



**North East Lincolnshire
Safeguarding Children's Board
Annual Report
2015/2016**

Foreword by Chair

I am very pleased to provide this overview of the North East Lincolnshire Safeguarding Children Board (NELSCB) Annual Report 2015/16. This is my third Annual Report as Chair of the NELSCB, having taken over a rapidly improving Board from the previous Chair in June 2014.

The year has been characterised once again, by deep reflection combined with a focused determination on continuous improvement and maintaining momentum within partnership activity. The body of the report describes some of those improvements in more depth, including Child Sexual Exploitation (CSE), Prevention and Early Intervention (PEI) and Performance Management.

The continuing climate of structural and financial turbulence across the public sector creates challenge and opportunities. I note in North East Lincolnshire (NEL), a culture based on spotting the opportunities in a changing landscape and then in a creative but measured and reflective way, capitalising on them, which, added to the energy and commitment of practitioners and partner agencies, enables the Board and its partners to feel optimistic about the future for Children and Young People in NEL.

There is much more to be done, and the body of this report describes some of that, as does the final section, which looks forward towards progress to be made into 2017.



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1) Executive Summary

The following Executive Summary provides a brief overview of each of the main sections, where appropriate highlighting progress as well as areas for development.

1.1) Local Background and a Changing Landscape

NEL has a relatively stable population, with above average levels of child poverty, high unemployment and reducing, but still high levels of teenage pregnancy. Progress has been made towards reducing the numbers of children formally in need of specialist children's services. In particular, the number of children subject to a Child Protection Plan (CPP) reduced significantly in 2014/15 and is now stable, but there is more to be done here. We have also seen a rise in Looked After Children (LAC) in 2015/16.

The national review of Local Safeguarding Children Boards (LSCB) and the Government's response to this creates challenges and emerging opportunities to do things differently as does the Future in Mind (FIM) agenda. At a local level, the development of Creating Stronger Communities, a holistic look at commissioning 0-19 and a commitment to joining complex agendas similarly, bring change and opportunity.

1.2) Governance of Safeguarding

Governance arrangements for the LSCB are now stable, with a Leadership Board, an Operational Board and a series of dedicated Subgroups. Levels of partner engagement in governance arrangements are strong, although attendance at Leadership Board meetings fell during 2014, and this is now being addressed.

Particular attention has been given to creating a more coherent and integrated governance infrastructure. For example, all LSCB Subgroups now have a set of performance indicators based on the LSCB Core Data Set and all groups providing quarterly Score Cards to the Operational Board. Score Cards have been warmly welcomed by the Board, in part because they provide consistency and enable the Board to focus in swiftly on key issues.

There are better links with other partnership groups and systems, and further links across sub-regional working such as the establishment of the Joint Child Death Overview Panel (CDOP). Further work is required to maximise the potential of collaborative working across strategic agendas, partnership groups and geographical boundaries and this will be informed by expected structural freedoms for multi-agency safeguarding arrangements in the Children and Families Act (2017).

1.3) Progress Against Priorities

Prevention and Early Intervention

This has been an area of continuous development and includes the introduction of:

- An additional threshold of need (Universal Plus enables families to be supported earlier)
- A Single Assessment (SA), spanning the journey of the child, operated on the principles of restorative practice. Received positively by families, there have been over 1200 Single Assessments started since implementation.
- Families First Access Points (FFAP) in 2016, with over 200 involvements across 496 subjects in the first few months of operations giving sufficient volume to analyse and respond to trends.
- Children's Centres as Family Hubs, offering information advice and guidance across 0-19 services.

Neglect

The Neglect strategy has been refreshed and extensive training has continued to be delivered. A targeted awareness campaign linked to public health awareness activity demonstrates an 'across the systems' approach to this priority. Tools to capture the child's voice have been piloted and NEL's work on neglect has received national recognition (Municipal Journal, Highly Commended) and been cited in national research. Although there has been a % reduction in Neglect as a key feature in Child Protection (CP) Plans, this is minimal and Neglect remains an area of attention focus and concern.

Addressing Child Sexual Exploitation

Public awareness of CSE is strong, supported by the “Say Something, See Something (SSSS) Campaign” . In 2016 a media campaign specific to young people experiencing issues relating to CSE was delivered (linked to the national campaign). The Home Office identified NEL’s work around CSE Operations as best practice. CSE work in schools is growing – a demonstration of good links across the system. Referrals into Early Help (EH) have grown, indicating that CSE risk is identified early through partnership activity.

Domestic Abuse

The One System Approach (OSA) to Domestic Abuse (DA) was launched and has been developed into a 3-year strategy and operational action plan. A new Centre has opened, providing counselling and support around domestic and sexual violence and more easily accessible and affordable legal advice via ‘Affordable Justice’, a local organisation. A training analysis shows practitioners are better able to identify the signs of DA and victims are more likely to report and access support. DA incidents rose by 12% during 2015/16, from 4200 to 4700 possibly due to increased confidence in reporting, but remain a key priority beyond 2016.

1.4) Safeguarding Vulnerable Children

Children subject to Children in Need (CIN) and those on a Child Protection (CP) Plan

Persistent attention and developing new approaches to thresholds has helped safely reduce the numbers of children open to statutory social care, with an 18% reduction in CIN over the year down to less than 1100 from nearly 1300. The numbers on CP plans has reduced from over 400 in 2014 to around 230 in 2015/16, closer to that of our statistical neighbours. At 5.2%, however the numbers of children on second repeat CP plans is nearly twice our statistical neighbours. On a positive note, all children have up-to-date plans that are reviewed regularly and positive feedback has been given by parents via peer observation and post-conference parent interviews.

Looked After Children (LAC)

LAC numbers have increased to 294 from 265 in 2014/15 creating pressures within the system, in part due to some large families and inevitable delays in proceeding to Special Guardianship or Child Arrangement Orders where children’s needs are complex. Nevertheless, attention has been given to children’s engagement in reviews and now nearly all children communicate their views prior to review and are reporting positively about their experiences. Links with health have helped increase LAC participation in health assessments and dental checks.

Missing from Home and Care

Good partnership working has helped to improve monitoring and recording of missing children. Audits have provided assurances of compliance with procedures and process and evidenced proactive work by residential staff to develop a ‘keeping safe’ environment. Debriefing of missing children is undertaken in all cases where the child consents and intelligence from debriefs is leading to improvement in planning and targeting of activity. As a result, improved intelligence has led to increased action on grooming; child protection investigations, drugs gangs and use of police disruptive tactics. The frequency of missing numbers and missing episode is reducing.

1.5) Key Safeguarding Children Processes

Allegations Against Professionals

Processes have been developed to include dip sampling of allegation management case records to ensure consistency and aid improvement. The annual report to the LSCB shows that most cases are resolved within the 3-month target, with around 40% of cases being substantiated. Emerging intelligence suggests that safe recruitment alone is insufficient to create a safe environment and must be underpinned by robust supervision and whistle blowing processes. This message is being disseminated across partners through training and planned workshops.

Safeguarding in Education

An active Education subgroup ensures a broad school perspective on safeguarding. A key annual process is the Section 175 (self-assessment) audit of safeguarding in schools which this year got a 100% completion response. Participation of schools in safeguarding goes beyond compliance with a self-audit and they have been actively engaged in developing ‘at-risk’ data sets; have engaged well in Child Protection Coordinator meetings, and shared

learning from audit activity. Increased resources to support activity around Elective Home Education (EHE) and Children Missing Education has also helped support a safeguarding in education agenda.

Female Genital Mutilation (FGM)

This issue has a national profile, and recent local activity gives us confidence that prevalence is minimal. We have invested in raising awareness about FGM and ensured compliance with local and national reporting requirements.

Policies Procedures and Guidance

Procedures are compliant with Working Together 2015 and reviewed twice a year, to include amendments arising out of Serious Case Reviews (SCR). There is evidence from case file audits that procedures are fit for purpose and accessible via the LSCB website which has received 12,000 visits since its re-launch earlier in the year.

Learning and Development Activity

A wide range of learning and development activity has been undertaken, with over 100 multi agency training and over 80 single-agency activities. Training is reviewed and updated as a result of SCR's and the changing local and national context. In 2015/16 there have been workshops for members and safeguarding e-learning has been offered more widely. An audit of training has helped identify gaps and identified a need for sexual abuse training in addition to the present CSE and Harmful Sexualised Behaviour (HSB) training.

Monitoring and Quality Assurance

Audits undertaken on LSCB priorities including Neglect, Missing and Disability have led to inter-agency action plans and improvements to practice and processes: revision of escalation procedures; School CP Coordinators meetings being reinstated; and increased emphasis on supporting good parenting. There has been impressive partnership engagement in audit activity across agencies, with all schools participating in the S175 audit. The next Section 11 (S11) audit process will be in 2016/17, but in 2015 a challenge day was held to review the 2014 S11 process and check progress against action plans. Young people were actively engaged in this process and greater involvement of young people across a range of audit activity is planned for the coming year.

Serious Case Reviews (SCR)

No SCR's have been directly commissioned in 2015/16 although NEL has participated in an SCR led by Waltham Forest. The SCR Subgroup has been active in progressing existing SCR's, ensuring learning is implemented and a revised more streamlined LSCB reporting format is in place to track progress. Audits demonstrate progress against key themes from SCR's, such as resistant parenting, disguised compliance and voice of the child. The SCR subgroup has also developed pathway for review of cases not meeting SCR criteria. NEL and North Lincolnshire subgroups are now chaired by the same health representative promoting partnership engagement and consistency across boundaries.

Child Death Overview Panel (CDOP)

11 deaths were reviewed in 2015/16 and partly in response to the numbers being insufficient to provide statistically valid analysis/trends of deaths, a joint CDOP has been established with North Lincolnshire to address this and improve efficiency. The CDOP is reviewing support available to bereaved parents. The annual CDOP report is presented to the LSCB.

Engagement with Children and Young People

Capturing the voice of children and ensuring it influences activity and services has been a long standing commitment of the LSCB and we see annual improvements in the range and sophistication of activities. Young people are engaged in S11 activity and Young People have actively influenced the re-vitalised website. Viewpoint is being increasingly used to capture voice and young people have been involved in recruitment of LSCB members.

1.6) Working With Partners

The aspiration in NEL is for strong strategic alliances around local priorities, including safeguarding of children and it is testament to partners that they are delivering on this aspiration in such times of volatility, complexity,

uncertainty and ambiguity. Statutory partners continue to provide financial resources to enable the LSCB to function and develop and all partners make a significant contribution of staffing resources to participating and sometimes leading activity. The body of the report includes submissions from each partner on their contributions to safeguarding in NEL.

2) Introduction and New Initiatives

2.1) Changing Local Context

There are a number of local initiatives designed to strengthen and support practice to safeguard and promote the welfare of children and young people.

2.2) Creating Stronger Communities

The Creating Strong Communities Programme was implemented by NEL Council (NELC) in April 2015, following a successful bid to the Social Care Innovation Fund. The model underpinning Creating Stronger Communities is designed to fundamentally change the way local practitioners and partners in NEL work together to safeguard vulnerable children. This new approach is expected to support culture change and the system shift necessary to dramatically reduce the numbers of individuals and families requiring intensive support.

In April 2015 the Council won additional money from the Social Care Innovation Fund to develop the Creating Strong Communities Programme. The programme includes the following four parts:

1. **Outcome Based Accountability (OBA):** Enables a focus on outcomes rather than process
2. **Restorative Practice:** Enables a focus to work with each other to resolve conflict at the earliest stage
3. **Signs of Safety :** Enables a focus to work collaboratively and in partnership with our community
4. **Family Group Conferencing (FGC):** Provides mediated support for the whole family

During 2015/16 some key achievements for the programme included:

- Development of a Council outcomes framework using OBA
- 187 Council staff developed in the OBA method
- Developed Council staff and partners in enabling restorative practice
- Over 1,400 Council staff and partners developed in the Signs of Safety method
- Development of a new Single Assessment and Plan which has replaced the Common Assessment Framework
- Establishment in October of a Family Group Conference service who have since worked with 44 families in developing Child Safety Plans
- Production of a Children's workforce development strategy and Professional Capabilities Framework which identifies the knowledge, skills and behaviours required for people who work, volunteer or lead work with children, young people and their families.

2.3) 0 to 19 Commissioning

0 to 19 Commissioning will have a positive impact on safeguarding children. Due to the complexity of change across the delivery, governance and operating model of children services nationally, the decision was made to undertake a review of all provision for children, young people and families across NEL. This has been called locally, the 0-19 programme. The programme is ambitious and long-term, with an estimated duration of three years including diagnostics and implementation.

The core purpose of the programme is to continuously improve outcomes for children, ensuring that they thrive and are safe. We will achieve this by safely tackling demand and rebalancing provision across the borough towards enabling a sustainable and collaborative prevention focused system. Commissioning has to be outcome focused and whole system in terms of approach. NELC is working in close collaboration with partners in order to undertake the system change necessary. The Children's Partnership Board, Chaired by NELC Deputy Chief Executive is the over-arching governance board for the programme.

2.4) Future in Mind (FiM)

Children can be more vulnerable where they have issues in respect of emotional health and wellbeing as a result of complex family issues and so NEL has a local transformation plan based on recommendations of the 'Future in Mind Report to promote, protect and improve our children and young people's mental health and wellbeing'. The plan is to provide an integrated whole systems approach to emotional health and wellbeing including health promotion and prevention, interventions for children with existing or emerging mental health problems. This will be delivered alongside the local prevention and early intervention model to build resilience through to adulthood. Work is ongoing to create a supportive environment that promotes children's mental health and wellbeing by:

- Empowering children, young people and families through building resilience and through self-care
- Intervening early and providing support as issues emerge for children, young people and their families
- Ensuring pathways into mental health support are effective and transitions into service are smooth
- Ensuring services are evidenced based, appropriate, accessible and meet the needs of those children, young people and families who need additional support
- Identifying the training skills, knowledge and awareness needed to support children and their families

3) Local Background

3.1) Population

NEL has a population of 159,570, with 34,309 being children under 18 years old. NEL's school children are predominantly White British (90.9%), compared to national figures of 68.9% in primary schools and 72.1% in secondary schools. NEL has a small, but increasing proportion of pupils from a Black or Minority Ethnic (BME) background (7.2%). Approximately 26.7% of the local authority's children are living in poverty (all children), compared to 18.6% nationally (2012).

4) Governance

4.1) LSCB Structure

The LSCB structure (Appendix 1) consists of a Leadership Board which is responsible for ensuring the effectiveness of local safeguarding arrangements. The LSCB Operational Board is responsible for the delivery of the LSCB business on behalf of the Leadership Board through its scrutiny of the work of the LSCB Subgroups. Subgroups are aligned to the LSCB statutory functions and priorities. (Appendix 3.)

LSCB Subgroups all have a set of performance indicators based on the LSCB Core Data Set. All groups provide quarterly Score Card reports to the Operational Board, which monitors performance and Subgroup activity in response to emerging themes, patterns or declines in performance. The Operational Board reports thematic information and performance variations to the Leadership Board.

Inter-agency audit tools are used to implement a themed practice audit calendar. Audits undertaken during the year include Child Sexual Exploitation, Disability, Neglect and Thresholds. The Section 11 (S11) (partnership) audits have been revised and are now held conducted biennially alongside a challenge event. There is a comprehensive Learning and Improvement Framework, aligned to LSCB priorities and learning from SCR's.

4.2) Membership of the Leadership Board

The LSCB member representation meets the requirements of Working Together 2015. Where agencies or interests are not represented on the LSCB, they are represented on the Operational Board and Subgroups.

4.3) Leadership Board Attendance Audit

Attendance at Leadership Board averaged 81% in 2015, slightly lower than 2014. Attendance is monitored at board level and appropriate substitutes identified where agency members cannot attend. There is a formal system in place to address attendance issues with individual agencies to explore reasons and seek resolutions.

4.4) Lay Members

The Board has three Lay Members, all from community backgrounds, who contribute fully to the LSCB work. The recognised value of lay members and the broader perspective they can bring, has following the last recruitment process, led the Board increasing its complement of Lay members from two to three in 2016.

4.5) Joint Working with Other Partners

The NELSCB 2014/15 Annual Report was presented to the Health and Well Being Board, elected members and the Police and Crime Commissioner. The strong links between and across the LSCB and the Children and Young Person's Partnership Board (CYPPB) and the Health and Wellbeing Board have been strengthened and governance arrangements formalised in a joint protocol. Regular strategic meetings are now held between the chairs of the LSCB, Health and Well Being Board and Safer and Stronger Executive Group.

The Chair of the Children and Young Person's Partnership Board (CYPPB) sits on the LSCB Leadership Board and reports on the progress of the CYPPB delivery of priorities. This arrangement allows for challenge by LSCB with regard to the work of the CYPPB. The CYPPB is now chaired by the Deputy Chief Executive NELC and has representation of key partners/stakeholders including Police, Health, Children's Services, Public Health and Elected Members. The CYPP Board is the key governance board for the 0-19+ programme and is seeking to ensure full partner engagement and ownership and that the programme delivers the improved outcome expected.

4.6) NELCB Resourcing and Budget

The NEL LSCB team comprises of the following :

- Strategic Manager for Safeguarding
- NEL SCB Manager
- Quality Assurance Officer
- LSCB Business Support Specialist

The LSCB team is co-located with the Safeguarding Adult Board (SAB) team, so increasing capacity for a consistent approach to business. The annual budgets for both boards is combined for the financial year 2015/16, and is attached at Appendix 2.

4.7) Progress against the 2014/15 Annual report Recommendations

There were nine specific recommendations in the 2014/15 Annual Report that were reflected in the Business Plan and LSCB priorities. These are more fully addressed further into this report, but the headline message is that good progress has been made in all areas, particularly those of reducing numbers of children subject to CP plans, embedding the use of Performance Score Cards and establishing a joint CDOP Panel with North Lincolnshire LSCB.

4.8) NELSCB Business Plan

The NELSCB Business Plan 2015-17 sets out the strategic priorities for NELSCB and how they will be achieved. NELSCB provides the mandate for each of the subgroups whose activity is key to the successful delivery of the LSCB Strategic Priorities and Statutory Functions. Over the year, in addition to the four LSCB priorities, work has focused on the following areas of the Business plan, as reported in the main body of the report.

(The relevant terms of reference for the NELSCB and Subgroups are at Appendix 3)

Demonstrate the impact of Early Help (particularly in relation to Neglect).

The LSCB Neglect Strategy is fully aligned to the Prevention and Early Intervention (PEI) strategy. LSCB partner agencies have developed a number of service level performance scorecards that capture all activity in respect of both PEI and Neglect. Both PEI and Neglect implementation has evidenced a positive direction of travel including embedding key elements of Creating Stronger Communities to support both strategies by equipping practitioners with Signs of Safety (SoS), Restorative Practice and Outcome Based Accountability (OBA).

To ensure the best possible care is received by children and young people in supporting their Emotional Health and Well Being.

The LSCB has been fully involved in the development of the local Futures in Mind Strategy and received regular progress updates. An LSCB Future in Mind dedicated website page has been developed to be published shortly.

Give particular attention to collaborative safeguarding activity across geographical boundaries.

Regular meetings of both regional and local LSCB managers and chairs have taken place on areas of collaboration including joint CDOP between North and NEL LSCBs, and work across the four local boards in response to the Concordat on children in custody and the sharing of best practice across Humberside Unitary authorities.

Embed collaborative working with partners where there has been, or will be significant change (Police/Probation/CRC/School Improvement)

The LSCB has continued to evaluate organisational change within partner organisations focusing on both potential risks and opportunities in the context of the impact on maintaining effective safeguarding arrangements.

Embed the use of Score Cards and the Core Data Set as a means of individually and collectively understanding our business and performance.

Quality assurance, performance and audit processes have been strengthened during the year. The OBA model is well embedded and provides clear direction of travel to the Leadership Board on the LSCB priorities.

Further improve systems and processes to capture the Voice of the Child in order to inform the development of better services.

The Voice Of The Child was a key feature of recent a LSCB Peer Challenge. The Neglect Subgroup has developed tools to capture the voice and of children at different ages and stages. The work plan with the young advisors is being revised to focus on key areas of LSCB work and ensure their active involvement with the Section 11 audit process.

Explore the development of a CDOP across the boundaries of NEL and North Lincolnshire.

A Joint Child Death Overview Panel was established with North Lincolnshire LSCB in April 2016 following the development of joint guidance and terms of reference. The panel has led to shared learning.

5) The Four Priorities

5.1) Prevention & Early Intervention

What did we say we were going to do?

During the reporting year, the following has been implemented as per the Prevention & Early Intervention (PEI) strategy & Creating Strong Communities programme.

What we have done

- Added an additional level (Universal Plus) to the threshold of need model to support families earlier
- Development of the Families First “brand”
- A new Family Support Pathway / Threshold of need document, practitioner’s toolbox and useful contacts
- The introduction of a Single Assessment (SA) underpinned by an audit framework, replacing the Common Assessment Framework. The SA spans the child’s journey, building evidence of what does or doesn’t work for the family or child, eliminating the need for families ‘repeatedly-telling’ their story when shifting between services.
- Introduction of the Families First Access Point (FFAP) in January 16
- Troubled Families criteria embedded into SA’s, enabling all plans to be tracked and claimed for as appropriate
- Group & 1:1 family support work conducted in Family Hubs at Early Help (EH) level or above according to need
- Audit framework developed for SA

- Introduction of weekly multi-agency Cluster Single Assessment Meetings (CSAM) within each cluster, to support the SA planning and review, chaired by hub managers or EH coordinators.
- Development of OBA scorecards reflecting NEL outcomes and vision; All people in NEL 'feel safe, are safe', 'enjoy good health and well-being' and 'fulfil their potential through skills and learning'.

Evidence, impact /difference made

There were 1225 SAs in 2015/16. Although too early to evidence the impact of the SA or Families First Access Point (FFAP) in terms of improved outcomes at Prevention and Early Intervention (PEI), CIN, CP or LAC levels, data cleansing on migration from Common Assessment Framework (CAF) to SA is ongoing and a planned evaluation will evidence impact and enable us to project on improved outcomes. For example; to date there has been positive feedback from families and practitioners including;

'Parents said that they really liked the fact that they had developed a safety plan themselves and felt this was important because it meant something to them and their children. They understood why services are involved and what they are worried about although the children were too young to understand this'

'We feel the use of the Single Assessment has strengthened our partnership working, the Early Help Coordinator has been a great support in helping us getting to grips with the Single Assessment'

Universal Plus support is now targeted at families residing in wards of highest deprivation acknowledging that multiple adversity can affect children's outcomes. This is evidence of using local knowledge of need and resources effectively to inform planning at a community level and develop appropriate universal activities.

CSAM are now well established in all 5 geographical cluster areas. Feedback from partners indicates positive benefits to the multi-agency approach to early intervention. On the whole, SAs reviews are timely, preventing drift and promoting better understanding of services available to support need.

E-start data now captures completion of Neglect Tools so that scoring on progress can be tracked, preventing drift, evidencing change and enabling the right support to be offered at the right time. Only one family where the Neglect Tool had been used was 'stepped-up' to MASH, due to no progress being made. Over 2015/16, completion of Neglect Tools has tripled, showing that Family Hubs are identifying neglect earlier and improving outcomes.

Next steps

- Evaluation – to evidence impact/improved outcomes
- 0-19+ Commissioning Programme – service effectiveness reviews & project plan bringing together the PEI strategy/CSC Program etc.
- Review of SA process/paperwork
- Capita reporting module – Families First data & scorecard development
- Audit SA's as per framework & LSCB Quality Assurance (QA) requirements
- Continued development of CSAMs – increase multi-agency involvement – adult services/police/Young People's Support Service (YPSS)/ Youth Offending Service (YOS) etc.
- 0-19+ Commissioning Program – review of Family Hub services, including CSAMs
- Baseline performance data to be further developed to identify targeted support at Universal Plus level

5.2) Neglect

What did we say we were going to do?

Embed the Neglect Matters strategy

What have we done

- Refreshed and re-launched the 'Neglect Matters' strategy and held a Spotlight on Neglect event in partnership with the NSPCC attended by 130 professionals.

- Continued to develop and embed the Professional Capability Framework to build confidence and competence
- Delivered 80 training events to over 1,650 participants in 2.5 years
- 78 inter-agency first line managers attended 'Supervision and Management of Neglect' workshop.
- Launched workshops, 'Attachment, Brain Development and Neglect' and 'SCR's and Neglect'.
- Run a public awareness campaign in South Ward combined with the 'Living Well' public health campaign.
- Developed and piloted tools to capture the 'Voice of the Child' across developmental stages and ages
- Shared Neglect resources with the Pan-London Boroughs.

Evidence, impact /difference made

- CP plans for Neglect have fallen from 51% (Q4) 2014-15 to 49% (Q4) 2015-16.
- 'Assessment Tool for Neglect' to be completed should a neglect case be stepped up to statutory services or progressing to child protection to evidence targeted support early.
- Neglect work received recognition with a Highly Commended award from the Municipal Journal.
- NEL children contributed to national research published November 2015 by Dr. Alice Haynes '*Realising the Potential: Tackling Child Neglect in Universal Services*'.
- 100% people trained in Neglect expressing that they feel confident to put learning into practice.

Next Steps

- Align work to Public Health outcomes and the issues, impact and prevalence of dental neglect
- Targeted those wards with the highest deprivation.
- Develop framework for long term support to families living with Neglect.
- Develop practitioner skills/ knowledge to respond effectively to emotional harm and neglect.
- Develop strategies for resistant-reluctant parents refusing to engage where neglect is impacting on care.

5.3) Child Sexual Exploitation

What did we say we were going to do?

- Develop Marketing / Communications via the (SSSS) campaign in tandem with Humberside police trigger plan re (SSSS) through Operation Make-Safe.
- Further develop young person's campaign through National Working Group (NWG) "Say Something", Linked to the missing person's charity.
- Strengthen links with frontline Health professionals through training and referral.

What have we done

- The (SSSS) campaign was implemented successfully. Key to this, was a media campaign aimed at young people experiencing CSE issues, delivered within the "Say Something" campaign, via the National Working Group, linked to the Missing helpline, a charity supporting young people
- The (SSSS) campaign was delivered through Safe Relationship for Young People.
- Operation PRIAM was noted as good practice following evaluation/scrutiny by external Government office

Evidence, impact /difference made

- 30 Operation PRIAM patrols conducted and 63 missing de-briefs completed on PRIAM
- 67 group work settings in schools
- 63% of CSE is at universal/PEI level thereby reducing the percentage going into CIN, CP and LAC
- 93% showing excellent or good in evaluation of LSCB Training
- 86% showing excellent through training evaluation of SSSS

Next Steps

- Use VIEWPOINT for young person's evaluation
- Refresh of Bedfordshire tool,
- Safe Relationship for Young People now includes primary school focus.
- Continuation of SSSS to the tourism industry.

5.4) Domestic Abuse (DA)

What did we say we were going to do?

A One System Approach (OSA) for DA has been established with a 3-year strategy and operational action plan.

What have we done

Areas of progress include:

- New Centre “Blue Door” opened providing specialist domestic and sexual violence support and counselling
- Designated officer assigned to coordinate the OSA.
- Introduction of “Affordable Justice,” a not-for-profit law firm providing affordable legal advice and representation for women fleeing violence and abuse
- Increased the issue of Domestic Violence Protection Orders, NEL now having the highest in Humberside
- Improved Multi Agency Risk Assessment Conference (MARAC) and data sharing arrangements
- Refreshed “Keep safe” booklet for victims and new Practitioners Guide for professionals

NB: In line with national trends, reported DA incidents in NEL have increased from 4205 in 2014/15 to 4702 in 2015-16. Agency referrals to MARAC have also increased to 51% against a national average of 36%.

Evidence, impact /difference made

Feedback indicates that increased awareness and training of practitioners has resulted in warning signs being detected and victims being increasingly likely to report incidents and access support.

Next steps

- Retain DA as an LSCB priority with a strong emphasis on this activity
- Workforce development across agencies and increase awareness of Claire’s Law and Domestic Violence (DV) protection orders
- Activities targeted at demographic and geographical groups
- Exploration of joint commissioning arrangements around specialist advocate support
- Developing comprehensive services for child victims and witnesses
- Early identification of victims, witnesses and perpetrators through routine enquiries by health professionals
- Ensuring referral pathways are robust, clear and accessible to all partners and community

6) Safeguarding Vulnerable Children

6.1) Multi Agency safeguarding Hub (MASH) & Children’s Assessment and Safeguarding Service (CASS)

What did we say we were going to do?

Ensure that cases open to statutory Children’s Social Care (CSC) are safely reduced, so that cases managed by CSC are those requiring safeguarding intervention. This has been done through embedding CIN, CP, and LAC Closure panels, working with EH Professionals to reduce CSC caseloads and tackle drift and delay on cases.

What have we done

A key priority for MASH and CASS this year has been to increase staff stability and ensure continuity of case workers wherever possible. Staff turnover has slowed significantly and following the most recent round of recruitment, NEL has appointed to all social work vacancies, all of which should be in post by end of September. The total number of referrals being taken within MASH has remained static for the past year and we continue to work with our partners to safely further reduce referrals to the service.

Evidence, impact /difference made

The number of CIN open to CASS has reduced from 1272 in April 2015 to 1097 in June of this year. This is a positive reduction though still higher than regional and national averages per 10,000 of the child population. By May 2015, the 2014/15 number of 300 children subject to a CP Plan had reduced to 219 and continued to fall.

Next steps

Progress continues towards proactive and preventative work with families through the use of Family Group Conferences (FGC) and the SOS approach, to support children being cared for safely in their own families with robust contingency planning rather than reactive placements for children with family members at crisis points.

6.2) Looked after Children - Children's Safeguarding and Reviewing Service (CSRS)

What did we say we were going to do?

- Ensure that the Performance Work Book continues to evolve to capture the right information and data to assist in future service planning and improvement.
- Obtain feedback on the Independent Reviewing Officer (IRO) Service Provision from children, parents and professionals to inform developments and incorporate into future service delivery.
- Undertake audits of the Quality Assurance Notifications (QAN) to collate thematic practice issues and use these to develop learning themes and improve practice.
- IRO work to continue to be subject of an audit program linked to the LSCB Quality Assurance Framework.
- Include baseline performance data aligned to LSCB Score Cards with narrative/charts explaining data.

What have we done

- The performance workbook is used to provide data for OBA Scorecard to ensure that key data is captured for management oversight and service improvement and reported quarterly to the LSCB
- The roll out of Viewpoint is a continuous piece of work
- Increased the numbers of children who attend their review in person, from 17 to 22%
- IROs are visiting children on a date prior to the review and using parent feedback and peer observations
- The Council for Children in Care share the records of their meetings with the Corporate Parenting Board (CPB)
- Peer observed practice sessions are being implemented
- IROs have also been involved in auditing cases identified in the LSCB Audit Program and attended practitioner sessions. The service has used thematic team meetings to reflect on cases and the associated practice issues.
- Routinely complete QAN to alert social workers, their supervisors and service managers to issues identified on cases in a more formally recorded and 'tracked' format.

Evidence, impact /difference made

- 1120 LAC reviews are recorded as having taken place during 15/16 and increase from 1049 in 14/15 reflecting the increasing numbers of LAC. 517 pre review visits recorded (under recording though)
- 97% of children over 4 directly expressed their views at review or via written or electronic communication
- 94% of reviews were held on time, with only 16 children having a late review and the direction of travel is up
- There are some good examples of children/young people participating in their reviews
- Children report positive experience of their IRO and parents report good experience of conference chairs

Next steps

- To collate findings from peer observed practice and obtain feedback on the IRO Service Provision from children and professionals to inform planning and incorporate into development of future service delivery.
- To identify and respond to thematic findings of QAN's so that areas for development can be targeted.
- IRO work to continue to be subject to an audit program linked with the LSCB Quality Assurance Framework.
- To implement and embed the SoS model of social work practice within the LAC review process

6.3) Looked After Children (LAC Through Care Team)

What have we done?

The completion of Initial Health Assessments by LAC Health Team paediatricians has improved in timeliness and quality, with the annual out-turn for annual dental checks and health assessments for children looked after for 12 months or more remains over 95%. A multi-agency team including LAC nurses, child psychology, social workers

and virtual head teachers meet regularly to discuss Strength and Difficulty Questionnaire (SDQ) outcomes and formulate plans for children. Capacity has been added to the LAC Education (LACE) team to support Personal Education Plan (PEP) completion. The NEL accommodation strategy has been updated, maintaining a good range of Care leavers Accommodation. With 79% of Care Leavers in suitable accommodation and 22% of care leavers either in Staying Put arrangements with former foster carers or having remained with carers on reaching 18, since moved into independence.

Evidence, impact /difference made

There have been small but demonstrable gains in terms of school attendance for children in residential care, including 1 girl with significant attendance problems - attending for exams and another child with complex problems beginning to engage with school provision. As a result of SDQ meetings - individual children have been supported to manage better in school as a result of the SDQ meetings and, in other cases, had tailored interventions to support placement stability. The improved initial health assessment process has enabled health conditions to be identified, investigated or treated at an early stage, benefitting the children involved.

Staying Put remains an option for all young people in foster care, turning 18 if both the young person & the carer wish for it. Research shows this is beneficial to young peoples' progress towards adulthood & independence.

Next steps

- Action planning to improve placement stability, ranging from innovative recruitment methods to culture change amongst the children's workforce.
- Proposal to support skills development for care Leavers is under consideration.

6.4) Court/Safeguarding

The Resource Allocation Meeting (RAM) process is now embedded, requiring social workers to work with children and families in a proactive and preventative manner to avoid unnecessary escalation to the Court Arena.

Work is ongoing in respect of being proactive and preventative with families through the use of FGC and the SoS approach to support children safely in the care of their parents with robust contingency planning rather than reactively placing children with family members at a point of crisis.

6.5) Missing from Home & from Care

What did we say we were going to do?

- Improve recording and monitoring of missing/debrief data to identify themes and inform plans
- Increase Looked After Children Education (LACE) team capacity to reduce risks from exclusions

What have we done

Debriefs were undertaken in every case except where children refused or police enquiries would be compromised. Missing Intelligence was shared and logged via monthly risk-management meetings and contributed to multi-agency 'Missing' audits. The LACE team appointed a teaching Assistant to provide for challenging behaviour and Child Abduction Notices (CAN) continued to be issued. An alternative education Academy was represented at Risk Management Meetings to help with planning for a vulnerable child.

Evidence, impact /difference made

Multi-agency risk management intelligence enables better planning and hotspots to be targeted so that children are located and risk-managed swiftly, evidenced through:

- Identified 'grooming' leading to criminal investigations and family support provision;
- Debriefs leading to CP investigations;
- Identified links to drug gangs and associated risks informing awareness raising and action planning;
- Substance misuse prevalence (particularly males, aged 14-15) and exploitative relationships triggering police disruption tactics; case-planning and awareness training

- Audits evidence procedural compliance alongside school's consistent response to absconders leading to swift action. Missing episode frequency has reduced whilst residential staff are proactive in locating, transporting home and conducting 'keeping-safe' work. One child with 18 missing episodes (2014/15), had no further episodes from September 2015.

Next steps

To continue to use debriefs to analyse, plan and target resources on prevailing features including family dysfunction and substance-misuse. We will improve database function and work closely with CSE and HSB provision.

6.6) Children Subject to Child Protection – Children's Safeguarding Reviewing Service (CSRS)

What did we say we were going to do?

- Further work to capture/ monitor participation and Voice of the child.
- Further Development of the SoS process and approach to conference.
- Data and performance reporting to be coordinated to coincide with relevant boards and other service areas.
- Produce a risk paper on the potential impact on recruitment of IROs removal of market supplement
- Further development of Observed Practice and its use in IRO workshops and training.

What have we done

- CP and LAC review chairs (IROS) report an Increased take up of viewpoint
- Some staff are identified as practice leads with regard to the SOS approach and attended 5 full days training programme. Remainder of staff will complete 5-day programme September/October
- Strengthened/ developed data/ performance scorecard reporting
- Secured the retention of staff and therefore continuity of worker for children and families
- Chairs completing peer observation monthly, and obtain feedback from family members about their experience of the service. Chairs routinely issue QAN to social work staff

Evidence, impact /difference made

- Between 1st April 2015 to 31st March 2016 the service conducted 582 CP Conferences representing 1147 children (on cases open as at 31st March) compared with 778 the previous year representing 1586 children. All children have up to date plan to address safety/ welfare.
- From a high of 407 children with a CP Plan in March 2014, numbers have continued to reduce to 221 March 2015 and have remained relatively stable as at March 2016 with 226 CP plans
- Case tracking is completed between CP reviews to check progress against the plan and challenge as appropriate.
- Feedback from parents is positive about their experience of conference process and the chair's practice
- Staff are involved in completing audits and implementing findings

Next steps

- Extending use of QAN to partner agencies at conference
- Identify and respond to thematic findings of QANs so that areas for development can be targeted.
- To continue to implement and embed the SOS model of social work practice
- Further development of Observed Practice and its use in IRO workshops and training.

6.7) Children Subject to a Child Protection Plan (Multi Agency Safeguarding Hub)

What did we say we were going to do?

Safely reduce the number of children Subject to a CP plan

What have we done

NEL has a duty to undertake Section 47 (S47) investigations for children at risk of or suffering harm. The number of S47 investigations has decreased in the number of S47 investigations undertaken from 102 in November 2015 to 61 in June of 2016. Figures remain high in comparison to the region and statistical neighbours in terms of children becoming subject to a CP Plan for a second time (29.7% of all children subject to a CP Plan) and in terms of children remaining on a CP plan for two years or more. Children remaining subject to a CP Plan for two years or more currently stands at 6.7% of the total cohort on CP Plan whereas statistical neighbours report a 2.77 percentage of their total. All of these children in NEL have a plan to either safely de-escalate or escalate the case where appropriate.

Evidence, impact /difference made

All of the above highlighted areas have action plans against them using the OBA approach to mitigate any further increase and manage emerging issues through the panel structure that is in place within the service.

Next steps

To build on SoS and promote the use of FGC to support other professionals so that families are receiving the right help at the right time and avoid escalation to CSC.

6.8 Families First Access Point (FFAP)

What did we say we were going to do?

In January 2016, NEL launched a pre-MASH front door FFAP offering information, advice and guidance to professionals and the community at PEI level to support early identification and single assessment, through a multi-disciplinary team.

What have we done?

- Review team set up to further develop FFAP – currently meets monthly
- FFAP Leaflet & Families First (FF) newsletters sent out to all partners
- FFAP team offer outreach support to aid completion of good quality assessments/evidence
- Weekly FFAP/MASH meetings to discuss decision making re thresholds & good practice examples
- Improved relationships between Family Hub/EH teams and MASH colleagues
- Developed EH response to police DA 913 submissions
- Too soon to evidence impact. Current data highlights increasing contacts in FFAP but also increasing contacts in MASH therefore data analysis is to be undertaken to understand the reasons behind this

Next steps

- Continued monthly review meetings
- Capita reporting module development to support FF scorecard and data cleansing
- Continue to work with police to develop EH response to DA
- Continued development & promotion of FFAP
- Audit of all open CAF's – review and transfer to SA or close
- Involvement in 0-19 commissioning programme

6.9) Safeguarding Children with Disabilities

What did we say we were going to do?

- Review safeguarding procedures for children with disabilities
- Review LSCB level 2 training course
- LSCB Audit of children with disabilities cases

What have we done

- Procedures reviewed – guidance agreed that safeguarding issues will be dealt with by MASH
- Training reviewed and new 1-day level 2 training course developed – pilot undertaken
- Dates for 2016/17 LSCB training programme set

- LSCB Audit undertaken

Next steps

- Audit action plan
- Evaluate disability training – impact
- Ensure all revised procedures are uploaded to LSCB webpages

7) Key Safeguarding Children Processes

7.1) Allegations Management – Local Authority Designated Officer (LADO)

What did we say we were going to do?

- Develop the use of technology to allow e-virtual meetings to ease capacity to maintain frequency of case reviews.
- To continue to audit LADO records through ‘dip-sample’ to ensure consistency and quality assure the process for timeliness, effectiveness/ impact.
- To continue to incorporate a programme of Observed Practice within the CSRS to promote the advice/ guidance offered to professionals when referring LADO cases.
- Develop and deliver workshops to share learning from the outcomes of referrals into the LADO process.

What have we done

- Now able to book conference calls to facilitate virtual meetings
- LADO records are subject to ‘dip-sample’ to ensure consistency and quality assure the process for timeliness, effectiveness and impact.
- An observed practice session has been undertaken
- Good practice advice leaflet in relation to engaging private tutors
- The annual report outlining themes arising out of cases and practice issues is disseminated to the LSCB and CPB.

Evidence, impact /difference made

- Appropriate referrals have been made to relevant governing bodies when required to ensure future safeguarding with 83% of cases were resolved within 3 months (slightly shorter than a 90% target)
- 15 cases were substantiated (there is sufficient evidence to prove the allegation), 2 cases were Malicious (sufficient evidence to disprove the allegation and a deliberate act to deceive) and 8 cases were false (sufficient evidence to disprove the allegation).
- 13 cases were unsubstantiated (insufficient evidence to either prove or disprove the allegation. The term, therefore, does not imply guilt or innocence).
- Themes included several cases where, despite following safe recruitment practices, the staff member has been dismissed due to his or her conduct with children and/or convicted of a criminal offence. It has become increasingly clear that safe recruitment practices alone is not enough but must be underpinned by vigilant oversight of staff practice, effective supervision, a robust approach and response to whistle blowing and whistle blowing policies and recognition that staff need proactive encouragement to be enabled to report colleagues whose behaviour raises safeguarding concerns.

Next steps

- To develop a User View Evaluation Tool to enable us to improve the service to partner agencies.
- To develop/ deliver workshops to share learning from the outcomes of cases.

7.2) Prevent

From April 2015 NEL accepted responsibility under Prevent government guidance for the coordination, chairing and management of the Channel provision. NEL appointed the strategic safeguarding manager for children and adults as the chair of the Channel panel to ensure full participation across Children’s and Adult safeguarding.

The Channel panel has been established with clear terms of reference, a referral pathway, training and awareness raising and provision and guidance within policies and procedures. Since June 2015 the Channel panel has met quarterly, moving to monthly meetings from early 2016. The chair has also established a pre-meet process to ensure that information is shared in a timely fashion. The procedures have been updated and the NEL Channel framework has established an effective format for meetings and for recording purposes that has been rolled out across Humberside. Regarding Prevent duties, the LSCB and SAB have initiated a Prevent compliance audit to all partners and reports back to the Prevent Silver group on responses to inform action planning.

7.3) E-Safety

The internet has become an integral part of children and young people's lives, providing invaluable educational, creative and social opportunities. However, the exposure to inappropriate, harmful or fraudulent content and potential risks of grooming, abuse and cyberbullying has led to widespread concern for the safety of children online.

What did we say we were going to do?

- Develop a response to E-Safety through the current CSE operational action plan.
- Adopt the CEOP (Child Exploitation and Online Protection) materials and ethos when dealing with and advising on e-safety.

What have we done

- Young and Safe vulnerability team has developed Safe Relationships for Young People (SRFYP) Programs.
- A universal program for young people, delivered within mainstream comprehensive settings to the majority of year groups and provide a supported approach to a broad curriculum of Sex and Relationships Education (SRE) and supports existing Personal, Social, Health and Economic (PSHE) Programs.
- Delivered in year groups 7 – 11 and Further Education (FE) / Higher Education (HE)

Evidence, impact /difference made

- Over 150 professionals have been provided CEOP awareness training through the LSCB CSE level 2 training course and 2 YPSS staff to complete CEOP ambassador training course in June 2016.
- Over 1500 young people have been provided with E-Safety awareness within SR4YP Programs and 115 programs been delivered in educational settings with positive feedback from schools and very positive, engagement with young people on the programs
- 100% of young people referred to Young And Safe for CSE support receive support with keeping safe on line.

Next steps

- Increase CEOP ambassadors within NEL and cascade CEOP to all agencies working with children

7.4) Safeguarding in Education

What did we say we were going to do?

Undertake an annual audit of safeguarding in educational settings.

What have we done?

Since the 2014-2015 annual report, the education subgroup has undertaken revision of the annual audit with a 100% response, the report of which is due for publication July 2016. We have established a data set on: exclusions; Behaviour and Attendance Collaborative (BAC) referrals; children missing from education (CME) and Elective Home Education (EHE) which includes vulnerable groups (CIN, CP and LAC). There has also been continued awareness raising of EHE/CME challenges in appropriate forums including appointment of an additional EHE assessor to meet the increased numbers and a turning the curve exercise.

Evidence, impact /difference made

The two-way communication and proactive participation from all NEL education establishments has markedly improved including via the annual audit, themed audits, challenge days and Child Protection Coordinator

meetings. The direct commissioning of alternative provision by the Wellsprings Academy Trust has enabled the enrolment of all children and young people subject to alternative provision to be on a school roll.

Next steps

The annual audit will be reviewed and revised during the summer for the new academic year. The group are also looking at CPC supervision, for example; how expertise and good practice could be shared and whether a peer mentoring/supervision system could be established.

7.5) Youth Offending Service (YOS)

What did we say we were going to do?

YOS has made further improvements in its key performance areas and continued to consolidate its relationship with Young and Safe services supporting the most vulnerable of young people with issues around CSE, DV and Prevention of Extremism.

What have we done

Other developments within the service include the consistent representation by the YOS Manager at the LSCB Operational Board meetings along with the development of a YOS Safeguarding Scorecard which highlights key areas of risk and vulnerability including information on young people in custody. The YOS manager is also a core member of the Channel Panel.

Evidence, impact /difference made

- Numbers of young people entering the Criminal Justice System have been reduced to the lowest figure for any 12-month period (61 young people entered the Criminal Justice System compared to 88 in the previous year).
- Young people receiving custodial sentences has reduced from 9 down to 6 during the last 12-month period compared to the previous year
- The percentage of re-offending has fallen from 42.3% to 38.7% during 2015/16.

All of the above reflects the quality of assessment, risk and vulnerability management and interventions that are undertaken and delivered with young people. Close partnership working with the Young and Safe Vulnerability team has led to improved risk management of young people at risk of/or involved in sexual exploitation, joint analysis and audits to inform improved practice and policy development.

Next steps

- Develop and implement our local response to the Concordat for young people in Police custody.
- Development of integrated working focusing on EH.
- Development workforce knowledge and practice on the impact of Mental Health, Substance Misuse and DA on children and families (Toxic Trio)
- Tackling the rising number of offences per re-offender to reduce criminality and improve life chances for children caught up in the Criminal Justice System.

7.7) Private Fostering (PF)

Private fostering regulations and practice has been re-launched within CASS and the community, ensuring that all social workers, families and professionals are aware of the specific requirements for PF cases. The number of PF cases open to this Local Authority is low.

7.8) Harmful Sexualised Behaviour

What did we say we were going to do?

- An awareness raising package around HSB has been developed for schools to use.
- Implement more AIMS training for practitioners to increase capacity

Staff capacity issues in undertaking the aim assessment have been identified and are being resolved.

Evidence, impact /difference made

AIMS risk assessment meetings continue monthly and although capacity to undertake assessments is limited, YPSS continue to undertake assessments and evaluations of case work at amber level intervention. An NSPCC evaluation of red level interventions for Turning the Page programme is in place and the guidance and action plan was updated in January 2016. The HSB strategic group is now part of the Keeping Children Safe Group and has benefited through being amalgamated with Missing, CSE & DA sub groups under one Keeping Children Safe Operational Group reporting directly to the LSCB Operational Board, first meeting 20th July 2016

Next steps

There is a need to identify new lead for HSB & prepare business case in respect of budget requirements for presentation to the LSCB Ops Board.

7.9) Female Genital Mutilation (FGM)

What did we say we were going to do?

Awareness of FGM and ensuring appropriate local arrangements was an issue which emerged for NELSCB during 2015/2016, resulting from the introduction of measures under Serious Crime Act 2015. An audit is required to evaluate partner awareness on civil law measures, FGM Protections Orders from July 2015 – and strategies offering the means to protect actual or potential victims from FGM. The audit is needed along with guidance for the mandatory duty for all regulated/ registered health, education and social care professionals to report any incidences of FGM in girls under the age of 18 to the police.

What have we done

The LSCB Leadership Board received a briefing on FGM, and health service arrangements at their August meeting and requested further assurance in respect of measures taken to raise awareness of Female Genital Mutilation across all agencies in NEL. The Leadership Board received a briefing at their February meeting on arrangements within all health services and across all schools and education establishments when provided assurance to the board that reporting arrangements are understood.

Evidence, impact /difference made

NEL has had no referrals or reports for FGM but it is acknowledged that this does not negate the need for professionals working in this locality to avoid becoming complacent about the possibility..

Next steps

The LSCB will continue to seek assurance from agencies to ensure a continued focus on awareness raising, and compliance with mandatory reporting.

7.10) Asylum Seekers

The number of Unaccompanied Asylum seeking children in NEL remains small although steadily increasing. Three young people entered the area in 2015/16 claiming asylum and assessed as under 18, bringing the total to 4 we support. We continue to work with the Home Office and immigration office and post 18, will continue to support them pending decisions about their status to remain in the country.

8) Partner Agency Safeguarding Reports

8.1) Police

Humberside Police have worked tirelessly over the past year to reshape and refocus safeguarding activity across all four unitary authority areas. In recognition of the demands within the Protecting Vulnerable People Unit, the Chief Constable has committed over £1million of growth which equates to an additional 25 members of staff.

The staffing complement within MASH has increased to ensure capacity within core hours to support joint decision-making and responses to safeguarding concerns and risk management. We have also supplemented the administrative support and Children's Safeguarding Coordinators to increase resilience and enable appropriate

attendance at Case Conferences. This will ensure that all available intelligence and evidence is shared appropriately to enable us and partners to appropriately safeguard children.

The CSE and Missing Persons teams have been separated to allow each to focus on their own areas of responsibility. CSE is a key priority for the Force and we are enhancing our capability to deliver investigations, support for MACE, and to deal more proactively and robustly with perpetrators.

Protecting Vulnerable People (PVP) remains a priority for Humberside Police, and we will deliver an effective response to all issues of vulnerability that affect the most vulnerable in our communities. Our training programme for all front line staff reflects the importance of safeguarding.

8.2) Children's Social Care

What did we say we were going to do?

Children's Social Care (CSC) is a key contributor to the LSCB, having active representation on the Leadership and Operational Boards, Chairing the SCR Subgroup and representation on many of the other subgroups. CSC has fully supported and helped deliver on LSCB priorities, particularly CSE, Neglect and PEI. It has linked the MASH with the newly developed FFAP and promoted a refocus on early response to families to reflect the development of SA and earlier support to families.

What have we done

Continued to invest in social work training and development to ensure all staff have up to date knowledge on the latest research and good practice. The roll out of SoS and Restorative Practice has supported this and is providing social workers with the skills and knowledge to respond to children and families within the Safeguarding arena. The service has also developed a number of internal panels to ensure all cases open to CSC are focused, timely and appropriate progress is made. NEL is committed to continuing to reduce social work caseloads and ensure appropriate referrals are dealt with by the MASH and families get the help they need at the right point.

Next steps

- Continue to implement the Creating Stronger Communities model
- Progress on the 0-19 Programme
- Make further progress on a Regional Adoption Agency

8.3) Children's Public Health Provision

What did we say we were going to do?

Children's Public Health Provision (CPHP) actively promotes the safeguarding of children to health colleagues, including CPHP staff, GP's, pharmacists and dentists.

- CPHP safeguarding staff are partners in MASH, FFAP and MARAC and seek to improve communication across health agencies; improving information sharing and supporting Children's Social Care.
- Participate in LSCB and internal audits; identifying actions for our service. We establish action plans and report progress to senior management within given timescales.

What have we done

- Delivered safeguarding training to community staff and monthly workshops to health visitors & school nurses.
- Offered safeguarding supervision to newly qualified staff for one year followed by staff access mandatory 3 monthly safeguarding supervision with a named supervisor – for all practitioners
- Promoted the SoS Model as a key component of training and practice and established champions within the workforce and supporting Mapping Workshops.
- Routine Enquiry in health visiting so that questions re: DA are asked at relevant contacts.
- School nurses are trained in respect of CBT (Cognitive Behavioral Therapy) and CBT with self-harm.

Next steps

- Changing electronic record templates to reflect SoS and improve standards of analysis and consistency of recording.
- Safeguarding nurses are working with social care colleagues to participate in case relevant panels.
- Deliver safeguarding supervision training to staff eligible to be supervisors; i.e. 2 years post registration.

8.4) Norther Lincolnshire and Goole NHS Foundation Trust (NLaG)

The Trust provides services to clients within the community and hospital setting of Northern Lincolnshire and Goole. The Trust has an executive lead at Board level, a lead for Safeguarding (adults and children) and is compliant with its statutory duties.

What did we say we were going to do?

NLaG works with a range of safeguarding issues including Child Exploitation, DA, FGM, EH and early identification to reduce of all forms of abuse and has systems in place to identify victims and work closely with our partners to tackle CSE. EH continues to be promoted and the number of EH assessments undertaken by staff is increasing. NLaG provide a 'Family Nurse Partnership' (FNP) team whose work is to help young people to be better parents. Safeguarding children training strategy has been in place since June 2011 and training figures are monitored monthly and all NLaG staff undergo this training. Staff access safeguarding supervision so that cases are reviewed ensuring that we do our very best for our patients.

What have we done

For children and young people who contact NLaG there is earlier identification of risk and there is good communication so that hospital information is shared with community services to promote follow up when necessary. Systems are in place to identify when children are on a CP plan, are LAC or at risk from DA. FNP work with young parents has in some cases meant the difference between parents keeping or losing a child.

Next steps

- continue to increase the number of staff who have safeguarding training.
- continue to audit practice to make children safe within the Trust
- continue to work with other agencies to keep children safe.

8.5) National Probation Service (NPS)

During the last year the NPS has continued to play an active role on the NEL LSCB and Operational group. It has ensured that decisions and initiatives taken forward by the LSCB are cascaded to operational staff to maintain the link between strategic decision making and operational safeguarding practice. The NPS has ensured that safeguarding children dovetails with other public protection arrangements such as Multi-Agency Public Protection Arrangements (MAPPAs), MARAC and the Multi-agency Child Sexual Exploitation panel. Safeguarding Guidance to enhance practitioner knowledge and practice has been published in addition to a new process management tool to enable consistent NPS practice across the country.

The NPS continues to:

- Identify and assess the risk of harm posed to children
- Identify children at risk of exposure to victimization
- Impact assess caring responsibilities and custodial sentences when making recommendations to Court
- Support families to access services to support rehabilitation, promoting positive outcomes for families
- Share safeguarding information to support the welfare of children

The NPS remains committed to working within the framework of a multi-agency environment of the courts and supervision of adult offenders, to the delivery and commissioning of rehabilitation services that ensure safeguarding continues to operate as a critical element of practice for staff and managers.

8.6) Community Rehabilitation Company (CRC)

Humberside Lincolnshire and North Yorkshire Community Rehabilitation Company (HLNY CRC) is run by Purple Futures, an Interserve led partnership. The CRC supports service users to achieve lasting change whilst simultaneously managing their risk and supports adults both in custody and in the community. Safeguarding children and young people is a priority within CRC service redesign and staff have trained in SoS and supported internal implementation of the SA.

HLNY CRC contribute to LSCB audits and share learning with staff. We are involved in the MACE process towards managing the risk of CSE. Close working relationships retained with NPS enables monitoring that ensures case conference reports are submitted on time. All staff have completed safeguarding training and receive regular management oversight. HLNY CRC undertakes quarterly quality assurance audits with an ongoing focus on safeguarding. Robust contract monitoring ensures that all of our service delivery partner agencies have effective child protection procedures in place.

HLNY CRC is keen to build upon links with the Family Hubs and integrate further with our LSCB partners.

8.7) NEL Clinical Commissioning Group (NELCCG)

What did we say we were going to do?

Has represented on NEL Safeguarding Children Board (NELSCB) by the Deputy Chief Executive until August 2015, then by the Director of Quality and Nursing from September 2015. The CCG financial contribution to the LSCB has continued.

In keeping with Working Together 2015, NELCCG has ensured the availability of the Designated Nurse and Doctor to act as professional advisors to the Board, with the Designated Nurse becoming a core member of the LSCB from August 2015. Designated Professionals have worked with providers in NEL to ensure health professional representation on all subgroups of NELSCB.

Has driven the transition of the LSCB Safeguarding in Health subgroup into a Health Advisory Forum which will facilitate communication between health services (both commissioning and provider), and allow a coherent approach to multi-agency work, both informing, and being informed by, LSCB priorities.

What have we done

As the accountable commissioner of healthcare for local residents, NELCCG does not directly provide services to children. However, it must ensure commissioned providers have robust safeguard children systems and processes, and they do this by ensuring a range of standards are identified for inclusion in all provider contracts which ensure compliance with LSCB priorities, s11 Children Act 2004, and CQC Fundamental standards – Regulation 13.

Designated Professionals, act as strategic professional leads for safeguarding across the health economy, and named professionals and practitioners provide effective management of more complex cases, and advise on escalation of serious incident management. NELCCG has a duty to support the improvement in quality of primary care services and designated and named professionals continue to support Primary Care professionals to improve contributions to safeguarding. This includes providing training, providing direct dialogue with safeguarding leads in GP practices and providing telephone contact when required.

Next steps

NELCCG has work plan for 2016/17, that is responsive to issues arising from local and national learning, reviews and inspections, including supporting quality arrangements in provider organisations and embedding arrangements for safeguarding across the health commissioning and provision landscape.

8.8) NSPCC

What did we say we were going to do?

The NSPCC has been committed to:

- Working with others to safeguard all children within NEL.
- Regularly attend and actively participate in LSCB subgroups and operational board meetings.
- Lead agency for the HSB pathway and risk management process.
- Lead the priority sub group ‘Neglect Matters’ to deliver on the agreed strategy.
- Delivery of training and workshops on Neglect for all family practitioners in NEL.
- Be a SoS champion.
- Deliver targeted services to children and families focusing upon improving their safety and well-being.

What have we done

The NSPCC nationally has many wide ranging activities and in NEL has worked with others to reach families needing help and support at an earlier stage so that children and parents difficulties don’t escalate and become entrenched. The NSPCC has taken a lead in developing tools and mechanisms for advocating on behalf of children and giving children a voice. We have also improved our assessments of children’s safety and wellbeing and taken action when we have concerns about these, particularly in the area of Neglect and Emotional Harm.

Next steps

Continue to refocus our services on helping families earlier so they have the right support at the right time.

8.9) Children and Family Court Advisory and Support Service (CAFCASS)

What did we say we were going to do?

Cafcass is a non-departmental public body sponsored by the Ministry of Justice (MoJ). The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families. It employs over 1,500 frontline staff.

What have we done?

The demand upon Cafcass services grew substantially in 2015/16 with a 13% increase in care applications and an 11% increase in private law applications. The grant-in-aid provided by the Ministry of Justice was smaller than the previous year. Notwithstanding this, Cafcass has met all of its Key Performance Indicators. Cafcass has worked with the LSCB and contributed to information and developments around the court processes and ensured that all staff are formally assessed in respect of safeguarding as an objective. In the last year 94% were assessed as Good.

Greater details of the work undertaken by Cafcass Nationally can be found at www.cafcass.gov.uk.

Locally a priority has been responding to the government **review of Special Guardianship Orders**.

Next steps

The Local Family Justice Board response to the review of Special Guardianship Orders has supported the commissioning of a local review and training programme led by the Cafcass Service Manager. This collaborative work involves the four Local Authorities in the area and will offer targeted workshops aimed at improving the quality of assessment and post proceedings support to children made subject to Special Guardianship Orders.

9) Policies, Procedures & Guidance

What did we say we were going to do?

The NEL SCB procedures are compliant with Working Together 2015. The LSCB commissioned Triex to manage, review and revise the LSCB procedures. The procedures are reviewed on a six monthly basis. The Young Advisors reviewed the Young Person’s section of the website in ensuring it is young person centred.

Evidence, impact /difference made

Significant changes have been added in respect of national guidance. The application and effectiveness of safeguarding procedures are measured as part of case file audits and SCR’s which is an ongoing process. Guidance for practitioners in respect of “Bruising to Non Mobile Babies Policy” has been developed and published

as a result of learning from a serious case review. Guidance on children visiting psychiatric wards has been developed.

There have been 12,014 visits to the website during 2015/16. The LSCB built on the existing Council supported LSCB website and have developed a dedicated LSCB Website supported and financed by the Clinical Commissioning Group. The website has dedicated sections for children, young people, families and practitioners, SCRs, procedures, training, performance, good practice and national research.

Next steps

The LSCB website will be developed on an ongoing basis and is overseen by the LSCB Operational Board. Each of the LSCB Subgroups feed into the Operational Board in respect of required updates to the website. The FiM page is being developed which will ensure it sits in one place and is fully accessible. Guidance on Modern Day Slavery is being developed and will be added to the procedures.

10) Learning & Development Activity

What did we say we were going to do?

- Deliver multi-agency Learning activities that address LSCB priorities. Evaluate effectiveness.
- Design/deliver Elected Member safeguarding programme.
- Carry out multi-agency training audit
- Support the workforce development element of the Creating Stronger Communities programme.

What have we done

- 178 safeguarding courses held, 3375 individuals trained (Appendix 1). 84 courses single-agency, 103 multi-agency. SCR practice forums held with 187 participants. Training courses reviewed to include learning from SCR's, updates to child concern model, practice changes from SoS approach and changes as a result of SA. Safeguarding e-learning courses offered to agencies.
- Commencement of workshops for Members, based around LSCB priorities. Guidance being produced to help Members with safeguarding duties.
- Multi-agency training audit undertaken. Informed gaps in training.
- Multi agency training provided on SoS, OBA and Restorative Practice (Appendix 2).
- Training review meetings undertaken to agree future actions.

Evidence, impact /difference made

Appendix 3 shows impact on practice feedback from some core safeguarding courses.

Next steps

- Minimum training standards to be aligned to the Capability Framework.
- L&D Subgroup to work with LSCB Operational Board to agree reasonable standards.
- Undertake review to understand performance against standards.
- Learning & Development Subgroup to agree future training offer with LSCB Operational Board – gaps identified and prioritised into Yr1, Yr2, Yr3.
- Communicate to all partner agencies but particularly to schools/academies
- Check out engagement with package offered – LSCB sub group to review attendance data quarterly.

11) Monitoring/Quality Assurance (QA) Activity (includes Audit activity)

What did we say we were going to do?

The QA Subgroup committed to undertaking a number of themed inter agency audits aligned to the LSCB priorities, to undertake a biennial Section 11 audit and annual safeguarding education audit.

What have we done

The LSCB developed 4 performance indicators that mirror its current priorities and are seen as bellwether indicators in assessing how well the LSCB is moving towards the overall outcome of 'All people in NEL feel safe and are safe' using OBA as the approach to performance management.

Undertaken neglect, Disability and Missing audits and developed and implemented inter agency action plans. Held a number of audit challenge days involving practitioners and managers which have informed audit action planning and learning.

Evidence, impact /difference made

The Missing audit evidenced that the missing procedures were understood and effectively implemented. All agencies are actively involved in LSCB audits and have undertaken individual audits of practice as part of multi-agency audits leading to identification of both areas of good practice and development.

Next steps

- Interagency audits will be undertaken on an ongoing basis
- Work will be undertaken to involve children and families in audits in ensuring they have the opportunity to contribute and inform learning.

12) Audits of Partner Agencies

What did we say we were going to do?

Undertake a Section 11 (S11) Audit on a biennial basis and hold a partner challenge day.

What have we done

A S11 audit was completed in November 2014. A partner challenge day was held in July 2015. Progress against agencies S11 action plans was assessed. The Lay Members and Young Advisors group contributed to the challenge panel alongside the LSCB chair and Director of Children's Services. There were no areas of significant concern.

The QA Subgroup has overseen 6 multi-agency practice audits and has developed action plans to improve systems and practice as a result of the audit findings.

Evidence, impact /difference made

There were no areas of significant concern. A general area of development for all organisations was the level to which they could evidence that service development was informed by the views of children and families. Questions were developed and asked by the young people, organisational leads found this element challenging and thought provoking.

Progress made by organisations included strengthening processes such as recording, information sharing and ensuring practitioners are appropriately trained in safeguarding. There has been particular progress in how organisations have sought to ensure service provision is informed by the experiences of Children and Young People.

As a result of audit activity the LSCB Escalation procedure has been revised, Child Protection Coordinators meetings have been reinstated and the Neglect sub group are working on long term support for families who would otherwise not be able to sustain good enough parenting. Other actions within the individual audit action plans are being monitored quarterly through the QA sub group.

Next steps

Planning is underway for the 2016/17 Section 11 Audit. A joint audit will be undertaken with the Safeguarding Adults Board (SAB) to enable processes to be aligned and the effectiveness of safeguarding arrangements assessed across both boards.

Partner's participation in the multi-agency audits has been excellent, and the QA subgroup has identified many examples of good practice within agencies. An example is the Threshold audit evidenced thresholds were applied appropriately.

13) Learning from Serious Case Reviews/Child Death Overviews

13.1) Serious Case Reviews

What did we say we were going to do?

The Serious Case Review (SCR) Terms of Reference state cases will be considered that meet the criteria and commission an appropriate review to ensure multi-agency lessons are learnt and practice is improved. We provide assurance to the LSCB that SCR recommendations are actioned and lessons learnt have been communicated and disseminated to partner agencies and frontline staff. Additionally we must ensure that lessons learnt are aligned to training and workforce development strategy.

What have we done

- Contributed to a SCR commissioned and led by Waltham Forest
- Developed and monitored an inter-agency action plan to ensure implementation.
- NEL is finalising a SCR which has been ongoing due to complicated legal and medical matters.
- Developed a process that allows review of cases that don't meet the SCR criteria, however, have the potential for multi-agency learning.
- Deliver multi-agency practitioner events to embed learning from local and national SCR's.
- Liaised with training/ development and quality assurance sub group to ensure future focus is informed by lessons learnt from SCRs.

Evidence, impact /difference made

Audits completed highlight progress and development in our key themes i.e. Resistant Parenting, voice of the child, response to neglect and disguised compliance and this has been disseminated via training and learning events.

Next steps

- Appointment of new chair from an agency outside the Local Authority in order to strengthen partnership working and encourage challenge and support across agencies as recommended from our recent peer review.
- Further multi-agency workshops to be delivered in respect of learning from National SCRs.

13.2) Child Death Reviews

What did we say we were going to do?

We said we would review all child deaths including expected and unexpected deaths and identify any modifiable factors and implement learning from the process.

What have we done

The Child Death Overview Panel (CDOP) reviewed 7 child deaths in 2015-16. Since 2008/9, 12% of child deaths were classed as having modifiable factors which is below the national average. From 2008/9 to 2014/15 59% of child deaths were classed as unexpected, however over the last three years the numbers of expected child deaths have been higher.

Evidence, impact /difference made

A joint CDOP has been created with North Lincolnshire, the first panel was held in April 2016. As numbers of child deaths are small there is a challenge on identifying trends and the joint panel has led to broader and shared learning. The LSCB continue to produce annual CDOP reports in evidencing learning. The CDOP has maintained an overview of support provided to bereaved parents, families and siblings. A review of available bereavement services is being undertaken, the findings will be shared with the CDOP.

A review of burial and cremation arrangements has been undertaken which led to additional information being available to families.

Next steps

- To review the child death process practice briefings.
- To continue to implement the learning from all child deaths.

14) Engagement with Children & Young People

What did we say we were going to do?

Ensure that there was a clear plan for capturing the voice and influence of children and young people.

What have we done

The LSCB has developed a number of mechanisms in capturing the child, young person's voice and in demonstrating their influence including:

- The active involvement of the Young Advisors in the section 11 process and recruitment processes.
- Young people's safety is a regular agenda item on the joint meeting held quarterly between Young Peoples voice groups and senior managers and councilors.
- Voice of the Child is a key element of the LSCB inter agency audits.
- The "Youth Voice" reviewed the content of the Children/ Young Persons section of the dedicated LSCB website in ensuring it is user friendly, accessible and approximately geared towards young people.
- The LSCB Intern worked closely with the Young Advisors on changes to the LSCB website to make it more accessible to children and young people.
- The roll out of View Point locally provides another medium for capturing views of Children and Young People.
- The Neglect Subgroup have reviewed and developed tools for gaining the views of Children and Young People.

Evidence, impact /difference made

- The views of family and young people involved in SCRs has informed practice through the dissemination of learning through practice forums.
- The young advisors actively influenced the appointment of the two LSCB lay members and the previous and present LSCB chairs.
- The Children and Young Person's Plan has been jointly developed by Young People for Young People.
- The involvement of young people in the Section 11 Audit actively challenged organisations on how service delivery was informed by children's involvement.
- The LSCB developed specific tools for capturing the voice of children which has been positively evaluated by young people.

Next steps

- To capture the Child's voice through the subgroup audits and development of tools.
- To ensure that all partnership activity and service provision incorporates an element of the voice and impact of Children and Families Views.

15) Communication

What did we say we were going to do?

Ensure that there are clear communication/media plans within Safeguarding strategies, targeting professionals, children and families.

Communication methods

Website - Contains all Board published information and information for Parents, Children and Young People and those involved in supporting Young People. Provides information about all NELSCB Multi-Agency training courses.

Newsletters

Quarterly newsletters provide up to date information about board activities; new publications and any external information concerning the broader aspects of safeguarding children. Newsletters seek to keep frontline professionals up to date with best practice using information from local and national Serious Case Reviews and serious incident reviews and Thematic Case Audits.

Publications

The Board publishes a range of guidance intended to provide additional tools for frontline workers, most Board publications are available on the website and will be promoted in the newsletter. Information leaflets for parents are published and available on the website. All SCR's are published on the Board website. This is subject to the conclusion of any court proceedings.

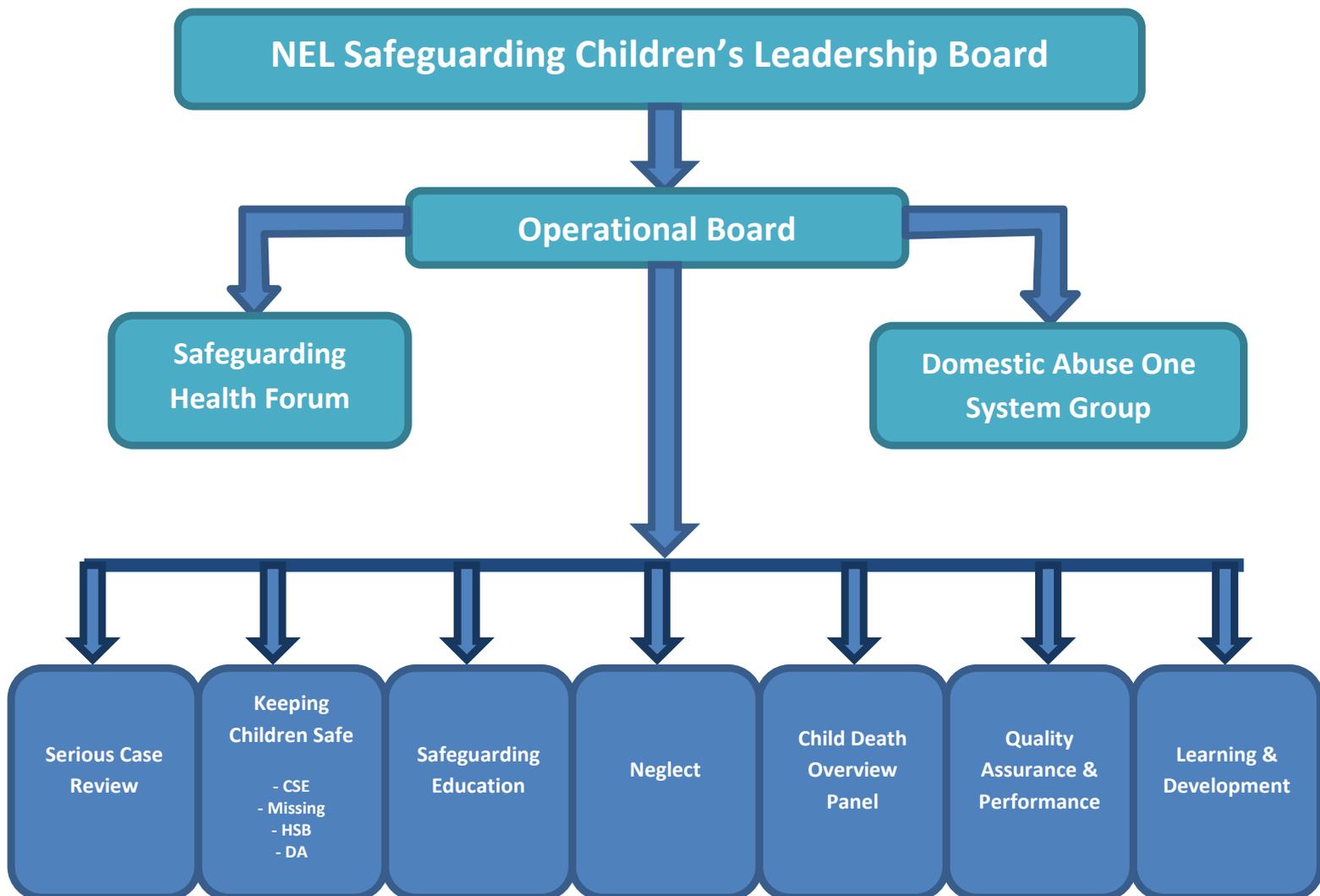
16) Conclusions/Challenges/Recommendations

This report has already mentioned the volatile, uncertain, complex and ambiguous environment in which we operate. This is what we may now have to consider as our 'steady state'.

This creates for us a series of opportunities and we must continue to grasp them in order to provide continuously improving services which help to keep children safe.

Alliances across issues and organisations will be key to our progress and the signs that this will be secured in NEL are good. We will take advantage of emerging flexibilities to develop local structures and arrangements for multi-agency safeguarding, creating even greater coherence and increased efficiency across they system without losing sight of our objective to keep people safe. We must also continue to focus on aspects of safeguarding where the risks to children are greatest or our performance levels are below those we would wish for. These were rehearsed in our recent development day and are summarised below:

- Embed the Neglect Tool to bring greater focus, coherence and consistency to our activity.
- Embed the Domestic Abuse One System Approach within the wider partner community.
- Continue to strengthen families and to reduce neglect and emotional abuse experienced by children
- Ensure a consistent and systematic approach to capturing the voice and influence of the child (Hearing & Acting on Child's lived experience and using it to shape practice)
- Ensure consistent and meaningful marketing and communication system across the partnership and community
- Ensure we are sighted on emerging issues such as modern slavery, criminal exploitation and E Safety



Appendix 2 - The annual income and expenditure of the board (financial year 2015/16)

CORE INCOME

Made up of contributions from

Humberside Police	£15,000
Clinical Commissioning Group	£33,500
CAFCASS	£550
NEL Council	£99,200

TOTAL INCOME **£148,250**

STAFFING

LSCB Board Manager
LSCB Administrator
50% Quality Assurance Coordinator
50% Strategic Safeguarding Manager, Children's and Adults
LSCB Chair cost

TOTAL STAFFING **£142,300**

OVERHEADS AND MANAGEMENT ON-COSTS:

Accommodation, IT, Running Costs

TOTAL EXPENDITURE **£150,683**

Appendix 3 - TERMS OF REFERENCE OF SUBGROUPS

The terms of reference for each of the LSCB boards and subgroups were revised during 2014 specifying reporting arrangements via Score Cards aligned to LSCB Core Data Set and LSCB priorities.

Leadership Board - Aims

The LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will cooperate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. The LSCB's role is to scrutinise local arrangements and it should therefore have a separate identity and an independent voice. It should not be subordinate to, nor subsumed within, other local structures in a way that might compromise it.

Outcomes - Evidence the effectiveness of local arrangements in safeguarding children. Demonstrate the difference made by the LSCB to safeguarding Children and Young People through the delivery of the LSCB business plan.

Operational Board - Aims

To scrutinise and support the work of the LSCB subgroups reporting to the Leadership Board on progress with the business plan; the identification of key safeguarding issues emerging from the work of the subgroups; overseeing the effectiveness of quality assurance / performance monitoring arrangements.

Outcomes - Performance indicators / audit mechanisms evidence the impact of safeguarding arrangements and the quality of practice. The work of the subgroups and Operational Board meets the identified outcomes within the LSCB business.

The Terms of Reference for each of the 11 sub-groups of the LSCB have been reviewed and revised. The key aims and objectives of each sub group are outlined below.

Child Death Overview Panel – Aims

To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death. To make recommendations to individual agencies based on action required to address any matters of concern affecting the safety and welfare of children in NEL.

Outcomes - Lessons learned from CDOP activities including modifiable factors identified through the review process are clearly communicated to all agencies and where appropriate the Public. Systemic or structural factors affecting children's well-being are given thorough consideration and action identified how such deaths might be prevented in the future.

Learning and Development Sub Group - Aims

To evidence the effectiveness and impact of safeguarding children training in informing practice and improving outcomes for children; to communicate key safeguarding messages, research, lessons and procedural expectations to agencies, professionals, in ensuring a consistent approach to safeguarding children and continuous learning.

Outcomes - Safeguarding training improves practice leading to improved outcomes for children. Professional practice is underpinned by continuous learning in safeguarding children.

Neglect Sub Group - Aims

To reduce the impact and prevalence of neglect in NEL over time, raise awareness at a public and universal level about the signs, symptoms and impact of neglect for Children and Young People aged 0-18 years old. To ensure that neglect is identified at an early stage and that it is responded to consistently, confidently and appropriately at the right threshold of need.

Outcomes - There is a reduction in the prevalence and impact of neglect upon Children and Young People in NEL

Quality Assurance Sub Group – Aims

To ensure a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.

Outcomes - There is a coherent and sustainable Quality Assurance and Performance Framework which is aligned to and informed by the NELSCB Strategic Priorities. All agencies contribute to and are committed to continuous learning and improvement within their respective agencies and collectively.

Safeguarding in Education Sub Group - Aims

To provide assurance to the Leadership Board that the LA, governing bodies of maintained schools, colleges, academies and all educational settings are meeting their requirements as laid out in “Keeping Children Safe in Education” published in 2014.

Outcomes – Quality Assurance including audit is undertaken as agreed to assure the effectiveness of all education establishments safeguarding arrangements. There is regular monitoring and review of schools, academies, colleges and other educational establishments, of safeguarding policies, practice and training

Serious Case Review Sub Group - Aims

Organisational lessons are learnt at a strategic level and changes implemented in informing practice and to prevent future incidents of serious child abuse or death.

Outcomes - To provide assurance to the LSCB, OFSTED, SHA, HWBB that recommendations arising from Serious Case Reviews have been actioned and learning from lessons have been clearly communicated and disseminated to all partner agencies and frontline staff.

Safeguarding in Health Sub Group - Aims

To advise on the ‘working together’ arrangements including commissioners of health services in NEL and commissioners of non-NHS services, to ensure there are effective, robust and collaborative safeguarding arrangements across the health economy, and across organisational and locality boundaries. These meetings will be split into two parts – Part A will be a clinically led meeting to discuss safeguarding issues and service issues / gaps that cut across the health economy, Part B will include commissioners and Strategic Leads where relevant issues from Part A will be discussed and if appropriate taken forward as a task and finish group. *Outcomes* - Establishing effective relationships between and across health commissioners and providers to ensure that children’s safeguarding arrangements are embedded. This will promote consistent safeguarding children practice across all health organisations and services and a coherence of commissioning arrangements with an alignment of safeguarding standards in contracts.

Keeping Children Safe - Aims

The four following subgroups previously came within the Young and Safe Subgroup. All four areas will now sit as separate subgroups and will report directly to the Operational Board.

Missing - Aims

To monitor the prevalence, and responses to children missing from home, care and education.

Outcomes - NELSCB has a system to monitor the prevalence of and the responses to children who go missing, including gathering data from NELSCB members and other stakeholders in order to understand trends and patterns. There are effective arrangements in place across the partnership for reporting, referring and responding to concerns about children who are missing.

Child Sexual Exploitation - Aims

Develop a NELSCB Partnership strategy to combat CSE which takes account of learning from SCR’s and good practice from other local authorities.

Outcomes - To reduce the likelihood of Children and Young People being sexually exploited and also to protect those who are involved by disrupting and bringing to account those who commit this form of child abuse.

Harmful Sexual Behaviour - Aims

To ensure that NELSCB is taking a consistent approach to the identification, assessment and intervention to those Children and Young People who are displaying problematic and HSB. To ensure all Children and Young People who display HSB received a timely evidenced based assessments and intervention.

Outcomes - The Strategy and Operation plan is embedded across children's services. Children and Young People who display HSB are assessed and appropriate services are provided which reduces the risk to themselves and others.

Domestic Abuse - Aims

NELSCB is visible and influential through effective arrangements with other multi-agency partnerships working to reduce the incidents and impact of children suffering or living in households and families where domestic abuse is present. To ensure there is a co-ordinated timely response to Children and Young People who are suffering or living in households where domestic abuse is present.

Outcomes - There is effective recognition, response and services for Children and Young People who are either victims of domestic abuse or living in households where domestic abuse is present.

Early identification of and intervention for children, young people and families across NEL partnerships and agencies.

Appendix 4 – A list of Acronyms used in this report.

A

AIM – Assessment, Intervention, Moving on

B

BAC – Behaviour and Attendance Collaborative

BME – Black or Minority Ethnic

C

CAF – Common Assessment Framework

CAFCASS – Children and Family Court Advisory and Support Service

CASS – Children’s Assessment and Safeguarding Service

CBT – Cognitive Behavioural Therapy

CCG – Clinical Commissioning Group

CDOP – Child Death Overview Panel

CEOP – Child Exploitation and Online Protection

CfCiC – Council for Children in Care

CHP – Children’s Health Provision

CIN – Child in Need

CME – Child Missing from Education

CP – Child Protection

CPC – Child Protection Coordinator

CPHP – Children’s Public Health Provision

CSAM – Cluster Single Assessment Meetings

CSC – Creating Stronger Communities

CSC – Children’s Social Care

CSRS – Children’s Safeguarding and Reviewing Service

CSE – Child Sexual Exploitation

CYPPB – Children and Young Person’s Partnership Board

D

DA – Domestic Abuse

DV – Domestic Violence

E

EH – Early Help

EHE – Elective Home Education

F

FE – Further Education

FF – Families First

FFAP – Families First Access Point

FGC – Family Group Conferencing

FGM – Female Genital Mutilation

FH – Family Hub

FiM – Futures in Mind

FNP – Family Nurse Partnership

G

GP – General Practitioner

H

HE – Higher Education

HLNY CRC – Humberside Lincolnshire and North Yorkshire Community Rehabilitation Company

HSB – Harmful Sexual Behaviour

I

IRO – Independent Reviewing Officer

J

K

KCS – Keeping Children Safe

L

L&D – Learning and Development

LA – Local Authority

LAC – Looked After Children

LACE – Looked after Children Education

LADO – Local Authority Designated Officer

LSCE – Looked After Children Education

LSCB – Local Safeguarding Children’s Board

M

MACE – Multi Agency Child Exploitation

MAPPA – Multi Agency Public Protection Arrangements

MARAC – Multi Agency Risk Assessment Conference

MASH – Multi Agency Safeguarding Hub

N

NE – North East

NEL – NEL

NELC - NELC

NELCCG – NELClinical Commissioning Group

NELSCB – NELSafeguarding Children’s Board

NLaG – Northern Lincolnshire and Goole

NSPCC – National Society for the Prevention of Cruelty to Children

NPS – National Probation Service

NWG – National Working Group

O

OBA - Outcomes Bases Accountability

P

PEI – Prevention and Early Intervention

PF – Performance Framework

PF – Private Fostering

PSHE – Personal, Social, Health and Economic

Q

QA – Quality Assurance

QAN – Quality Assurance Notification

R

RAM – Resource Allocation Meeting

S

S20 – Section 20

S47 – Section 47

SA – Single Assessment

SAB – Safeguarding Adults Board

SCR – Serious Case Review

SDQ - Strength and Difficulty Questionnaire

SOS – Signs of Safety

SR4YP – Safe Relationships 4 Young People

SRFYP – Safe Relationships For Young People

SRE – Sex and Relationships Education

SSSS – See Something Say Something

T

Toxic Trio – Domestic Abuse, Substance Abuse and Mental Health

U

Uni+ - Universal Plus

V

W

X

Y

YOS – Youth Offending Service

YPSS – Young Peoples Support Service

Z