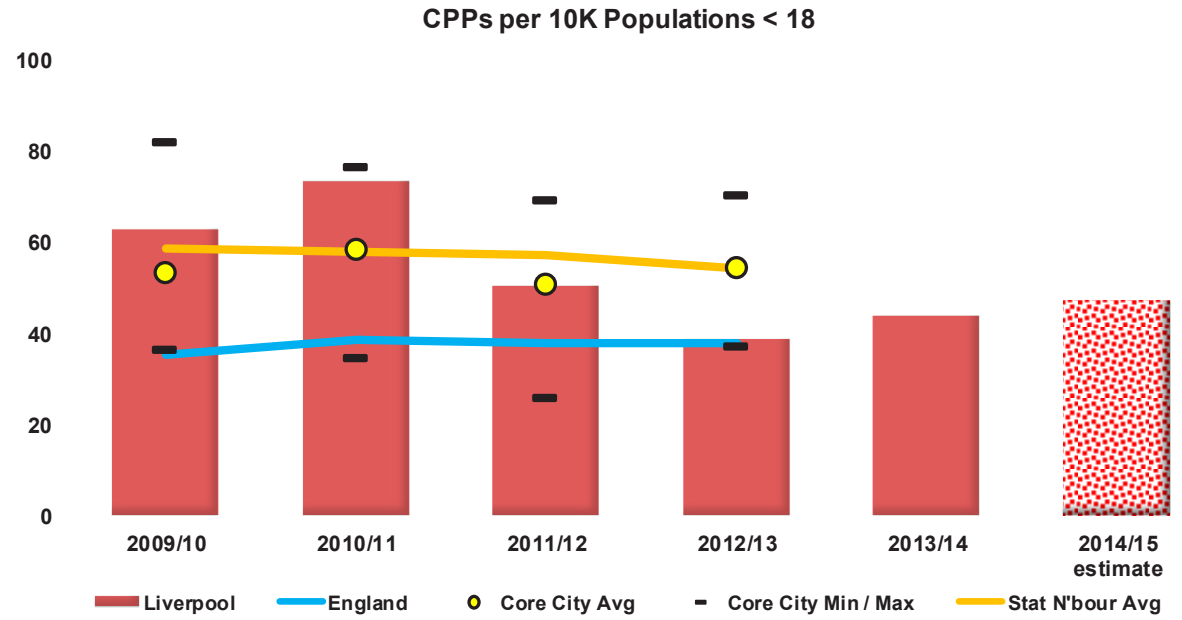
0 to 4	**= 37%**
5 to 9	**= 30%**
10 to15	**= 29%**
16 to17	**= 4%**

The next section shows that there is an improving picture and this will be monitored.

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Children Subject of CPP	391	413	456	457	423								
CPP per 10K pop < 18	43.7	46.2	51.0	51.1	47.3								

CPPs per 10K population < 18	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 estimate
Liverpool	**62.7**	**73.3**	**50.4**	**38.6**	**44.0**	**47.3**
England	35.5	38.7	37.8	37.9		
Core City Avg	53.0	58.4	50.8	54.1		
Core City Min / Max	36.3	34.7	25.9	37.2		
Core City Max	81.9	76.5	69.3	70.3		
Stat N'bour Avg	58.7	57.8	57.1	54.2		
Stat N'bour Min	30.4	28.6	29.4	27.7		
Stat N'bour Max	108.7	95.8	80.0	86.0		





4. Current Child Protection Plans (CPPs) lasting 2 years or more

Children's Social Care and other agencies involved in child protection processes have to carefully balance two factors:

- the need to keep children safe and not allow them to be in a situation of significant risk of harm for too lengthy periods
- the need to ensure that parents can sustain the change that has led to risk factors being reduced.

Whilst we do not wish to see a large number of children subject to a child protection plan for 2 years or more, we recognise that there are times when working longer with a family reduces the likelihood of a child or children being at risk again in the future. This trend shown seems to be a result of an improved focus on outcomes within child protection plans.

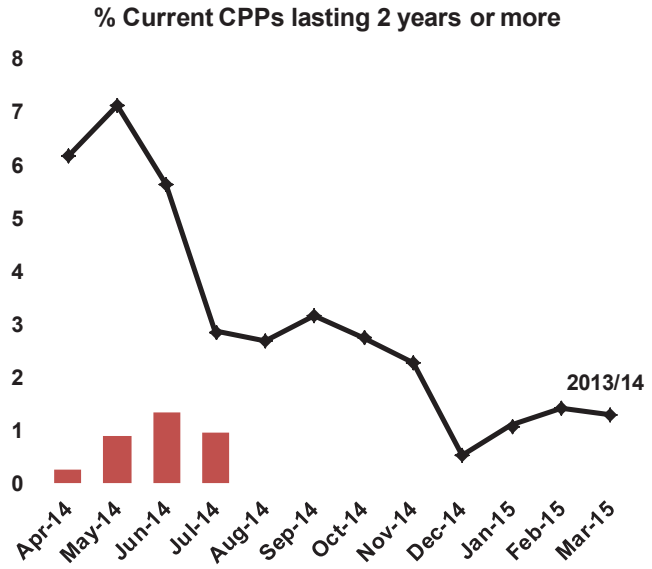
Page 33 illustrates the numbers of children who were the subject of a child protection plan that was in place for 2 years or more.

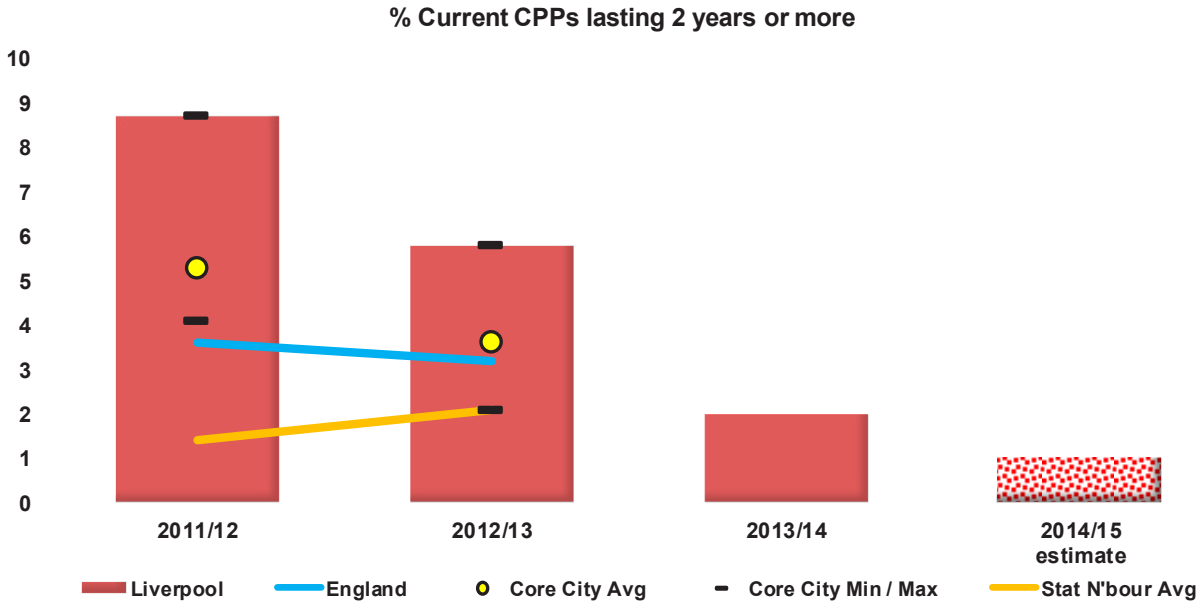
It is important for the LSCB to monitor this area as we need to be assured that children are left in a position of significant of harm for very long periods. The table on the right displays comparative data.

We can see that the percentage of Liverpool children subject of CP Plans, whose CP Plan lasted 2 years or more, has fallen continuously over the three previous reporting years. The current trend indicates a further expected reduction.

	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Number of CPP	391	413	456	457	423								
No 2+ years in period	8	1	4	6	4								
Current % 2 + years	2.0	0.2	0.9	1.3	0.9								

% Current CPPs lasting 2 years or more	2011/12	2012/13	2013/14	2014/15 estimate
Liverpool	**8.7**	**5.8**	**2.0**	**1.0**
England	3.6	3.2		
Core City Avg	5.3	3.6		
Core City Min / Max	4.1	2.1		
Core City Max	8.7	5.8		
Stat N'bour Avg	1.4	2.1		
Stat N'bour Min	0	0		
Stat N'bour Max	8.7	5.8		





5. Looked After Children (LAC) subject to Care Orders made by the Family Court

Whilst the number of looked after children is high, the recent Ofsted inspection (June 2014) reported that Liverpool were looking after the right children. Liverpool has had an above national rate of looked after children per 10K of the population and research shows this is linked to areas of deprivation.

In the majority of cases children are looked after because of compelling evidence of abuse and neglect, however, all new entries to care continue to be scrutinised to ensure family support and early help can avoid entry into care. There was an increase of fourteen children in July 2014 to a total of 1001 which is comparable to the total six months ago.

Looked After Children are those that are considered to be at a level of risk which requires the Local Authority to care for them, because of abuse, neglect or their parents being unable to keep them safe. The table above illustrates figures for this year and the previous 4 years.

The table illustrates comparative data for averages across England and core cities.

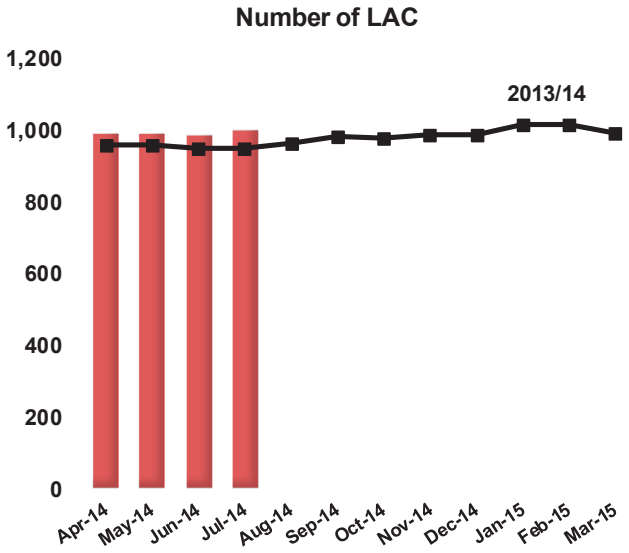
	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Number of LAC	990	992	990	987	1,001								
LAC per 10K pop <18	110.8	111.0	110.7	110.4	112.0								

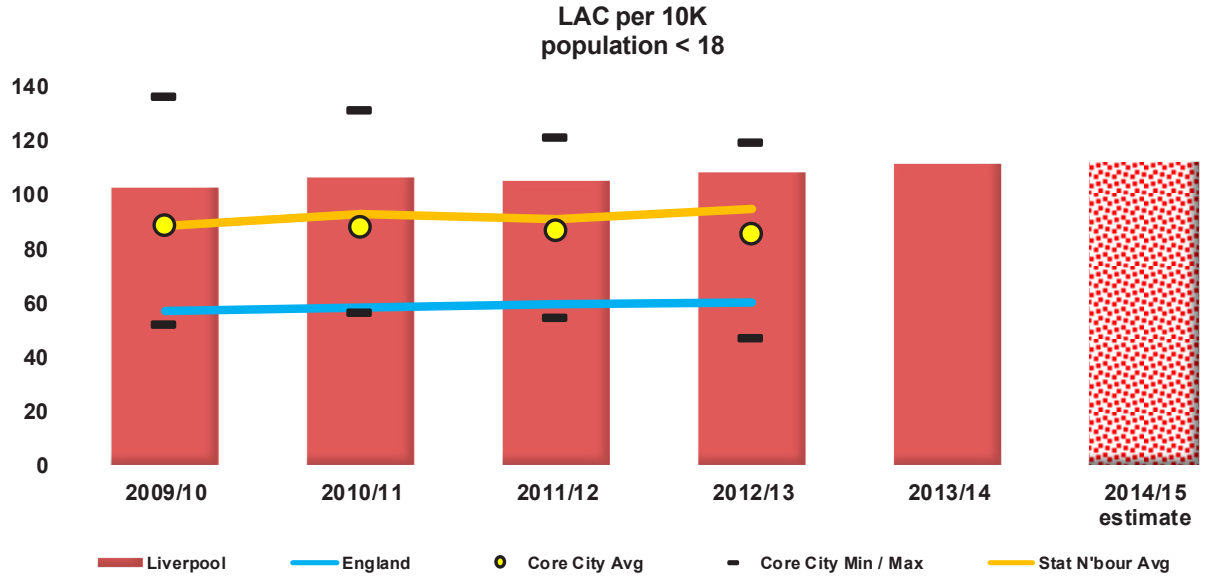
LAC per 10K population < 18	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15 estimate
Liverpool	**102.0**	**106.0**	**105.0**	**108.0**	**110.8**	**112.0**
England	57.0	58.0	59.0	60.0		
Core City Avg	88.1	87.6	86.3	85.3		
Core City Min / Max	52.0	56.0	54.0	47.0		
Core City Max	136.0	131.0	121.0	119.0		
Stat N'bour Avg	88.0	93.0	91.0	94.3		
Stat N'bour Min	54.0	47.0	44.0	51.0		
Stat N'bour Max	108.0	123.0	113.0	120.0		

Data concern:

For a child be identified as LAC in ICS, two tasks need to be undertaken. Completion of a Placement Information Record exemplar and an entry in Panel 13 of personal Details for Looked After History.

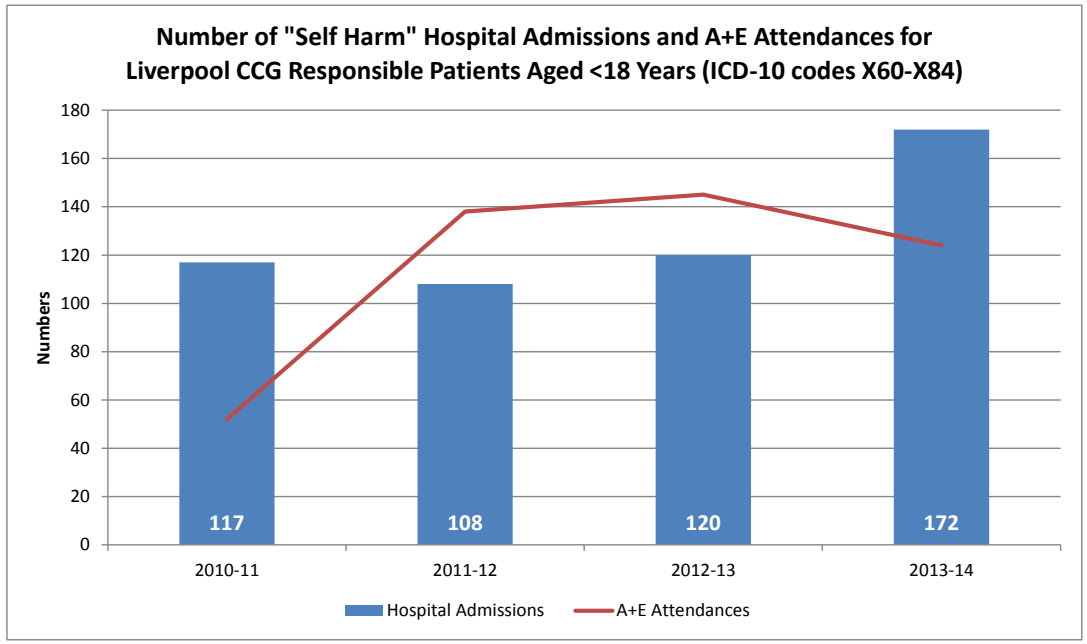
These tasks are not being carried out consistently.





6. Selected Health Data Linked to our Strategic Priorities

In 2013-14 there were 124 attendances at A+E for self-harm from Liverpool CCG responsible patients aged under 18 years. This represented a 14% decrease from 2012-13, and an 11% decrease from 2011-12. There were 172 hospital admissions for self-harm from Liverpool CCG responsible patients aged under 18 years. This represented a 43% increase from 2012-13, and a 59% increase from 2011-12.



Admissions to Hospital Related to Self Harm

Financial Year	Number of Admissions	Rate per 100,000 Population
2010-11	117	131.2
2011-12	108	121.6
2012-13	120	134.3
2013-14	172	192.4

Attendances at A+E Related to Self Harm

Financial Year	Number of Admissions	Rate per 100,000 Population
2010-11	52	58.3
2011-12	138	155.4
2012-13	145	162.3
2013-14	124	138. 7

7. Youth Justice: Young People who Commit Offences

- The number of substantive offences committed in 2013-14 is 7% higher than the number committed in 2012-13.
- The most common age characteristics of offenders in 2013-14 continue to be white males aged 15-17 years. This group also includes the largest proportion of victims of crime. Comparisons with other areas show that Liverpool has proportionately fewer young people involved in crime than the average for major cities and only slightly more than the average for England as a whole. Looked After Children represent a smaller proportion of this total than in any other core city and significantly fewer than the England Average.
- The number of young people offending for the first time has decreased each quarter in 2013-14, but is higher in total than 2012-13.
- 17.4% of all offence outcomes resulted in a custodial sentence in 2013-14. In 2012-13 the figure was 19.6%.
- The latest re-offending rates (2012-13) have seen a -0.14% decrease, with reductions seen in our rates of re-offenders and offences.
- Almost 60% of young people who started and finished an order in 2013-14 and who were NEET were in ETE by the end of their order. This is a positive performance.

MANAGING ALLEGATIONS AGAINST PROFESSIONALS AND VOLUNTEERS

The Local Authority Designated Officer (LADO) has a responsibility for the management and oversight of allegations against adults who work with children. In accordance with 'Working Together to Safeguard Children 2013 the duties of the LADO are:

- Manage and oversee individual cases
- Provide advice and guidance
- Liaise with Police and other agencies
- Monitor progress of cases for timeliness, thoroughness and fairness.

We provide information on the local context, analysing the casework in Liverpool and identifying key themes and patterns, the training offered through the year to agencies around managing allegations and some of the challenges that will be taken into 2014 -2015. We show the data and offer an analysis on the information which will influence future plans. There have been a number of changes made that have affected and influenced LADO activity. These include the Protection and Freedoms Act and the regulations, "Dealing with Allegations of Abuse against Teachers and Other Staff". The new Disclosure and Barring Service (DBS) has been established. 'Working Together 2013' defined the criteria under which an allegation should be considered

In addition to this, there have been a number of serious case reviews elsewhere in the country during previous years which have fed into the development of training and continual improvement for LADO arrangements during the previous year: There is a recurring theme in these serious case reviews: a lack of safer recruitment processes being implemented in organisations which resulted in a failure to prevent and

deter the abuser. In Liverpool, links have been made with departments that do not technically have workers in 'regulated activity' with children; but who do have responsibilities around safe working practices. One such area of concern is that there is no specific safeguarding guidance in relation to direct payments. Carers who receive money from the council tend to employ friends, family members or people they know from social groups. This has led to a blurring of boundaries which could leave children at risk. Safeguarding contracts are needed between Liverpool and the carer and then the carer and the employee. This arrangement will be developed over coming weeks.

What we have done

- The Guidance for LADO has been refreshed in line with 'Working Together 2013'
- Allegations management training has been significantly timelier and records outcome.
- DBS training and guidance has been implemented.
- Revised formatting of reports ensuring that recommendations following strategy meetings are complied .
- Developed key contacts within agencies and identified at a local, regional and national level
- There were 190 referrals to the LADO during 2013/14

Next Steps

Allegations relating to people working in schools continue to be the highest number across all agencies. This group has the most contact with children. We are now able to gather useful data in relation to the outcomes of allegations to be analysed by the Board. In 2015 we will:

- Continue to update training in line with government guidance policy and procedure.
- Offer training in safe recruitment and allegations will be included on all the Board's Level 1 safeguarding courses
- Develop training with local community groups and work with them to identify how to raise the profile of managing allegations.

PRIVATE FOSTERING

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts. The National Minimum Standards for Private Fostering require that the local authority report annually to the Local Safeguarding Children Board (LSCB) and the Director of Children's Services regarding private fostering activity within their area and what measures are in place to ensure that the welfare of privately fostered children is satisfactorily safeguarded.

This year's activity includes the following:

- There are currently five children in Private Fostering arrangements. All of the children are female and between the ages of 11-15 years.
- For this reporting period there are no outstanding Private Fostering assessments.
- During the period 1st April 2013 to 31st March 2014 there were 2 referrals in relation to 2 females. One female is White British and the second female is Egyptian.
- Of the above 2 referrals, just 1 referral, which was in respect of the female young person, progressed to a full private fostering assessment and was agreed at the Private Fostering Panel. This arrangement continues to be viewed as a positive arrangement.
- The second referral regarding the girl under 5 years, did not progress to a full private fostering assessment. The involvement of Private Fostering was brief as the child was subsequently made a "Ward of Court" which meant the arrangement ceased to meet the criteria. The assessment ceased and the case closed to Private Fostering.
- In addition to the 2 referrals, there were a further 18 enquiries (including a sibling group of 2) which did not proceed to a Private Fostering Assessment for a range of reasons including those as follows.
  - inappropriate referrals to Private Fostering in respect of them not meeting the criteria
  - change of circumstances
  - child became "looked after"
  - child returned to her mother's care
  - child returned to her father's care
  - safeguarding and child protection concerns – not accepted
  - issues around identification in respect of the child
  - no referral / further information received
- Of the 18 enquiries, 3 children were non-British. One enquiry was in respect of a 15 year old male from Nigeria, the second was with regard to a 5 year old male from Sri Lanka, and the third was in respect of a 12 year old male from China
- While there has been a decrease in the number of referrals / notifications in the last 12 months, the number of enquiries has doubled. This may indicate that there is a growing awareness of Private Fostering. The majority of the enquiries were either not appropriate referrals or did not progress due to a change in circumstances, an increase in numbers suggests the profile of this area of social work is rising. The sources of the enquiries indicate that awareness is building. Two thirds of enquiries came directly from safeguarding teams, who are more likely to encounter private fostering arrangements. In 1997, Lord William Utting said in his report "People Like Us" that privately fostered children are the most vulnerable.

Private Fostering Panel

There is no requirement within the Private Fostering Regulations and Standards, for local authorities to have a Private Fostering Panel. However, Liverpool Local Authority believes this to be the most effective way to agree decisions about Private Fostering arrangements. The Private Fostering Panel is held every 6 weeks. Panel members are multi-disciplinary professionals, including representatives from Health agencies and the Youth Offending Service. There are plans to widen the membership. The Private Fostering Panel is informed of all enquiries and notifications, as well as the progress of any on-going assessments. Assessments and reviews of Private Fostering arrangements are presented to the panel for consideration for agreement.

Key Developments This Year

- There has been a significant drive to raise awareness in the Liverpool area:
- New leaflets have been produced with updated information and contact details of the private fostering workers. This is to encourage direct communication and increased collaboration and working together; they are currently in the process of being translated into 6 languages; those being the most widely used in the city or those with a prominent community in the Liverpool area;
- Information letters and DVDs have been sent to all Team leaders in Safeguarding, including the Disabled Children's Team, the Joint Intervention Team, the Early Intervention Team, and Careline;
- Through the Fostering Service, there are now firm links with all Children's Centres throughout the city. Updated information leaflets have been distributed to all centres with presentations / talks planned for the coming year;
- The membership of the Private Fostering Panel has expanded and links have been made with the School Family Support
- The Policy in respect of Private Fostering in Liverpool and the Statement of Purpose have been updated.
- In order to fully capture all of the enquiries made in respect of Private Fostering, a database has been devised to ensure all correspondence and contact with Private Fostering is recorded. This is to help guide the Local Authority in moving forward in respect of awareness raising as such information can indicate what is effective and what may prove beneficial. The database also allows for a more detailed report and analysis each year.

5.The Contribution of Our Partners

LSCBs consist of a number of agencies and the work we do collectively helps practitioners work together and families to get the help they need when they need it. Some of the work we undertake leads to changes in how local agencies work. The LSCB must continually strive to challenge local agencies, whilst supporting and encouraging them to improve.

Section 11 of the Children Act 2004 requires LSCBs to check that local agencies work in ways that safeguard children and promote their welfare. This includes a whole range of activities from how staff are recruited, trained and supervised, right through to how lessons from serious case reviews are embedded within practice. We have a range of mechanisms for examining how well agencies do in relation to their Section 11 duties. We audit their arrangements, we ask them to present key information at Board meetings, we audit frontline practice and we talk directly to the staff in their agency. Agencies give clear examples of where challenge from the LSCB has helped them to improve their safeguarding practice.

Partner agencies have contributed to the development of safeguarding activity in a number of key ways. Some of the most significant in 2013/14 include the following.

- The Council, Merseyside Police and The Clinical Commissioning Group have been working together to establish a Multi-Agency Safeguarding Hub in the new year
- Merseyside Police have led on establishing a Pan-Merseyside Strategy for Child Sexual Exploitation; the Council has dedicated specific staff to this and this will also be done by Police in the new year
- The Clinical Commissioning Group has led our work on multi-agency audit of children's cases and have doubled their financial contribution to the LSCB to improve this further
- The Council has led on the revision of our thresholds of need and has restructured its social care services to support this; in times of financial stringency, it has maintained its spending on child protection services and will enhance its contribution to the LSCB in the new year. A new "single assessment" has been introduced to help information sharing and to reduce the level of intrusion to families where this is not necessary
- The Council has led on the Early Help and Neglect Strategies; it has formed a new Early Help Team and is revising the role of Children's Centres to support early help. The CCG will be part of this new model. The Council has also developed Family Group Conferencing to help families to cope with difficult, stressful situations.
- All partners have had a heavy involvement in spreading the learning from Serious Case Reviews and other studies. There has been a strong commitment to training, not least in relation to sexual exploitation
- Public Health is leading on our work to develop a single, multi-agency approach to the use of data. This will link to similar work across the North West and to NHS work nationally so that we can see what the priorities need to be in Liverpool. Public Health also leads our work to learn from the sad instances of child deaths.

6. Learning and Improvement

Learning from Practice Audits

During 2013/14 the Audit Sub-Group were focused upon undertaking multi-agency case file audit activity. The Audit Sub-Group conducted audits either randomly or around selected themes often related to recent local serious case reviews.

When the LSCB wants to learn from a case, a review is undertaken. Sometimes this is a Serious Case Review; when a child has died or was seriously harmed, abuse was a factor or suspected and there are concerns about how professionals worked together. We also undertake other reviews on less serious cases and these also help us to understand how we can improve the way we work together and with families.

We try and learn about the systems that professionals are working in. All agencies do things differently and professionals have distinct roles to play. Different families have different needs and the risks to children can be difficult to identify when parents hide their abuse and pretend to work with professionals. Family systems linked to single and multi-agency organisational systems, national guidance and legislation, all combine to make a complex safeguarding system that needs to work effectively to identify the risks to children and reduce it.

We know that our workforce is committed to their work and we must recognise the challenges and difficulties they face every day. When mistakes happen or things don't go to plan, it is important to learn about the barriers that were present for our staff and volunteers to make good decisions and deliver upon them. Then, as a partnership, we work to fix the systems problems; rather than apply blame and introduce a new policy that tells practitioners what they must do – removing yet more of the expertise and decision making skills from their work.

Thematic areas reviewed include:

- Physical abuse and safeguarding concerns related to a teenage girl
- Neglect, non-engagement and risk taking behaviour by children including 'gang' association
- Lack of supervision and poor parenting capacity
- Chronic poor school attendance
- Historic Domestic Violence and Neglect
- Forced Marriage
- Children subject to long term neglect
- Child Sexual Exploitation and grooming related to teenage girls
- Children with mental health concerns and self-harming behaviour
- Children born into a family with historic safeguarding concerns

We learnt that:

- Children's Services needed a more robust approach to the written agreements drawn up between the service and families; and that these agreements need constant monitoring.
- Children need to be seen alone and we need to improve how we observe and record the interactions between children and their parents/carers.
- The Probation service is an important partner in safeguarding children and we must ask them what they know to help us understand all we can about the child's life and the potential risks posed by people they come into contact with.
- To make good decisions and draw up the best plan we can for children at child protection conferences, we need all agencies to provide a written report prior to the conference. This must detail all of the relevant historic information that the agency has on the family and be a good quality, analytical report.
- Child in Need plans and Child Protection Plans can fall victim to drift and delay and we need to help social workers sharpen their focus on implementing the plan.
- Understanding chronic poor school attendance is crucial in understanding the lived experience of children. Education Welfare Officers can help us with this and we need to ensure they are involved in Child Protection Conferences.
- The learning from Serious Case Reviews and other reviews needs to reach all corners of the workforce in a timely way and feel relevant to frontline staff.
- When there is a change in the social worker, the focus on the child is reduced and drift can occur.

Learning from Serious Cases and other reviews - What do we need to improve?

1. Early Support

- The Common Assessment Framework is not embedded within multi-agency practice.
- The emphasis of partnership working with parents and the reliance on CAF as a method of engagement inhibits professionals from sharing concerns about families which do not reach the threshold for Child in Need/ Child Protection and who will not agree to, or engage with, the CAF process.
- Early and robust Intervention is required on a multi-agency basis in cases of chronic school non-attendance. Poor school attendance, as in many others, was an indicator of severe family problems.

2. Application of Thresholds and the Response to Levels of Need

- Thresholds are felt by some professionals to be too high and the expertise of colleagues from other agencies is not recognised.

3. Escalation of Professional Concerns

- When a practitioner is concerned that a child is not receiving support or protection at the level they need, professionals reported that they feel unable to challenge decisions with which they disagree.
- Similarly, challenging decisions made in relation to a child, is considered time consuming and rarely productive.

4. Information Sharing

- Cross boundary information sharing was poor in one case and this made it difficult for professionals to know the full situation and make good decisions.
- There are weaknesses in information sharing processes and practices in relation GP's for cases for which no formal Child Protection Plan is in place.
- One case highlighted problems about how intelligence and information was not shared between agencies in relation to the formation of a 'street gang"

5. Multi-agency assessment and interventions

- Managing diverse and complex issues within families requires detailed planning across agencies and one case highlighted issues in this area.
- Current methods of agency interventions are not effective when professionals are working with complex families. A "team around the family" approach should be considered.
- Good quality multi-agency assessments require a collaborative approach from all involved agencies.
- Complex, hard to engage families require a more coordinated multi-agency approach that is achievable under current collaborative arrangements.

5. Neglect

- The failure to effectively assess whether parents have the capacity, willingness and motivation to work with professionals on agreed concerns results in professionals wasting time and effort and leads to drift and delay in addressing the needs of children, especially where neglect is a factor.
- There are potentially serious weaknesses in the shared knowledge and skills of practitioners in relation to the nature and impact of neglect on children's on-going development

Learning from Professionals – What is working well?

In the majority of cases, professionals work well together to help

children and their families. Even cases reviewed because of issues with practice can highlight what is working well and how we can build on this. Below are some of the key themes we have learnt about good practice and professionals working well together.

- Evidence of professionals working well and delivering a multi-agency approach
- Professionals enjoy working together and as part of a multi-agency team. This helps them to feel more confident in their practice.
- When professionals feel confident in each other they work well together. This enables them to identify risks and reduce them.
- Professionals can engage positively with parents, even when things get off to a difficult start
- Professionals are clear about the roles of others and the functions of partner agencies.
- Voluntary Sector practitioners have more confidence and are more engaged in early help and child protection processes as a result of involving them in multi-agency meetings and training.

Overall

When professionals have confidence in one another, they work well together and listen to each other. This helps them to make good decisions and provide good support. Confidence is increased when professionals understand one another's roles and how they provide help and support to children.

What has changed as a result of our learning?

- All agencies must now complete and return an agency report ahead of the child protection conference and these now includes all the historic information that the agency has on the family.
- Children's Services have developed a standard template to ensure written agreements are drawn up and monitored appropriately
- The Safeguarding Unit is more effectively monitoring attendance at case conferences; whilst Education Welfare Officers are now routinely involved
- The Probation service are routinely consulted during all single agency assessments Children's Services single assessment has been launched and includes checkpoints to ensure the child is seen alone and the interaction of the parent with the child is observed and recorded.
- The Safeguarding Unit oversees the effectiveness of the core group meetings to ensure actions are progressed effectively; and now actively monitors the quality of reports to Case Conferences Guidance to social workers in respect of Children In Need Meetings has been revised to ensure a sharper focus on the monitoring and implementation of CIN plan targets
- The Safeguarding Unit Manager now routinely monitors all CP plans that have moved beyond the third conference Children Services managers have become more effective at managing cases where there are changes in social workers

7. LSCB Effectiveness and Our Plans to Improve Further

LSCB member agencies have shown drive, energy and commitment in delivering good services for children and young people during the previous year. Board members are. The maturation of senior professionals' relationships and the sense of collective responsibility of partners is evident via the continually developing scrutiny of local arrangements and subsequent challenge of one another to improve these. This section critically analyses key areas of our work and explains how we will continue to develop as a partnership and drive further improvement during 2014-15.

Performance Management

The Performance Management Sub-group of Liverpool Safeguarding Children Board has examined a wide range of data and information and attempted to distill the vast array of multi-agency information into a more streamlined and workable format. However, this dataset remains unwieldy and does not always include an analysis of underlying trends and causes. This area requires improvement.

Next steps

- We will refine the dataset against our priorities and the main Board consider it quarterly.
- We will hold agencies to account against the performance information and also challenge agencies to improve their commitment to providing what the Board requires.
- We will include more data across professions and align our work with the Joint Strategic Needs assessment.

Policies and Procedures

There remain sections of the multi-agency procedures that require review and revision. Nevertheless, the sub-group that leads on this area has made significant progress during the previous year in bringing the procedures up to date and to be compliant with Working Together 2013. Testing the use of these procedures is required and the improved links with other sub-groups that are beginning to develop through the Executive Group will ensure that this takes place. This area requires improvement but is getting closer to 'good'.

Next steps

- We will draft a work-plan that indicates lead individuals and timescales to review the remaining LSCB procedures and ensure all are compliant with Working Together 2013.
- We will act on information on the findings of SCRs and other reviews that relate to policies and procedures
- Upon the completion a new procedure or significant amendment due to the learning from a SCR, audit or other review, we will highlight the mechanisms by which other sub-groups can monitor and measure the impact of the change
- We will seek representation from the Education Sector. The sub-group has itself noted this as a gap.

LSCB Training

The statutory responsibilities for LSCBs in this area are not to deliver training but to ensure that it knows the training needs of the workforce, monitors attendance to ensure that those needs are met; and to evaluate the impact of training upon frontline practice. Nonetheless, Liverpool Safeguarding Children Board, along with the majority of LSCBs is the key mechanism for co-ordinating and delivering the safeguarding training programme. A range of training courses are

offered and these courses are aligned to the thematic priorities of the LSCB. There remain gaps, however, in the training programme that could be considered training priorities given the learning from reviews undertaken during the previous 2 years. As Liverpool LSCB has assumed local responsibility for training delivery, this matter will be taken forward by the Board.

There is not yet a comprehensive needs analysis for the LSCB to assess how many practitioners and which agencies they work in, that enables training delivery to be planned against need and assists the Board in holding agencies to account against this need. The LSCB should agree the core competencies for the workforce and analyse need against this framework. The impact of training upon frontline practice is currently largely self-reported and with some alterations to the governance and broadening of the Learning and Improvement Framework, can be systematically triangulated via other activities, such as practice audits, Section 11 scrutiny and performance data. This area currently requires improvement..

Next Steps

- Ensure training is developed on other parental factors that impact upon children in the household: ie. drug/alcohol use; mental health
- Commission or develop training to enable practitioners to better recognise disguised compliance and assist them in assessing parental capacity to change at all thresholds
- Develop and implement a safeguarding competency framework
- Undertake a Workforce Training Needs Analysis against the agreed LSCB competency framework Work with neighbouring LSCBs to support the evaluation of the impact of training; this will bring added value in the form of independent challenge and oversight.

Learning and Improvement

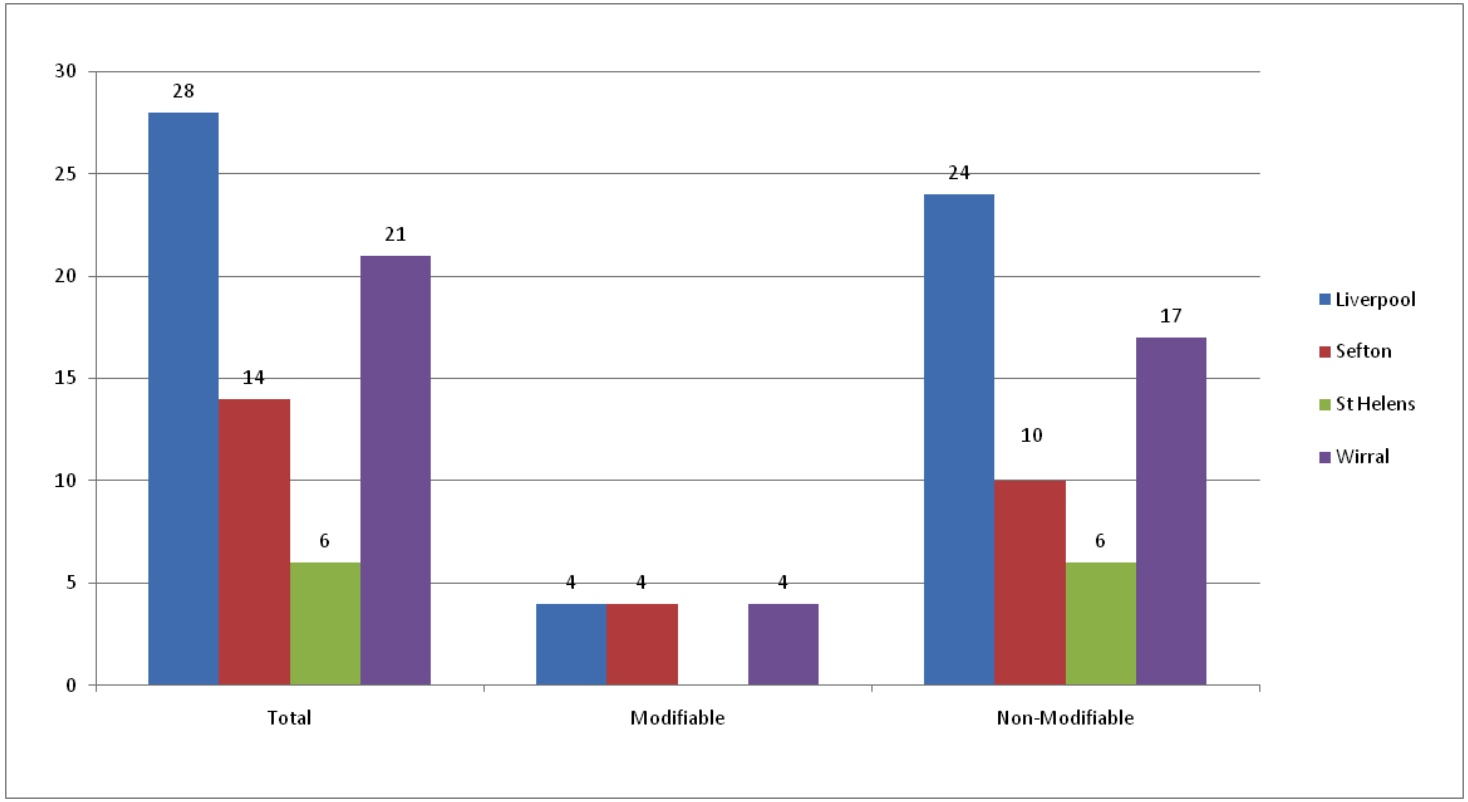
The Learning and Improvement sub-group leads on all training and awareness raising activity and implementation of the LSCB local Learning and Improvement Framework (LIF). The interpretation of statutory guidance has been to focus on Learning and Improvement as the 'systematic cascading of learning within agencies' following a Serious Case Review or other review.'Learning' is the process of extracting what we need to know via these activities. Improvement is the range of work we undertake to fix problems we find and encourage good practice when we find what works well. Training and awareness raising is one method we use to improve but there are others. We believe that our current interpretation of Learning and Improvement is limiting and does not ensure the "double loop learning" required for the LSCB to be assured that its improvement plans have had the desired effect. OFSTED commented that we need to "audit and evaluate the implementation of serious case review (SCR) action plans". This will be led by Critical Incident Group.

Next Steps

- The LSCB will review the governance arrangements in relation to maintaining a robust Learning and Improvement Framework (LIF)
- A comprehensive LIF will be devised that illustrates all of the learning gained by the LSCB during 2013-14 and beyond; the gaps in knowledge for which further learning is required, the emerging trends and themes, the plan for improvement and; and the double loop learning activities that will be undertaken to measure this improvement. The LIF will be updated quarterly.

The table below highlights the cases considered for which modifiable factors were identified.

4 of the 13 Liverpool child deaths had modifiable factors.



Appendix 1

Risk assessment

We have identified a number of local and national factors that could have an impact on the ability of the LSCB to safeguard children and young people in Liverpool. The Board is taking steps to reduce the impact of each risk or concern.

Risk	Effect of the risk	Action to be taken to reduce the impact of the risk
Geography/cross border issues	Duplication of efforts or gaps in intelligence and information in relation to CSE. Duplication of efforts, missed opportunities for economies of scale and added value	Shared Merseyside CSE Strategic group Exploration & development of joint commissioning arrangements where possible (eg. CSE and LSCB training)
Membership of LSCB	Potential for statutory Board members to not be able to carry out their responsibilities whilst they do not have membership on the main Board	Review membership in line with statutory guidance. Audit the engagement in key safeguarding initiatives of; and challenge of and from, Health partners who are no longer members of the LSCB if they are to remain non-members
LSCB – Capacity of Support	Increased expectations upon LSCBs due to Ofsted Inspection Framework; and growing number of reports and guidance documents making recommendations for LSCBs. Potential for skills and knowledge to be lost due to temporary nature of support posts	Assess support needs of the LSCB Agree and secure the long term funding needs of the LSCB Recruit additional Quality Assurance post Secure permanent staff within LSCB support posts
Education developments: Academies/Free Schools/LADO arrangements	Concerns that individual schools will not engage with the LSCB and/or Local Authority in order for us to be assured of their safeguarding arrangements	LSCB to build on support offered to schools, including academies and free schools by evaluating the S175 returns for trends and themes which can be communicated to schools and an LSCB event arranged and delivered LSCB to receive reports from LADO that clearly disaggregates data re. sections of education sector. LSCB to request that LA School Improvement Partners assist the Board in understanding safeguarding issues within schools; both generally and in specific schools

Appendix 2

LSCB Budget Information

Contributions from Partner Agencies 2013-14	£
Children's Services	82,612
Clinical Commissioning Group	50,000
Merseyside Probation Trust	9,400
Merseyside Police	31,105
YOS	7,343
Mersey Care	7,729
Liverpool Community Health Trust	10,000
Royal Liverpool Hospital Trust	2,000
CAFCASS	550
TOTAL	**200,739**

Priority areas of expenditure 2014 – 15

- Core training and learning events flowing from our Priorities
- Establish a Development Fund to support specific work linked to our Priorities
- LSCB Staffing - including additional capacity for Quality Assurance activities and establishment of an apprentice post targeted at a former service user
- LSCB Member Development
- Maintenance of SCR and Review and dissemination of learning from these reviews

Appendix 3

Membership

- Independent Chair
- Independent Board Members x 2
- Director of Children's Services; Liverpool City Council
- Assistant Director of Children's Social Care, Liverpool City Council
- Chief Superintendent, Merseyside Police
- Assistant Chief Probation Officer, Merseyside Probation Service
- Assistant Director, Supporting Communities; Liverpool City Council
- Chief Nurse; Liverpool Clinical Commissioning Group
- Designated Nurse; Liverpool Clinical Commissioning Group
- Public Health Consultant, Liverpool City Council
- Secondary school representative
- Special school representative
- Primary school representative
- School Governors Forum representative
- Public Health Consultant, Liverpool City Council
- Adult Services, Liverpool City Council
- Liverpool Charity and Voluntary Services/0-25 network
- Representative of NHS England
- Adult Services, Liverpool City Council
- CAFCASS
- Cabinet Member for Children's Services as a Participant Observer