Leicester Safeguarding Children Board

Annual Report

2013 - 2014

Independent Chair of the Board and report author: Dr. David N. Jones

Format and content based on the exemplar model endorsed by the Association of LSCB Chairs

A draft annual report was considered by the Leicester Safeguarding Children Board (LSCB) in week commencing 22nd September 2014 and this final version was published on 30th September 2014.

The format of this report takes account of the analysis of LSCB Annual Reports carried out by the Association of LSCB Chairs in May 2013. The content of this LSCB Annual Report largely reflects the recommended model laid out in the Association's analysis report.

The term "LSCB" stands for 'Local Safeguarding Children Board', although in a local context it is also taken to mean the 'Leicester Safeguarding Children Board'. In Leicester, the terms are used interchangeably.

The Independent Chair wishes to thank contributors to the report:

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1. Foreword by the Independent Chair of Leicester Safeguarding Children Board

I am pleased to present my fourth annual report as Independent Chair of the Leicester Safeguarding Children Board.

The report covers another year of significant challenge for all agencies represented on the Board. We held a highly successful children's summit during the year and we continue to look for ways in which we can be better informed about the views and experiences of children and young people from all the diverse communities in Leicester. All agencies have contributed to work to improve our services, especially in respect of better coordination of support for children, young people and families at an early stage before problems deepen (early help), more in depth study of ways to intervene effectively where children are being neglected and more systematic evaluation of the effectiveness of multi-agency services.

The national media has been full of discussion about child abuse throughout the year. Much of the public debate has focussed on non-recent abuse, often by well-known figures, but some cases well publicised in the national media have involved more recent abuse. We are conscious of the need to provide evidence that services in Leicester are working effectively together and that children and young people in the city are safe. This report includes evidence about the effectiveness of local services and the work we have been doing to strengthen our oversight of the multi-agency system.

Our work takes place in a challenging national environment, with increasing inequality and growing pressures on families, increasing 'demand' in many areas, rising child poverty and reducing budgets. The Board has been acutely aware of the impact of the government's welfare reforms on the income and housing of those who have least resources. I welcome the focus of the Children's Trust on poverty and the work to implement the report of the City Council's Child Poverty Commission and its recommendations, which have safeguarding implications.

The Board wishes to encourage a climate in which children and young people have the opportunity to express their concerns and be treated with respect. Any child or young person who experiences ill-treatment or abuse should feel able to talk to somebody about it and to seek help. We know that, for some young people, the experience of abuse can drive them to exhibit difficult and anti-social behaviour, which can provoke some adults to reject them and seek punishment. Statistics show that many in our prisons and mental hospitals have suffered different forms of abuse

as children. We do not condone anti-social behaviour but if we are to enable those who have experienced abuse to seek understanding and help, and to create a safer community for all, we must get behind the behaviour and show humanitarian concern and respect. We have provided training to help staff engage with children and young people with more understanding. Our safeguarding summit aimed to respect the young citizens of Leicester, involving 106 children and young people aged from 5 to 18. It was a great success. The LSCB accepts the challenge to hear the messages from that summit and use them to reshape our services.

We understand that the safety and wellbeing of children and young people is very important to parents and to the whole community. We therefore welcome public scrutiny of our work. We recognise that there are continuing challenges. We have a professional and legal responsibility to take action to protect children and promote their welfare, but we cannot do this alone. We welcome comments and suggestions from the community about how we tackle those challenges. Safeguarding is everybody's responsibility and we call upon people in Leicester to play their part in helping our children and young people to have the best life we can give them. If you have concerns, please contact the police, children's services or any other agency known to you. We will do our best to listen respectfully and to follow-up your concerns appropriately.

I am required to give a personal report on the quality of safeguarding in the city and this overview forms chapter 2, which is in effect the Executive Summary of the following chapters.

I would like to thank all the members of the Board and our working groups for their commitment and achievements over the past year.

I was reappointed by the Board for a second three year term in 2013. I am grateful for the confidence placed in me and reaffirm my commitment to serving the families and people of Leicester to the best of my ability, always preserving my independent scrutiny and judgement.

David N Jones (PhD, MA, BA, CQSW, RSW)
Independent Chair

2. Executive Summary

2.1 STATUS OF THE ANNUAL REPORT

This is my fourth annual report on the work of the Leicester Safeguarding Children Board and its member organisations. It is the second published under the government's 2013 statutory guidance:

> *'The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. This is a statutory requirement under section 14A of the Children Act 2004.' (Working Together 2013)*

The report is presented in a format recommended by the Association of Independent LSCB Chairs.

This chapter is my personal report to the people of Leicester on the work of the Board during 2013-14. It is followed by chapters which present the supporting detail, recording the work of the Board, its working groups and many individuals from partner agencies. Our intention is to provide 'a rigorous and transparent assessment of the performance and effectiveness of local services, identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action' (Working Together 2013).

2.2 JUDGEMENT ON THE EFFECTIVENESS OF LOCAL SERVICES

On the evidence available to me from many different sources, I consider that, whilst services are working together effectively to minimise the risk to children and young people in Leicester and to provide help when needed, there must be a continuing commitment across the multi-agency partnership to improving the quality and consistency of work with families

I am satisfied that the LSCB is 'independent' and not subordinated to, nor subsumed within, other local structures. I have appropriate access to the City Mayor, Police and Crime Commissioner and chief officers of all agencies to raise any safeguarding concerns when needed.

Parents are responsible for the care of their children in the first instance and nobody can prevent all instances of ill-treatment and poor care. Helping to keep children and young people safe in Leicester is a responsibility of us all. Public agencies have special responsibilities for safeguarding and must work well together to minimise risks to children and young people but they can never be in a position to completely remove risk nor to prevent all instances of child abuse. As I reported last year, I am satisfied that all agencies are committed to providing help to families facing

difficulties, doing their best to understand the needs of parents and providing support for good-parenting.

I am confident that agencies are working together in Leicester to improve services and to learn from problems which are identified. The recommendations of external research, commissioned to evaluate services and suggest improvements, have been implemented, services respond quickly to external inspections, Serious Case Reviews (SCR) are commissioned when necessary and their findings are quickly fed back to staff and used to make improvements. We are strengthening multi-agency case file audits, agencies have their own internal case audits and the results are shared. The Board is updated every six months on service pressures in member agencies, which is used to inform future planning and service delivery. There is an honest discussion of problems and a determination to improve.

Areas for priority attention in 2014-15 include:

i) improving our contact with children and young people and ensuring their perspectives are taken into account more effectively,
ii) implementing improved arrangements for early help when problems are first identified,
iii) more effective intervention to reduce the number of children who stay on plans for longer periods and the number who are put on plans for a second time. We continue to focus on arrangements to improve the quality of work with families where there are long-term problems of child neglect, something which has been identified as a national challenge. Continued work to strengthen the joint approach of agencies to monitoring the effectiveness of services is underway. Initiatives to strengthen our response to child sexual abuse and exploitation are being implemented and we have established a working group to develop a robust approach to the prevention of female genital mutilation.

Agencies need to make sure that they continue to resource front-line services so that they can respond to the complexity in child protection referrals and, just as importantly, provide the longer term support which families need.

Agencies are working well together on the national strategy to improve early help which is given to children, young people and families when problems first emerge. This includes help to the increasing number of vulnerable newborns.

2.3 LOCAL CONTEXT

Leicester is the largest city in the East Midlands, with a population of 329,839, of whom around 21% are children and young people under 18 (69,369 approx). Leicester's adult population is relatively young compared with England; around 20% of Leicester's population are aged 20-29 years old (14% in England).

The Leicester population is predicted to grow to around 346,000 by 2020, an increase of nearly 40,000 from 2010. The birth rate has been rising significantly in recent years creating increasing demands on midwifery, health visiting and school services. The population is very diverse; 55% of the city population comes from minority communities. The Board is aware of its responsibilities to children and young people from all the communities in the city and the need to ensure that people from all communities have confidence in services to support parents and protect children and young people.

Leicester has a high level of deprivation, the 25th most deprived local authority area in the UK. Whilst poverty and child rearing problems do not necessarily go together for all families, we know that poverty and related issues do make it more likely that families will experience a range of social problems, including increased risk of mental health problems, suicide and self-harm, domestic violence and problems with children. Given the national economic environment and reductions in the financial support available to families, the Leicester Board has been predicting an increase in the number of families experiencing significant problems. The number of families needing support continues to increase and problems are becoming more complex.

The past year has seen continuing changes in the structure and organisation of agencies which are members of the Board. Major changes are taking place within the police, health, city council, probation, housing and schools, with significant impacts on voluntary and private sector providers. A programme of visits to Chief Executives of local agencies has been initiated by the Chair of the Leicestershire and Rutland Board and myself to ensure that safeguarding continues to receive a high priority. Effective child protection depends on trust and good cooperation between all agencies. This can be undermined when the key people change and there are organisational uncertainties. It is to the credit of local agencies that, so far, the reforms have been implemented without significant disruption.

2.4 STATUTORY AND LEGISLATIVE CONTEXT

Each local authority is required to establish a Local Safeguarding Children Board (LSCB) for their area (Section 13 of the Children Act 2004) and the organisations and individuals that should be represented on the Board are specified in the Act. The government issues detailed statutory guidance about how the Boards must operate and has been consulting on major revisions to that guidance. The revised Working Together guidance was published in March 2013. This restated the significant role of the LSCB but very significantly reduced the amount of central guidance, leaving more to be determined by local areas and individual practitioners. The Leicester Board has anticipated these changes and continues to work through the implications.

Child protection, especially in the context of sexual abuse, has been the focus of continuing media attention and public concern throughout the year. The Board has been kept informed of national and local developments and local agencies have

made significant contributions to national work on improving policies to identify and protect children who go missing and those at risk of sexual abuse.

2.5 GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The Board meets on a quarterly basis. Board membership is listed at Appendix A. Attendance at the Board is reported in Appendix B. In order to provide effective scrutiny, the LSCB must be independent. The local partnership and accountability arrangements are specified in the Board's Constitution. The LSCB has approved protocols with the Children's Trust and Health and Wellbeing Boards which specify their respective functions and relationships. The LSCB and the Leicester Safeguarding Adults Board (LSAB) share a joint values statement which underpins the work of the two Boards. Board office arrangements are hosted by Leicester City Council.

A number of working groups operate on a Leicester, Leicestershire and Rutland (LLR) basis, recognising that children and families do not limit their activities by local government boundaries and also reflecting the organisational structures of the police, health service providers and some other agencies.

Dr. David Jones, the Independent Chair of the LSCB was re-appointed in April of 2013 for a second 3 year term. The Chair is accountable to the Chief Operating Officer of the City Council who acts on behalf of the Board partners. The Chair holds 6-monthly meetings with the City Mayor, Assistant Mayors and Strategic Directors. The first summit of Chief Officers of statutory members of the Board was convened to discuss the findings of the annual reports of the LSCB and LSAB.

2.6 BOARD PRIORITIES AND WORKING GROUPS

2.6.1 Children and young people

Listening to and respecting the voices of children and young people is at the heart of the values of the LSCB. This is not always easy to achieve and requires constant renewal of commitment.

The aim of the participation work is to:

- Ask children and young people across the City whether they are safe and feel safe
- Work with children and young people to ensure that they know how to keep safe
- Consult with children and young people about service delivery
- Ensure young people's representation on the LSCB Board

The work was co-ordinated through a Participation Group including young people, key participation leads from across the city, primarily the City Council, the Schools Development Support Agency and education providers including colleges.

The Board appointed a young person as one of the two statutory lay members.

A ground breaking Safeguarding Summit was organised by young people from the City's Participation Groups working collaboratively, including the Big Mouth Forum, the Children in Care Council (CICC), School Councils and the Young People's Council. It was the first City-wide consultation event for young people about feeling safe and staying safe in Leicester. The strongest messages from the young people were about bullying; the need for safe places to play and the importance of street lighting. These messages have been relayed to the agencies and decision makers who have influenced the responses to these issues.

A new leaflet for young people who are subject of a child protection conference has been introduced, designed to increase participation by young people.

The former Looked After Children Project worker carried out a project with 9 young men who had missing from care episodes (7 from City children's homes and 2 from foster placements) and the findings were reported to councillors and senior managers. The Regulation 33 Visitor and one of the Children's Rights and Participation Officers visited the 5 City children's homes and spoke with the young people about a range of issues including use of physical interventions, whether they feel safe and whether they have any concerns about their treatment within the home. All children placed out of the City area received visits and completed a questionnaire about personal safety; they all report feeling safe and knew who to contact if necessary. The outcomes are reported to councillors and senior managers.

2.6.2 Implementing safeguarding service priorities

Work on the following priorities shared with the Children's Trust has been overseen by multi-agency sub-groups.

Priority 1 - Prompt assessment and effective child protection planning

The LSCB commissioned Professor David Thorpe to examine referral and assessment practices in Leicester, taking account of evidence that the rate of referrals for child protection investigations in Leicester was higher than comparable areas, suggesting the possibility that more families experienced a police and social work investigation than was strictly necessary. The action research resulted in the implementation of a new way of screening initial concerns about the care of children and led to an overall and appropriate reduction in the number of families undergoing a full child protection investigation. Most of the families whose children were not assessed to require a safeguarding assessment were offered less intrusive forms of assistance. All agencies are committed to providing early help and support to parents and children

in ways which they find helpful and also ensuring that there are thorough and timely assessments when there is evidence of safeguarding concerns. A new single assessment process in Children's Social Care is resulting in an overall improvement in the quality of assessments.

Priority 2 - Preventative and safeguarding action where children are at risk from domestic violence

The Multi-agency Risk Assessment Conference (MARAC) process is working well with good representation and involvement from partner agencies. There is a prompt and effective response from services to children who use sexually abusive behaviour towards other children, with good access to therapeutic services for children which reduces the behaviours and supports families.

Priority 3 - Safeguarding young people

A protocol for children and young people who run away or go missing from care was launched, supported by good strategic and operational systems, and agencies strive to undertake return interviews after a 'missing' episode. There is a joint Leicester and Leicestershire/Rutland Board Child Sexual Exploitation Group with robust systems and joint working between children's social care and the police. Over 100 teachers in Madrassa (Muslim centres) have been trained in anti-bullying and safeguarding work. Work has been done with foster carers and adopters, and targeted work done with young people at risk and parents to raise awareness on the consequences of online activity.

Priority 4 – Implementing thresholds for service

Following an extensive consultation with partners, a multi-agency thresholds guidance document was developed and launched.

Priority 5 – Listening to the voice of the child/young person.

See 2.6.1 above.

Priority 6 - Reducing accidents and serious incidents.

There are good systems of dissemination across the partnership of lessons learnt from local serious case reviews. Child Death Overview Panel (CDOP) arrangements are well established and work has been done to ensure there is a robust approach to monitoring the learning identified in each case. Reducing infant mortality continues to be a priority, with campaigns carried out in the year on areas such maternal obesity, early access to maternal services, teenage parenthood and safer sleeping.

2.6.3 Procedures

A sub group of the LSCB oversees the LSCB Child Protection Procedures, ensuring that they are up to date and used across all agencies. It was agreed at the disaggregation of the former tripartite board (2009) that the procedures would remain joint with the Leicestershire and Rutland Board, since this made better sense for agencies and families. The procedures have been updated to ensure compliance with new statutory guidance, *Working Together* 2013.

2.6.4 Single and Multi-Agency training provision

The LSCB has a statutory duty to develop policy and procedures in relation to 'training of persons who work with children or in services affecting the safety and welfare of children'. (Regulation 5 LSCB Regulations 2006) and specifically to:

- develop policy and procedures in relation to 'the training of persons who work with children or in services affecting he safety and welfare of children.'
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.
- ensure that a culture of information sharing is developed and supported as necessary via multi-agency and single agency training.
- support a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children.

Safeguarding learning across Leicester, Leicestershire and Rutland (LLR) is overseen by the Safeguarding Multi-Agency Training, Learning and Development Commissioning and Delivery Group, and is supported by the Training Project Development Officer and Multi-agency Project Co-ordinator. The work on evaluation of the impact of learning feeds into the work of the Safeguarding Effectiveness Group.

For the multi-agency training programme, there is a mixture of quantitative and qualitative evaluation data, which shows overall that there was an increase in skills, knowledge and confidence reported by participants 3 months after the event. Work continues to strengthen data collected about the impact of training and development.

In 2013 – 14 the following has been achieved:

- 2014 training strategy endorsed.
- Implementation plan launched in March 2014.
- Launch of revised LLR safeguarding learning website.

- Continuation of LLR strategic sub group for safeguarding learning.
- SCR briefing session on Child Q offering up to 240 spaces for practitioners.
- Interagency programme, offered over 1200 places to 'level 3' staff.
- Work with adult services and others to support the whole family approach.
- Work with key staff in early years to support the early years workforce.
- Development of Quality Assurance activity in relation to safeguarding learning.
- Continued support of Level 2 'essential awareness' training for the private, voluntary and independent sectors.
- Partnership work with Leicestershire & Rutland Board and Safe Network to pilot a 'Designated and Named Person course' for the Voluntary Sector.
- Work with the Department for Education (DfE) and local partners to explore how best to use the DfE Neglect toolkit.

2.6.5 Child Sexual Exploitation (CSE) and Children Missing

This work is overseen by an LLR sub-group which focuses on CSE, child trafficking and missing children. The work undertaken during 2013/14 includes:

- Launch of a combined CSE, trafficked and missing children Sub Group and associated strategy
- Launch and revision of a Missing from Home and Care Protocol
- Launch of awareness raising campaign with children and families including the performance of 'Chelsea's Choice' in schools
- A campaign to raise the awareness of key service providers such as taxi drivers, hotel and leisure providers
- Reduction in numbers reported missing (inc. children in care) and repeat missing episodes
- Increased and more appropriate CSE referrals
- Successful outcomes following joint operations in specific cases (ie convictions and appropriate care plans)
- Agreement for the development of a co-located multi-agency team

2.6.6 Private Fostering

Private fostering is where a child or young person under the age of 16 (under 18 if disabled) is cared for by anyone other than a close family member (related by blood or marriage) for more than 28 days. The Local Authority must be informed of all

such placements in order to ensure children are safe and support can be provided where necessary. The regulations and minimum standards were introduced following the Victoria Climbié enquiry. The Board receives an annual report on private fostering and is taking steps to ensure that schools, health visitors, general practitioners and others are aware of the need for notification.

2.7 ASSESSMENT PROTOCOL AND FRAMEWORKS

There are established assessment protocols and frameworks in place in line with relevant legislation and policies. Working Together 2013 specified that the maximum timeframe for an assessment to be completed in children's social care should be no longer than 45 working days from the point of referral. In July 2013 Children's Social Care introduced a revised single assessment process. Quality assurance carried out by the local authority shows that the overall quality of assessments has improved.

2.8 EARLY HELP

The concept of early help reflects the widespread recognition that it is better to identify and deal with problems early rather than to respond when difficulties have become acute and demand action by more expensive services. Early help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. Universal and targeted services must be coordinated to identify, reduce and prevent specific problems from getting worse or becoming entrenched. In January 2014 the Children's Trust agreed Leicester's early help strategy.

Early help indicators are included in the Board's performance framework and the Safeguarding Effectiveness Group (SEG) receives regular information on the outcome and impact of quality assurance work across early help services. Quality assurance activity has been strengthened and now includes a structured programme of auditing early help activity through file audits and assessments. The overall quality of early help work is improving with interventions more targeted and focused on children and young people's needs.

2.9 ALLEGATIONS AGAINST PROFESSIONALS

The Allegations Service includes the Local Authority Designated Officer (LADO) function and is responsible for chairing strategy and outcome meetings, maintaining management information and providing advice and guidance for professionals making referrals and enquiries where there are allegations against an adult who comes into contact with children in a work or care setting and where there is cause to believe a child is suffering or likely to suffer harm. Between April 2013 and March 2014 the Allegations Service worked with 302 referrals.

The service delivered 4 training sessions offering 60 places. The service also provided bespoke training to groups of staff within a health setting, transport and specific faith groups. 26 primary schools, 2 secondary schools and 2 special schools received whole school safeguarding training.

The total number of referrals in the year was 302, an increase of 11 % over the previous year. There was sufficient evidence to substantiate the allegation in 12% of cases, a small increase in the proportion of referrals that are substantiated, and the relevant employer took appropriate remedial action. Although the number of substantiated cases is relatively low, actions and recommendations were also made in respect of all of the cases where the outcome was unsubstantiated and unfounded. File audits have found that referrals are dealt with in a timely way.

2.10 QUALITY AND EFFECTIVENESS OF THE SAFEGUARDING SYSTEM AND OF WORK WITH FAMILIES

The Safeguarding Effectiveness Group (SEG) is responsible for monitoring the effectiveness of safeguarding arrangements of the partner agencies. This enables the LSCB to reach a judgment, based on the work submitted to SEG, about the effectiveness of the local safeguarding arrangements.

The work of SEG can be divided into four interlocking domains:

- Performance Framework – monitoring statistical data about service delivery
- Co-ordination of Audits – undertaking multi-agency case file audits and Section 11 audits to provide a qualitative perspective on the statistical data
- LSCB Effectiveness – reviewing the work and effectiveness of the Board itself
- Embedding Learning from Review processes – tracking the recommendations of case reviews

The following activity was completed by agency partners, supported by the Board Office, during 2013/14:

- Section 11 Audit - satisfactory assurance was received in regard to members safeguarding arrangements. No concerns were noted. (See section 2.9.3).
- Serious Case Review action plans were reviewed and assurances obtained in relation to implementation of case recommendations.
- Clarification and refining of safeguarding indicators – which are aligned to the children and young people's plan.
- Development of data and commentary reporting sheet.

The quality assurance activity that SEG has either commissioned or received indicates that safeguarding and child protection arrangements are safe in Leicester. SEG has

laid the foundations for a strong framework of quality assurance and critical challenge, which will be further developed in the year ahead.

SEG has a wide remit across the whole safeguarding system in the city. The engagement of partner agencies has been strengthened during the year. Partners are submitting information to SEG in relation to key performance indicators and reports summarising their internal quality assurance work.

The outcomes of this work are reported annually to the City Mayor, Chief Executives of partner agencies, the city council Scrutiny Committee, the City Health and Wellbeing Board, the Police and Crime Commissioner, the Clinical Commissioning Group and other boards and agency managers.

2.10.1 Monitoring pressures and vulnerabilities in the arrangements

The Board receives reports twice a year by partner agencies, analysing service trends, pressures and vulnerabilities, including the consequences of service and budget changes. These reports are intended to help partners to strengthen joint planning and take account of wider system in changes in service development. They also provide evidence of strengths and weaknesses in the system and feed into the SEG overview of safeguarding arrangements in Leicester.

2.10.2 Section 11 audits 2013-2014

The 'Section 11 Audit' is a statutory requirement designed to allow the LSCB to assure itself that agencies placed under a duty to co-operate by the Children Act (2004) are fulfilling their responsibilities to safeguard children and promote their welfare. The outcomes from the audit contribute to the monitoring activity of the Safeguarding Effectiveness Group and the Board's overall judgement about the effectiveness of the safeguarding arrangements in the city.

The main issues raised by the 2013/14 audit are as follows:

- All agencies stated that they were compliant against the standards
- Agencies identified that they need to do more to take into account the views of children and families
- There is further work required to embed a wider family approach in agencies where the focus of their work is mainly on adults
- Information sharing is a standard for which some agencies did not feel confident they could demonstrate full compliance. Information sharing protocols are being reviewed.

The Board convened a special meeting of statutory partners to review the outcome of the Section 11 audit process for the first time. Senior officers presented their audit statement, reported on progress with their action plan where relevant, and were

questioned by partners. This process was welcomed by all agencies and will be repeated. It was also agreed that we should develop a more sophisticated audit tool and seek to involve more agencies on a voluntary basis.

2.10.3 Serious Case Reviews and Management Reviews

The Board oversees a number of processes which review individual cases, including the Child Death Overview Panel, Serious Case Reviews and other forms of case review. The outcome from reviews feeds into the work of the Safeguarding Effectiveness Group and informs the overall judgement about the effectiveness of safeguarding arrangements in the city and the wellbeing of children.

The only Serious Case Review conducted by the LSCB during 2013-14 was the case of an eight month old baby girl, known as Baby Z, who had suffered fractures to her skull, ribs and legs. The girl was severely brain damaged and as a result of her injuries is "severely visually impaired". The injuries represented "multiple episodes of non-accidental injury". Baby Z's mother admitted causing grievous bodily harm and was jailed for two-and-a-half years. She was later returned to India as she had overstayed her student visa.

The review, which was published in February, found there were missed opportunities when a referral to social services could have been made, which would have led to further assessment of the child and possibly to a safeguarding investigation. Baby Z was seen by health visitors and GPs when she was six months old and her mother pointed out marks on the baby's back. At this point children's services should have been informed. The learning from the review was shared in a series of briefings to multi-agency audiences.

2.10.4 Child Death Overview Panel (CDOP)

One of the duties of the LSCB is to ensure a review is undertaken into the deaths of all children, whatever the cause, who are normally resident within their area (*Working Together 2013*, chapter 5*)*. During this period, 47 cases were reviewed by Leicester, Leicestershire and Rutland (LLR) CDOP and 8 panel meetings were held. Two of these meetings were used as developmental sessions and six were utilised to review cases. The child death overview process is not an investigation and does not supersede the need for organisations to undertake their own reviews following the death of a child. It is intended that the child death overview process will incorporate issues identified within case review processes to ensure shared learning.

Learning that has taken place within partner organisations as a result of CDOP cases has led to a range of actions and improvements, including:

- Working with partners to seek clarity on the protocols associated with the transportation of children pronounced 'dead at the scene'.

- Close work with the Joe Humphries Memorial Trust and also the Heart Start initiative, resulting in a number of consultants committing to teaching (in their own time) basic life support skills to school children.
- Feedback from the perinatal mortality review panel to neonatal staff has continued and three sessions were completed in 2013.
- A series of infant mortality road-shows in each District bringing together children's centre staff and service providers to highlight the risk factors and promote awareness of the services available to tackle them.

2.10.5 External inspection findings

Partner agencies have formal inspections undertaken by a number of national inspectorates. External inspections provide an external check on the effectiveness of services and contribute to our understanding of the local systems. Their findings are taken into account by the Safeguarding Effectiveness Group.

Ofsted did not inspect safeguarding or looked after children's services in 2013/14. The last full inspection was carried out in December 2011, when safeguarding services were judged adequate overall with good capacity to improve.

Her Majesty's Inspectorate of Constabulary (HMIC) have not specifically inspected police work on child protection, but other inspections have included a reference to child protection. For example, the domestic violence inspection found that Leicestershire Police was identifying and safeguarding children and making appropriate referrals and the data integrity inspection looked at sexual offences and highlighted a very positive victim led approach.

Following its inspection of Leicester's hospitals on 13-16 January 2014, the Care Quality Commission found that "the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led".

The national inspection of the Children and Family Courts Advisory and Support Service (CAFCASS) by Ofsted in January 2014 found that outstanding leadership has led to a wholesale transformation in organisational culture, radically improving the services children and families receive, and has steered the organisation to receiving an overall grading of good. The inspection found that the CAFCASS social workers consistently work well with families to ensure children are safe and that the court makes decisions that are in children's best interests.

2.11 CONCLUSIONS AND RECOMMENDATIONS

This annual report has identified a substantial range of safeguarding activities, the involvement of a wide range of partner agencies and some significant achievements, such as the Children's Summit, improved evaluation of service delivery, implementation of an agreed threshold policy, a range of training opportunities and

a new system of evaluation, effective scrutiny of child deaths, new initiatives to address child sexual exploitation and the situation of children who go missing from home or care, a new Early Help Strategy, a new assessment protocol and effective management of allegations made against professionals. The Board reviews its governance arrangements and its own effectiveness and engages with a range of multi-agency strategic structures in the City.

The report also identifies areas for continuous improvement, but with a specific focus on sustaining and strengthening our efforts to ensure that the voice of children and young people is heard clearly in case reviews and also in service monitoring and planning discussions; developing performance monitoring and a more robust analytical approach to information which is collected; monitoring implementation of the Early Help arrangements and ensuring that staff in all agencies are aware of the opportunities for early help; monitoring support to staff to enable them to deliver more consistent, quality work; strengthening responses to child sexual exploitation and trafficking, developing new approaches to prevention and disruption of this activity; ensuring that victims of non-recent abuse have access to services they need; completing the governance review of the Board; encouraging partner agencies to sustain partnership working and strengthen joint planning of services; and ensuring that children, young people and adults in Leicester know where to get help when they are concerned about a safeguarding issue and that they are heard respectfully.

3. Local background and context

The following key information is taken from the latest 2011 Census and other local statistics.

Leicester is the largest city in the East Midlands with a population of 329,839 and the 10th largest city in the United Kingdom and England's 11th largest urban area

Leicester is also the most densely populated city in the East Midlands with 4,500 people per sq. km, equivalent to about 45 people on a rugby pitch.

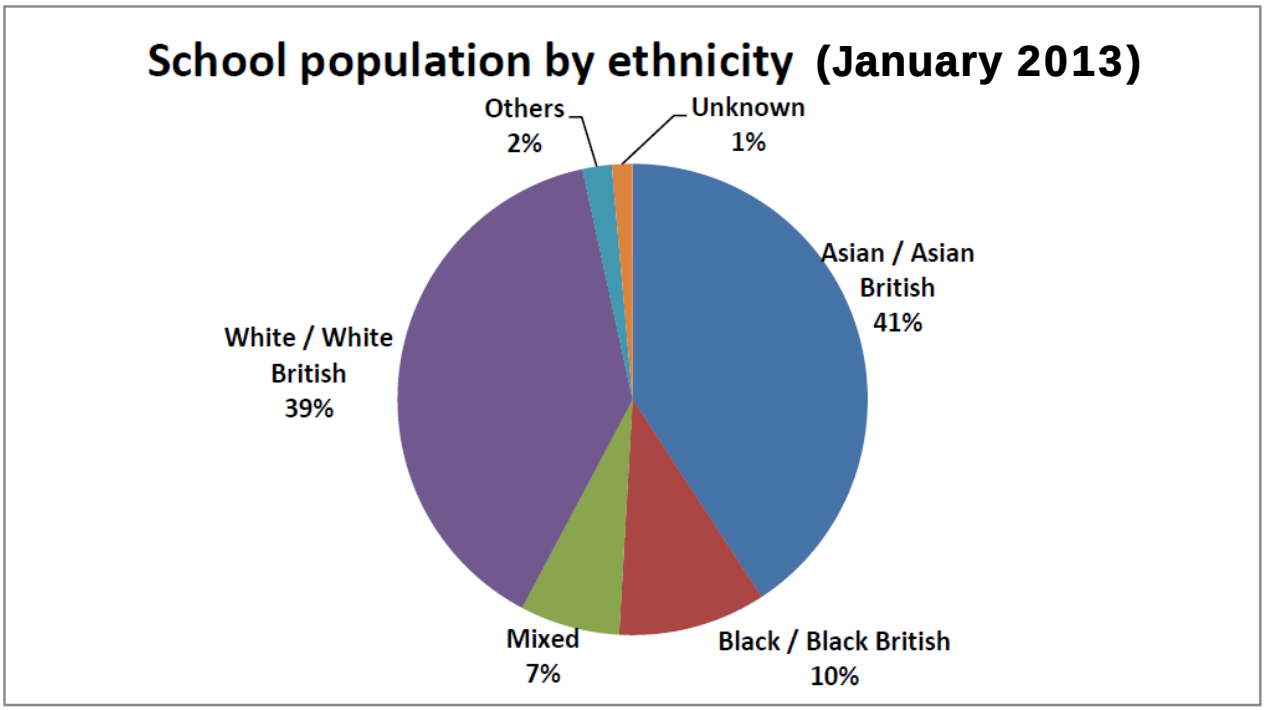
Leicester is a deprived city – the 25th most deprived local authority area in the UK. Over a third of Leicester's children are living in poverty. Our work takes place in a challenging national environment, with increasing inequality and growing pressures on families, increasing 'demand' in many areas, rising child poverty and reducing agency budgets. Whilst poverty and child rearing problems do not necessarily go together for all families, we know that poverty and related issues do make it more likely that there will be a range of social problems, including increased risk of mental health problems, suicide and self-harm, domestic violence and problems with children. Given the national economic environment and reductions in the financial support available to families, the Leicester Board has been predicting an increase in the number of families experiencing significant problems. The number of families needing support continues to increase and problems are becoming more complex.

Leicester has a diverse population when compared to that of the East Midlands and England. 45.1% say they are White British the next largest group being Asian/ Asian British: Indian at 28.3%. The Board is aware of its responsibilities to children and young people from all the diverse communities in the city and the need to ensure that people from all communities have confidence in services to support parents and protect children and young people.

Around 70 languages are spoken in Leicester however 72.5% would consider English as their main language.

Leicester's birth rate has been rising significantly in recent years creating increasing demands on midwifery, health visiting and school services.

79% are over the age of 18 (260,470) with 11.3% of those over the age of 65.


School population by ethnicity (January 2013)
Others
2%
Unknown
1%
Asian / Asian British
41%
White / White British
39%
Mixed
7%
Black / Black British
10%

4. Statutory and legislative context for LSCBs

Section 13 of the Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specified the organisations and individuals (other than the local authority) that should be represented on LSCBs.

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) relates to the LSCB Serious Case Reviews function and regulation 6 relates to the LSCB Child Death functions.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

2. In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The LSCB does not commission or deliver direct frontline services.

While the LSCB does not have the power to direct partner or other organisations, it does have a role in making clear where improvement is needed.

Each Board partner retains their own existing line of accountability for safeguarding.

5. Governance and accountability arrangements

LEICESTER SAFEGUARDING CHILDREN BOARD STRUCTURE

The Board meets on a quarterly basis and the format of its' meetings alternate between standard business meetings (June and December) and less formal "development" meetings (March and September), which enable the Board to consider particular priorities or topics in greater depth.

Board membership is listed at Appendix A.

Attendance at the Board by partner agencies is contained in Appendix B.

In order to provide effective scrutiny, the LSCB must be independent. It is not subordinate to, nor subsumed within, other local structures.

The local partnership and accountability arrangements are specified in the Board's Constitution document available on the LSCB's website at: **www.lcitylscb.org/**

The LSCB has approved protocols with the Children's Trust and Health and Wellbeing Boards which specify their respective functions and relationships. The LSCB and LSAB share a joint values statement which underpins the work of the two Boards. This is available as Appendix C.

A number of working groups operate on a Leicester, Leicestershire and Rutland (LLR) basis, recognising that children and families do not limit their activities by local government boundaries and also reflecting the organisational structures of the police, health service providers and some other agencies. These groups are detailed in Appendix D.

INFRASTRUCTURE ARRANGEMENTS

Board office arrangements are hosted by Leicester City Council. The Board office structure is made up of the LSCB Manager, an LSCB Policy Officer and 1.5 full time administrative staff.

A Project Development Officer is hosted by the city's LSCB to ensure development and coordination of the training programme. The cost of the post is shared across Leicester, Leicestershire and Rutland.

The LSCB office is located in city council premises at 6 St. Martins, Leicester, LE1 5DB.

INDEPENDENT CHAIR ARRANGEMENTS

Dr. David Jones, the Independent Chair of the LSCB was re-appointed in April of 2013 for a second 3 year term. Dr. Jones is also the Independent Chair of the Leicester Safeguarding Adults Board.

A central responsibility of the independent chair is to hold all agencies to account for their work in relation to safeguarding.

The Chair is accountable to the Chief Operating Officer of the City Council who acts on behalf of the Board partners. There are regular meetings to review progress, which also include the two Strategic Directors for Children and Adult services. The Chair also holds 6-monthly meetings with the City Mayor, Assistant Mayors and Strategic Directors to report on the effectiveness of safeguarding and to discuss emerging issues. The first summit of Chief Officers of statutory members of the Board was convened to discuss the findings of the annual reports of the LSCB and LSAB and to review key themes. The summit recognised the need to strengthen the arrangements for monitoring the effectiveness of the safeguarding arrangements.

Dr Jones served as the Vice Chair of the Association of Independent LSCB Chairs during the period of this report and took over as Chair of the Association in July 2014. He ensured that the Board was kept informed of national and international developments in areas relevant to the Board's work.

LSCB BUDGET

The contributions from the partner agencies during 2013/2014 were agreed and received as follows:

	£	%
Leicester City Council	129,030	52.7
NHS Leicester City	55,759	22.8
Leicestershire Constabulary	43,944	17.9
Leicester & Rutland Probation Trust	15,556	6.4
CAFCASS	550	0.2

The expenditure against this budget is detailed as follows:

Cost areas agreed as part of the LSCB Business Plan for 2013/14	Planned 2013/2014 Spend	Actual Spend for Q1	Actual Spend for Q2	Actual Spend for Q3	Actual Spend for Q4	Outturn 2013-14
	£	£	£	£	£	£
Staff costs	132,500	22,800	21,400	26,100	30,600	**100,900**
Transport costs	1,000	100	200	300	100	**700**
Supplies and Services	8,500	100	4,400	2,700	500	**7,700**
Independent Chair	32,200	4,600	5,400	0	13,200	**23,200**
Serious incident review process costs	30,000	1,000	0	0	2,000	**3,000**
Child Death Overview Panel costs	8,400	0	0	0	0	**0**
Conference and Room Hire	10,000	1,400	2,800	4,400	14,800	**23,400**
LSCB Procedures	1,900	1,900	0	0	0	**1,900**
Marketing and Advertising	6,400	0	0	700	0	**700**
Participation	0	0	0	0	1,100	**1,100**
Other	15,000	300	300	300	2,400	**3,300**
TOTAL	**245,900**	**32,200**	**34,500**	**34,500**	**64,700**	**165,900**

One-off Cost for 2013/14	Planned 2013/2014 Spend	Actual Spend for Q1	Actual Spend for Q2	Actual Spend for Q3	Actual Spend for Q4	Outturn 2013-14
	£	£	£	£	£	£
Project Dev. Officer -	21,600	10,900	10,900	8,900	8,900	**39,600**
VAL Training Support	15,700	0	7,800	0	7,800	**15,600**
Research	43,000	18,000	0	18,000	0	**36,000**
StaySafe	0	0	0	6,500	0	**6,500**
TOTAL	**80,300**	**28,900**	**18,700**	**33,400**	**16,700**	**97,700**

	£
Total Projected Spend 2013-14	165,900
Total Projected one-off spends 2013-14	97,700
	263,400
less contributions from partner agencies 2013-14	135,800
less LCC contribution 2013-14	130,000
less contributions from L&R LSCB for E Ranger 2013-14	22,000
Training Income 2013-14	15,600
less b/fwd underspend from 2012-13	192,532
	495,932
underspend c/fwd into 2014-15	**- 232,532**

6. Board priorities and working groups

The Board has established working groups to oversee its main priority activities. These are shown in Appendix D. This chapter reports on the work of those groups and the delivery of the Business Plan objectives.

6.1 Engagement with and participation of children

Listening to and respecting the voices of children and young people is at the heart of the values of the LSCB. This is not always easy to achieve and requires constant renewal of commitment.

What have we done?

Ensuring that Children and Young People are consulted and listened to regarding safeguarding issues was identified as core business for the LSCB and a priority in the 2013/14 Business Plan.

The aim of the participation work is to:

- Ask children and young people across the City whether they are safe and feel safe
- Work with children and young people to ensure that they know how to keep safe
- Consult with children and young people about service delivery
- Ensure young people's representation on the LSCB Board

Consultation with and the participation of children and young people with regards to services that they receive is good practice. Working Together 2010 and the recently revised Working Together 2013 both endorse that approach.

The work was co-ordinated through a Participation Group chaired by the Head of Children's Safeguarding and Quality Assurance Leicester City Council and supported by the LSCB Policy Officer. Representation on the group, in addition to young people, included the key participation leads from across the city, primarily the City Council, the Schools Development Support Agency and education providers including colleges.

One of the objectives for this year was to appoint a young person as a lay member of the LSCB. The recruitment process was successful and a young person is able to attend the Board meetings and to contribute a young person's perspective not only

to the Board but also the sub-groups. She was involved in the planning of the Safeguarding Summit which was held in October 2013.

How well did we do it?

Safeguarding Summit was ground breaking in that it was organised by young people from the City's Participation Groups working collaboratively including the Big Mouth Forum, the Children in Care Council (CICC), School Councils and the Young People's Council. Also it was the first City-wide consultation event for young people about safeguarding regarding feeling safe and staying safe. A detailed report of the findings was presented to the LSCB. The event was well received with positive feedback from the attendees and accompanying adults. The strongest messages from the young people were about bullying; the need for safe places to play and the importance of street lighting.

Since that event the participation group has continued to collaborate on a range of initiatives including working with health to increase participation and engagement. The following extracts from the report of the Safeguarding Summit highlight the main findings.

Who or what do you think is most likely to harm you?

The range of risks identified by the young people included:

School & College

- Bullying
  - from peers
  - intimidation by older students
  - carrying of weapons
  - fear of violence from gangs and in fights
- Peer pressure
- Strangers on the school grounds/intruders
- Smoking on school grounds
- Being alone

Home

- Going online
  - Cyberbullying
- Unhealthy relationships
  - With or between siblings, parents and partners
- Being left alone
- Household hazards
  - Associated with unsupervised use of gas, water and electricity

Out and about

- Stranger danger
  - Fear of abduction
  - Being followed on foot and in cars
  - Being abducted by car
  - Gangs
- Threat of violence
  - Robbery (for money or possessions)
  - Sexual attack
- Environment
  - Dark streets
  - Alleys
  - Parks
  - Isolated places
- Risk from vehicles
- Drunk people
- Risk from dogs
  - Strays
  - Dogs not on a lead
  - Dog mess

Leisure and transport

- Risk of collision
  - In cars, buses and on bikes
- Getting lost
  - Not taking a safe and/or known route
- Crossing or playing near railways
- Feeling unsafe in taxis
- Stranger danger
  - Risks posed by fellow passengers

How do you avoid or deal with risk?

After identifying the risks in a number of contexts the children and young people were asked to consider how those risks could be minimised. The children and young people were good at identifying different means of dealing with the risks they did or might encounter. Examples of this were:

- Phone for support
  - Emergency and non-emergency numbers were known
- Don't get involved
  - Ignore the situation

    - Walk on by
    - Don't respond to provocation
- Talk to or seek help from an adult
- Stay with a friend
    - Safety in numbers
- Be clear about your route
    - Know where you are going

What would make you feel safer?

There were a number of protective factors identified by the participants. Among them were:

- Being part of a community
    - Friendship group, church, school, mosque
- Knowing who to trust
    - Being comfortable with the people you are with
- Security measures
    - Good lighting
    - CCTV
    - Locks
    - Identity badges
- Importance of a healthy family environment
- Staying alert
    - Not daydreaming
    - Remaining alert
    - Not being distracted by headphones
    - Not being under the influence

Have we made a difference?

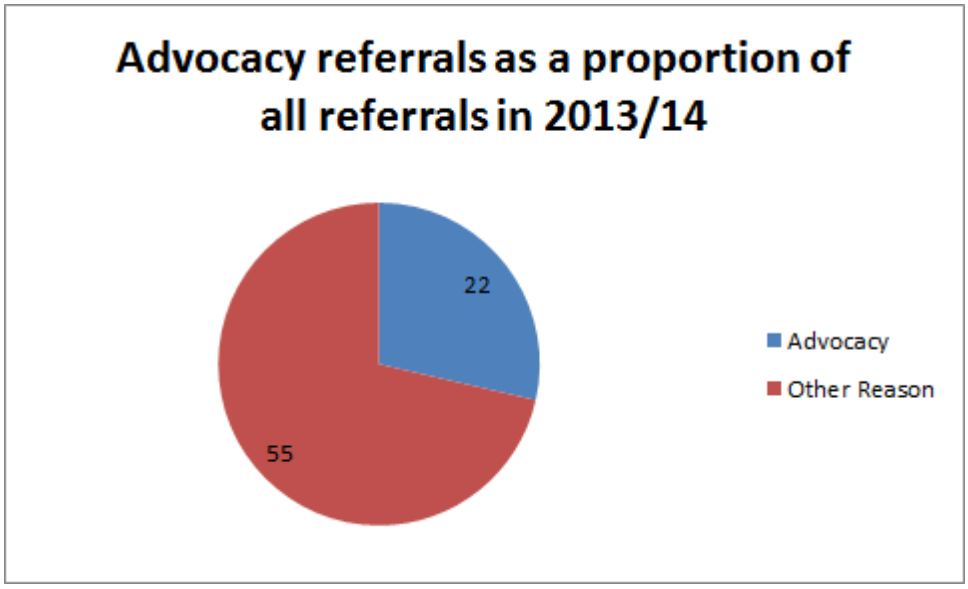
The Children's Rights and Participation Service accepts referrals from young people going through social care processes where there is a need for conflict resolution with the local authority and also provides an advocacy service.

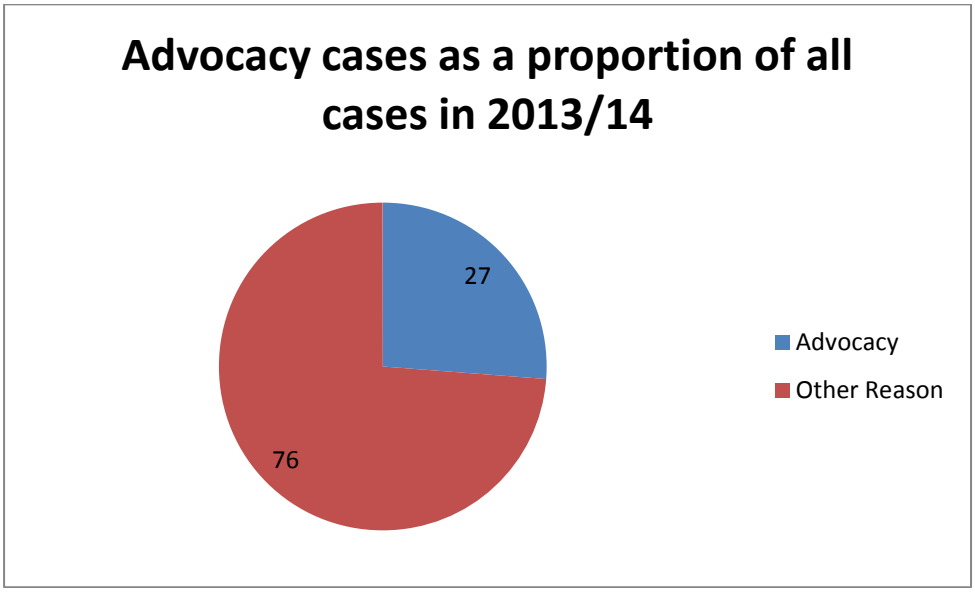
Out of 103 referrals being worked throughout the year, 27 of the referrals have been for advocacy (26%). Of these, 4 young people were requesting support to attend Child Protection Conferences. Young people report that this input makes a difference.

One young person said that she "switches off' when her social worker speaks to her and so valued the time that was spent going through the conference report and record. She said that when under stress, she doesn't always "hear" and process the information.

Although young people seem willing to attend their Children who Use Sexually Abusive Behaviours (CUSAB) or Child Sexual Exploitation (CSE) meetings, the numbers who attend Child Protection Conferences need to increase. Conference chairs ensure that best practice is promoted and attendance is monitored. However this continues to be an area for development.

A new leaflet for young people who are subject of a child protection conference has been introduced and it is anticipated that this will lead to increased participation by young people and that there will be more requests for an advocacy service as awareness increases. This year 29% of referrals were for advocacy and the current establishment of 1.6 f.t.e officers were able to meet this level of need.





Several other referrals involved safeguarding issues. For example, two young people raised concerns about an out of authority placement including use of physical interventions and both these young people were moved in response to these concerns. One young person sought support in relation to safe contact arrangements for her child. One young person disclosed non-recent abuse in a previous foster placement and this was referred on for investigation. Another young person was supported to go to the police to make a complaint about an alleged assault.

The Service has advocated for four young parents where there are safeguarding concerns in relation to their child(ren). The young people are positive about this input; one young person says she valued the continuity as she has had lots of different social workers; one young person said that she felt that the service was 'there for her when no one else was'.

Two young people were unhappy about the way that they were treated in a foster placement and these concerns were addressed and led to one young person moving in line with her views, wishes and feelings. Young people express a high level of satisfaction with the service that they have received. They know that they are being heard and feel that the service helps them to give their views. Some young people say that the input has helped their relationship with their social worker.

Twenty five younger children attended a participation event organised by the Children in Care Council with facilitation by an external arts company where one of the themes was Staying Safe. The children were asked to design and describe a safe place and all were able to do this. For many of these children, their bedrooms were where they felt safe. When asked about bullying, they said that they would tell a teacher or a carer if they were being bullied. Having a pet seemed to be a key factor to increase a child's sense of well-being. These findings were reported to Corporate Parents and helped inform service developments.

The former Looked After Children Project worker carried out a project with 9 young men who had missing from care episodes (7 from City children's homes and 2 from foster placements) and the findings were reported to Corporate Parents at the LAC Pledge Review. Young people's reasons for running away included 'to get away from staff'; "cos I was bored", "cos I was upset"; "to calm me down". These young people did not believe that they were at risk on the streets as they knew where to go; one said that he always went to the same place. These findings help inform the substantial work that is carried out in conjunction with partners to reduce incidences of missing and to respond appropriately when children go missing to ensure their safety and well-being.

The Regulation 33 Visitor and one of the Children's Rights and Participation Officers visit the 5 City children's homes and speak to the young people about a range of

issues including use of physical interventions, whether they feel safe and whether they have any concerns to raise about their treatment within the home. All children placed out of the City area receive visits and complete a questionnaire about personal safety; they all report feeling safe and know who to contact if necessary. Issues are followed up with robust reporting systems including monthly reports to OFSTED. Most young people are in agreement with the way that they have been restrained. One young person said that it made him feel safe.

Next steps for the Safeguarding Unit

- Make sure that the leaflet for young people who are subject to Child Protection Conferences is being effective. We will know this is the case if there is an increase in attendance at Child Protection Conferences and increased requests for advocacy.
- Make sure that the lay young person on the LSCB is having an impact. We will know this by evaluating her role including asking her and other Board members what difference it has made.
- Strengthen the links between the Children in Care Council and the Corporate Parenting Forum so that the views of young people impact on Service developments.
- Improve data collection from the Children's Rights and Participation Service to collect data in relation to safeguarding.
- Make sure that the critical messages about safeguarding from young people in public care are reported to the LSCB as well as the Corporate Parenting Forum so that agencies are held to account.
- Seek more information from children in care and care leavers about bullying and whether they are or were bullied because they are or were in care. This information can be used to improve the anti- bullying work across Services.
- Ask school councils to respond to the Safeguarding Summit report and agree 3 priority actions to take forward.

6.2 Implementing safeguarding service priorities

The Stay Safe Group is the multi-agency vehicle for driving forward, coordinating and/or implementing the safeguarding priorities contained in the Children and Young People's Plan. The 6 priorities are shared with the Children's Trust Board. Progress and impact has been made throughout the year against each priority. Work has been overseen by multi-agency sub-groups.

Priority 1 - Prompt assessment and effective child protection planning.
The LSCB commissioned Professor David Thorpe to examine referral and assessment practices in Leicester, taking account of evidence that the rate of referrals for child protection investigations in Leicester was higher than comparable areas, suggesting the possibility that more families experienced a police and social work investigation

than was strictly necessary. The action research resulted in the implementation of a new way of screening initial concerns about the care of children and led to an overall and appropriate reduction in the number of families undergoing a full child protection investigation. Most of the families whose children were not assessed to require a safeguarding assessment were offered less intrusive forms of assistance. All agencies are committed to providing early help and support to parents and children in ways which they find helpful and also ensuring that there are thorough and timely assessments when there is evidence of safeguarding concerns. A new single assessment process in Children's Social Care is resulting in an overall improvement in the quality of assessments.

Priority 2 - Preventative and safeguarding action where children are at risk from domestic violence

The Multi-agency Risk Assessment Conference (MARAC) process is working well with good representation and involvement from partner agencies. Following a commissioning review of domestic violence services, there was positive take up in terms of referrals to services for children, victims and perpetrators. There is a prompt and effective response from services to children who use sexually abusive behaviour towards other children, with good access to therapeutic services for children which reduces the behaviours and supports families.

Priority 3 - Safeguarding young people

A protocol for children and young people who run away or go missing from care was launched, supported by good strategic and operational systems, and agencies strive to undertake return interviews after a 'missing' episode. There is a joint Leicester and Leicestershire/Rutland Board Child Sexual Exploitation Group with robust systems and joint working between children's social care and the police. Over 100 teachers in Madrassa (Muslim centres) have been trained in anti-bullying and safeguarding work. Work has been done with foster carers and adopters, and targeted work done with young people at risk and parents to raise awareness on the consequences of online activity.

Priority 4 – Implementing thresholds for service

Following an extensive consultation with partners, a multi-agency thresholds guidance document was developed and launched.

Priority 5 – Listening to the voice of the child/young person.

In October 2013 a Young People's Summit took place with over 100 children from schools across Leicester on how safe children feel in different aspects of their lives (education, out and about, leisure and home). This was the first time that Leicester (through the LSCB who coordinated the event with young people) consulted with children and young people on this scale. The outcomes from this event were compiled in a report which was presented to the Children's Trust Board for

consideration and the difference and impact of the work will be evident from the extent to which partner agencies incorporate the messages on stay safe into their service planning and commissioning processes. See also 6.1 above.

Priority 6 - Reducing accidents and serious incidents.
There are good systems of dissemination across the partnership of lessons learnt from local serious case reviews. Child Death Overview Panel (CDOP) arrangements are well established and work has been done to ensure there is a robust approach to monitoring the learning identified in each case (see below 2.10.4). Reducing infant mortality continues to be a priority, with campaigns carried out in the year on areas such maternal obesity, early access to maternal services, teenage parenthood and safer sleeping.

6.3 Policies, procedures and guidance for multi-agency arrangements, to protect children and promote their welfare

How much did we do?

A sub group of the LSCB oversees the LSCB Child Protection Procedures, ensuring that they are up to date and used across all agencies. It was agreed at the disaggregation of the former tripartite board (2009) that the procedures would remain joint with the Leicestershire and Rutland Board, since this made better sense for agencies and families.

The Procedures and Development sub group meets on a quarterly basis to co-ordinate the revision and addition of procedures to ensure that they reflect changes necessary as a result of previous learning, emerging priorities and new developments.

How well did we do it?

The procedures have been updated to ensure compliance with new statutory guidance, *Working Together, 2013*.

Work over the year has led to amendments in the guidance on the following topics:

- Common Assessment Framework
- Statutory Framework
- Early Intervention when there are Child Welfare Concerns
- Leicester's Early Help & Prevention Offer
- Recording that a Child is the subject of a Child Protection Plan
- Safeguarding Children and Young People from Child Sexual Exploitation
- Children Moving Across Boundaries

- Complex (Organised or Multiple) Abuse
- Fabricated or Induced Illness
- Achieving Best Evidence in Criminal Proceedings
- Historical Abuse Allegations
- Support for Staff Following the Death of a Child
- Appeals by Parents / Carers and Children against Child Protection Conference decisions plus the 7 appendices.
- Responding to Child Death
- Learning and Improvement Framework
- Children and Young People who Run Away or go missing from Home or Care Joint Protocol 2013
- Private Fostering

The procedures are "hosted" for the Board by a third party: Tri-X. The shared procedures are accessible at:
http://www.llrscb.proceduresonline.com/chapters/contents.html

Is anyone better off? What difference has it made?

Audit and review processes have not identified any deficiencies in terms of the procedural guidance available for practitioners.

6.4 Single and Multi-Agency training provision

The LSCB has a statutory duty to develop policy and procedures in relation to 'training of persons who work with children or in services affecting the safety and welfare of children'. (Regulation 5 LSCB Regulations 2006.). The LSCB learning, Development & Training Strategy and associated work supports this duty and responsibility.

Safeguarding learning across Leicester, Leicestershire & Rutland is overseen by the Leicester, Leicestershire & Rutland Safeguarding Multi Agency Training, Learning and Development Commissioning and Delivery Group, and is supported by and the work of the Leicester, Leicestershire & Rutland LSCB Training Project Development Officer and Leicester, Leicestershire & Rutland LSCB Multi agency Project Co-ordinator.

The subgroup has representation from key partners from Leicester, Leicestershire and Rutland; representatives on the group have the strategic authority to shape safeguarding learning, training and development. Agencies represented include Social Care and Safeguarding, Clinical Commissioning Group, Primary Care Trust, University Hospitals Leicester, Youth Offending Service, Corporate Learning and Development / Workforce Development, Adult Services, Voluntary Action Leicestershire, Leicestershire Police, Probation, Education.

As well as supporting the implementation of the Learning, Development & Training Strategy, the sub group supports the statutory duty and responsibility of the LSCB:

- To develop policy and procedures in relation to 'the training of persons who work with children or in services affecting he safety and welfare of children.'
- To monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.
- To ensuring that a culture of information sharing is developed and supported as necessary via multi-agency and single agency training.
- To support a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children.

These duties are determined by Working Together 2013, Regulation 5, Local Safeguarding Children's Boards Regulation 2006 & Children Act 2004.

The work on evaluation of the impact of learning feeds into the work of the LSCB Safeguarding Effectiveness Group. The training strategy has an emphasis on evaluation and scrutiny of learning, as follows:

- By using the clear guidance about the expected content and knowledge for practitioners in the Children's Workforce in relation to their safeguarding learning, based on suggested content from Working Together 2010.
- Development of standards for knowledge (Competency Framework Operational April 2014) and delivery (Best Practice in Safeguarding Learning) for safeguarding learning.
- Development of a formal process for Quality Assurance Framework for safeguarding learning, and audit and evaluation information for the multi-agency programme.
- Quarterly monitoring reports are produced providing detailed evidence, analysis and evaluation of the Multi-agency Safeguarding Training Programme. These provide information that provide evidence for inspection purposes, and by which effectiveness can be measured. This quarterly reporting allows for learning to be measured; but also this will provide data in relation to uptake, attendance etc. The infrastructure for the multi-agency programme will allow for contributions by partners and priorities to be tracked and measured.

Changes made as a result of previous learning/priorities and new developments

During 2013 – 14 work has continued on supporting the implementation of the training strategy, combined with preparing for the launch of the revised strategy in April 2014. Other work streams to support single agency and multi-agency safeguarding learning are as follows:.

- Continuing the Trainers Network to offer support to all staff that deliver or have involvement with development of safeguarding learning, and strengthening links to the adult's trainers network.
- Regular mail outs of resources and information to staff, managers and safeguarding trainers.
- Development and launch of a joint LLR website page for safeguarding learning that promotes the April 2014 strategy and provides information on standards, resources and links to learning opportunities.
- Development of the infrastructure and supporting documents to support the revised Leicester, Leicestershire & Rutland Safeguarding Learning, Development and Training Strategy – April 2014.
- Work on the implementation strategy for the new Strategy, including briefing sessions and engagement work with organisations and individuals and promotion and publicity.
- Best Practice Principles and matrix in safeguarding learning becoming operational.
- Review and continuation of multi-agency programme, and associated planning and development for 2013 – 14, which includes undertaking a priority needs analysis for the multi-agency programme and developing a process for tracking and audit purposes which will support the Quality Assurance process. This also links in with tracking how recommendations from SCR's and business plan priorities are met.
- Continued quarterly evaluation reports and analysis of multi-agency training programme.
- Continuation of partnership work across agencies in relation to safeguarding learning (by regular formal meetings of the group, and contact with Project Co-ordinator and Project Officer with partners across the workforce.)
- Endorsement of the Competency Framework for safeguarding learning.
- On-going support and commitment to provision of Level 2 training to the Private, Voluntary and Independent (PVI) sector.

Contribution to LSCB current priorities

- The primary focus of the group is to support practitioners in the children's workforce to have the skills, knowledge and confidence to undertake their roles and responsibilities in relation to safeguarding. This work contributes directly to meeting the LSCB core business priority of 'Training, learning and development'.
- The work contributes directly to safeguarding children and promoting their welfare, by supporting organisations to have clear guidance about the expectations and learning that is required, in order to support the workforce to effectively safeguard and take appropriate action in line with their roles and responsibilities.

- The scrutiny role allows the LSCB to consider the impact and effectiveness of safeguarding learning and how this is embedded into practice and looks at what difference it makes in terms of outcomes to children and young people.
- The proposed refreshed standards and essential content for training and also the competency based approach will allow for a formal basis for the workforce to be assessed against.
- For the multi-agency training programme: There is a mixture of quantitative and qualitative evaluation data, which shows overall that there is an increase in skills, knowledge and confidence at the 3 month stage of evaluation; this supports one of the key priorities of learning and interagency working, which interagency training can support building more effective working relationships.
- As systems and evaluation methods are further developed into more detailed focus groups, we will be able to further measure the direct impact on practice, which in turn should support effective safeguarding practice.
- The on-going liaison and work to develop and implement the training strategy has developed and strengthened existing relationships, and allowed for new working relationships with key partners to be developed. Small task and finish groups have allowed for the work to have a broader multi-agency perspective, and this input has supported engagement and commitment to the multi-agency programme and training strategy.
- The development and implementation of the Quality Assurance Framework and Competency Framework, will give all partners clear guidance in terms of the expectations and scrutiny role that the LSCB will undertake. However an approach of consultation and cross agency development work with many of the partners, has underpinned the work and has indicated support for the new Framework, which in turns promotes and supports the culture of continuous learning.

How much have we done in the last 12 months up to March 2014?

In 2013 – 14 the following has been achieved:

- Revised 2014 strategy and supporting infrastructure documents, standards and assurance processes developed and endorsed.
- Implementation plan developed and launched in March 2014, which has also included briefings to over 130 managers and key individuals in March 2013
- Launch of revised LLR safeguarding learning website.
- Continuation of LLR strategic sub group for safeguarding learning.
- SCR briefing session (Child Q) offering key learning messages following the Serious Case Review (June 2013) offering up to 240 spaces for practitioners.
- Continuation of the Interagency programme, which offered over 1200 spaces on a variety of learning events of 'level 3' staff who require multi-agency

safeguarding learning. This programme has been well supported by partners, who have funded the programme via delivery, funding and venues.
- Work with adult partners and the wider workforce to a support whole family approach.
- Development and engagement work with key staff in early years (Quality and Improvement teams) and county teams to support the early years workforce in relation to the 2014 training strategy.
- Work with the LSCB project officer to support Quality Assurance activity in relation to safeguarding learning.
- Continued support (in partnership with Leicestershire and Rutland LSCB) of Level 2 'Essential awareness' training for the private, voluntary and independent sectors.
- Partnership work with Leicestershire & Rutland Board and Safe Network to pilot a 'Designated and Named Person course' for the Voluntary Sector.
- Continued work with Safe Network.
- Work with the DfE and local partners to look at the DfE Neglect toolkit, and how this can be used to support training and safeguarding learning across Leicester, Leicestershire and Rutland.

How well did we do?

- The co-ordinated programme increased in terms of a number of different courses and priorities and also doubled the number of staff trained; the courses formally reflect LSCB business priorities and learning from local and national reviews. There has also been a decrease the percentage of non-attendance from the previous year.
- The continued progression and work of the strategic group, and strengthening of relationship with other LSCB sub groups and other sectors (i.e. adult / wider workforce) has assisted in raising the profile of safeguarding learning. The feedback from this group continues to be positive.
- The endorsement of the 2014 strategy and infrastructure, alongside a significant change in approach to safeguarding learning indicates that the subgroup has continued to build on the strong foundations of safeguarding learning, which the LSCB has delivered to for many years.

How do we know if the training has made a difference?

Tangible outcomes from learning, training and development are difficult to define and evidence but clear evidence about the impact of the multi-agency learning from the interagency programme is beginning to emerge, including evidence about the difference it has made to practice. The 4 stage evaluation process considers pre and post training knowledge and follows up after a number of months. Returns have indicated an increase and improvement in knowledge, skills and attitude scores.

The move towards a competency based approach will allow organisations to start to consider and measure the impact of learning and how this translates into practice and improved outcomes for children.

What is the evidence for that?

- The interagency programme has quarterly monitoring reports which feedback qualitative and quantitative data in respect to the inter-agency programme.
- SEG have also started to undertake quality assurance on single agency and multi-agency training and learning – this will provide further evidence and assurance.

What are the priorities for the work over the next 12 months from April 2014?

For 2014-15 the priorities are as follows:

- Continued support for the implementation of the new training strategy, including continued engagement work with organisations, using this information to support the strategy.
- Continuation of briefing sessions for the new strategy.
- Delivery of workshops on assessing competency.
- Continued liaison with LSCB and updates in relation to the strategy.
- Review and update of documents.
- Continuation of trainer's network, and also planning joint events with adult and children's networks – to support a 'whole family' approach.
- Review and analysis of multi-agency learning / inter agency programme.
- Development of a work stream on neglect and DFE tools.
- Continuation of working relationship with safe network and support to voluntary and community sector.
- Continued work with Early Years Sector to support a significant number of providers.
- Continuation of work to support the LSCB quality assurance processes for single agency and multi-agency learning.
- Continuation and review of the Interagency Programme.
- Consultation process on proposals for charging for non-attendance and for profit organisations.

6.5 Child Sexual Exploitation (CSE) and Missing Children

CSE and Missing has been a key priority for the LSCB in response to both national expectations and locally driven priority setting for a number of years. A sub-group focusing on CSE, child trafficking and missing children was established in 2012/13. The sub-group is sub-regional to ensure effective co-ordination between Leicester, Leicestershire and Rutland reflecting the geographical area covered by Leicestershire Police.

Details of work undertaken during 2013/14 are set out below:

- Launch of a combined CSE, trafficked and missing children Sub Group and associated strategy
- Development of the multi-agency operational meetings to a sub-regional level
- Launch and revision of a Missing from Home and Care Protocol
- Implementation of the new missing definition - 'absent' category
- Launch of awareness raising campaign with children and families including the performance of 'Chelsea's Choice' in schools seen by over 8000 children in 39 schools across the County, Rutland and the City. This resulted in an increase in referrals and disclosures.
- A campaign to raise the awareness of key service providers such as taxi drivers, hotel and leisure providers to the incidence of CSE and how to report cases;
- Practitioner seminars – missing, CSE and e safety
- Ongoing multi-agency training for practitioners
- Attendance at national NWG forums
- Reduction in numbers reported missing (inc. children in care) and repeat missing episodes
- Increased and more appropriate CSE referrals
- Increased level of disclosures
- Reported increase in awareness amongst practitioners
- Successful outcomes following joint operations - Operation Fedora/Kilroy and Orchestra
- Agreement for the development of a co-located multi-agency team

More police officers have received awareness raising training and the police CSE team have more comprehensively mapped any identified organised crime groups involved in CSE related offences. A more consistent approach to the recording of offences has been adopted.

There are already good virtual operational arrangements in place between partners across Leicester, Leicestershire and Rutland. It has been identified that the development of a co-located multi-agency team hosted by the police would enhance the current arrangements. This is a priority for 2014/15. This joint team will be established to capitalise on the success of a court case where a number of perpetrators were successfully prosecuted and sentenced for sexually exploiting a young person. It will also strengthen existing partnership arrangements and address lessons learnt following the investigation and subsequent trial including the implementation of best practice such as supporting the victim and family pre, during and post-trial and engagement with local communities.

LSCB objectives

- Have a greater understanding of the extent of CSE in Leicester
- Produce a local CSE strategy
- Raise local awareness of CSE
- Seek assurance that the risks for young people are being addressed
- Disrupt and Prevent CSE
- Ensure victims are supported
- Ensure partnership arrangements are effective and in line with latest policy and guidance

What were the issues for the sub-group?

- The quality of referrals was variable
- There was limited strategic oversight of CSE and Children Missing from Home and Care (CMHC)
- There was no strategy in place,
- No routine multi agency operational meetings taking place.
- The first joint operational meeting with the police identified over 50 cases of children where CSE and CMHC was a concern. At least 17 of these were deemed as high risk by the police.

What work has been done by the sub-group?

- June 2012 - Following a series of task and finish meetings the Leicester, Leicestershire and Rutland LSCB CSE, Trafficking and Missing Sub Group was established
- January 2013 - launch of the LSCB CSE, Trafficking and Missing Strategy and the Missing Protocol.
- June 2013 - the LSCB launched the CSE awareness campaign in schools with more than 8000 children targeted
- During 2013/14 more than 500 practitioners from across the partnership have been trained
- Successful CSE prosecutions have been effectively publicised in the media, further raising awareness.
- The LSCB has provided funding to the CSE subgroup (£42K) to support the strategy implementation
- Additional funding of the formation of the co-located multi agency team has been agreed and is in the process of implementation

What has been the outcome of this work? What difference has it made?

- The school education programme has led to a number of young males making direct disclosures of online grooming that are now the subject of an ongoing police investigation
- The quality of referrals has improved

Challenges remain to be addressed. These include:

- The continued variability in the consistency and quality of responses to CSE across areas remains a risk, particularly in light of evidence of cross border CSE and trafficking and the fact that children and families move across borders including vulnerable groups such as 'looked after children'
- An agreed consistent approach to data collection and problem profiling regionally and nationally needs to be achieved to enable comparative data and the building of a comprehensive evidence base, potentially supported by a single IT solution
- Increasing the numbers reporting CSE from under-represented groups including boys/young men and children/young people from BME communities
- Building improved trust, confidence and awareness within BME communities, specifically faith organisations, to support children and parents to identify and report CSE
- Information sharing agreement work nationally and locally should help address barriers in relation to health services and patient confidentiality issues
- Greater analysis needs to be undertaken in relation to the nature and scale of child trafficking similar to the work undertaken in relation to CSE by the OCC
- The link between CSE and internal and external child trafficking needs to be better understood by agencies and the public
- The influence of changing culture resulting from the internet and use of social media: the impact of the availability of online pornography on children and young people; the risks associated with young people 'sexting' each other; and increasing numbers of children being exploited through technology, targeted by online abusers and use of blackmail and extortion – a national response to these issues is still under development
- The new 'Missing Protocol' covering Leicestershire, Rutland and Leicester City was launched in February 2013 and has been in operation throughout 2013/14.

6.6 Private Fostering

Private fostering is where a child or young person under the age of 16 (under 18 if disabled) is cared for by anyone other than a close family member (related by blood or marriage) for more than 28 days. A close family member could be a birth parent, step-parent (by marriage) aunt, uncle or grandparent. It can be argued that the children residing in private fostering arrangements are the most vulnerable; the regulations and minimum standards were introduced following the Victoria Climbié enquiry.

The Children (Private Arrangements for Fostering) Regulations 2005 came into effect on 1 July 2005. These provide guidance as to the regulatory responsibilities of Local Authorities in responding to those children living in their area, subject to private fostering arrangements. In 2006 new policies and procedures were devised to meet the requirements of these regulations. These were implemented after a thorough consultation between all three local authorities.

What have we done?

An action plan is in place and improvements are being made. Additional tasks have been added in light of a national report published by Ofsted in January 2014 on 'Private Fostering: better information, better understanding'. This report called for the active and sustained engagement of the LSCB in promoting private fostering given the fall in notifications is a general trend for most Local Authorities. It cited a number of general 'raising awareness' campaigns undertaken by many Local Authorities, with little results. It concluded that notifications are more likely to come from other professionals and that the onus should be on the various agencies/key contact points to verify that children are living with their parents.

Significant work has taken place to address performance issues and improvements have been noted in relation to visiting frequency especially since the recent audit.

How well have we done it?

There has been some improvement on the performance in the previous year, specifically in relation the 6 weekly visits for those arrangements in the first year.

Practice on the whole appears to be good, with children and young people's needs considered appropriately. As a result of variations in practice, cases are now allocated to a single Social Worker and therefore managed by one manager. This provides a level of expertise and a commitment to addressing the shortfalls previously identified.

The implementation of Liquid Logic (data information system) in April 2014 assists practice in a positive way as it ensures mandatory fields for recording the review of

the private fostering arrangement (the statutory visits). The practice of undertaking six monthly audits will continue.

Prevalence

In total there have been 17 private fostering arrangements known to the Local Authority in the year 2013/2014.

Future developments

There is a need to consider how to increase the reporting of private fostering arrangements. This is a consideration that requires a multi-agency approach and has the drive and support of the LSCB.

Information leaflets have been refreshed, so that Carers and Practitioners alike are aware of the arrangements around Private Fostering.

In the autumn of 2014, multi-agency information briefing sessions will begin, as a means of further raising the awareness of practitioners across the safeguarding partnership.

6.7 PREVENT

The Board has been informed about the government's strategy to align certain aspects of the Prevent agenda with the work of the Safeguarding Boards.

Prevent consists of three core areas of focus with regard to violent extremism: institutions, ideology and individuals. It is the "individuals" strand of the strategy, which offers a tailored support system to safeguard those vulnerable to radicalisation that is being mapped against the local safeguarding structures.

The Prevent Coordinator was invited to sit on the Voluntary and Community Sector LSCB Reference Group which has ensured that training and awareness-raising workshops have been able to reach beyond statutory partners and reach key voluntary sector roles within the children's workforce. In addition, local Prevent training has been aligned against the new safeguarding competencies framework so that attendance supports the required competencies for people in those roles.

Prevent has now been drafted into the LLR LSCB policies and procedures to reflect its safeguarding significance. Referrals from concerned members of the public about the welfare of a child in relation to Prevent can legitimately be made via the LSCB standard referral routes. This is a significant step forward as some people may still have a reluctance to contact the Police in such circumstances.

7. Assessment Protocol and Frameworks

There are established assessment protocols and frameworks in place in line with relevant legislation and policies. In March 2013 Working Together to Safeguard Children was revised and reissued following the review of child protection undertaken by Professor Eileen Munro in 2012, with greater emphasis placed on the quality of assessments.

Working Together 2013 specified that the maximum timeframe for an assessment to be completed in children's social care should be no longer than 45 working days from the point of referral. In July 2013 children's social care introduced a revised single assessment process in line with Working Together 2013, with quality assurance work carried out by the local authority which shows that the overall quality of assessments has improved.

Prompt assessment and effective child protection planning is a priority in the Children and Young People's Plan (2011-13), and remains a priority in the plan to cover the period 2014-16. This area is also a work stream for the Stay Safe Group. The quality and effectiveness of assessment processes is a key element of quality assurance activity undertaken by children's social care, and is always considered in multi-agency case file audits co-ordinated by the Safeguarding Effectiveness Group.

In Working Together 2013 there is a requirement for the LSCB to publish a threshold document, which should include the process for an early help assessment, the type and level of early help services to be provided, and the criteria for when a case should be referred to children's social care. Following an extensive consultation with partners a multi-agency thresholds guidance document was developed covering Leicester, Leicestershire and Rutland. The development of this guidance coincided with a change of emphasis in the way in which referrals are dealt with by children's social care, arising from LSCB commissioned research by Professor David Thorpe. As a result of this, children and families are the subject of better, more focussed referrals that result in a more effective assessment of need. The new arrangements have reduced the number of Section 47 (child protection) investigations ensuring that some families are more appropriately supported by early help or general services and not subjected to a potentially traumatic police and social work investigation.

8. Early Help

The concept of early help reflects the widespread recognition that it is better to identify and deal with problems early rather than to respond when difficulties have become acute and demand action by more expensive services. There is now strong evidence of the factors that place children at risk of neglect or abuse, of developing mental health problems, of failing in education, or of becoming involved in crime or anti-social behaviour. These negative outcomes are not only damaging to the children or young people concerned, to their families and the communities where they live, but also result in significant costs to the state.

Early help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. Although research shows that the most impact can be made during a child's early years, early help is not just for very young children as problems may emerge at any point throughout childhood and adolescence. Early help and prevention is about how universal and targeted services are coordinated to identify, reduce and prevent specific problems from getting worse or becoming entrenched. Early help and prevention gives families the opportunity to address their problems; ensuring children stay safe and achieve their full potential.

In January 2014 the Children's Trust agreed Leicester's early help strategy. The philosophy underpinning this strategy is that early help is everybody's business and this approach and strategy has been signed up to by the Children's Trust.

Working Together 2013 is clear about the importance of effective early help services and the role of safeguarding boards in assessing the effectiveness of early help. The Safeguarding Effectiveness Group has included early help indicators in its performance framework and is receiving regular information from children's services in the city council on the outcome and impact of quality assurance work across early help services. Quality assurance activity across early help services has been strengthened and there is now a structured programme of auditing early help activity, including case work activity through file audits, and assessments carried out under the common assessment. The overall quality of early help work is improving with interventions more targeted and focused on children and young people's needs.

9. Allegations against professionals

How much have we done?

The LADO and Allegations Service is based within the Safeguarding and Quality Assurance Unit, Learning Performance and Quality Division.

This service is responsible for chairing strategy and outcome meetings, maintaining management information and providing advice and guidance for professionals making referrals and enquiries.

Guidance was introduced in 2006 to ensure that all Local Authorities had procedures for responding to and dealing with allegations against an adult who comes into contact with children in a work or care setting.

This includes volunteers, foster carers and prospective adopters. (Working Together to Safeguard Children 2006 revised 2010 and 2013 supported by Handling Allegations of Abuse Made Against Adults Who Work With Children and Young People-Practice Guidance DCSF 2009, Guidance for Safer Working Practice, 2009 and Keeping Children Safe In Education-2014).

Chapter 7.2 of LSCB procedures sets out the local guidelines and is designed to ensure that if an allegation of harm is made, or if there is any suspicion of harm, appropriate enquiries are made to protect children and maintain public confidence in services.

The guidance provides a framework and procedure for managing allegations where there is cause to believe a child is suffering or likely to suffer harm.

The procedures should be used if it has been alleged that member of staff, foster carer or volunteer has:-

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child
- Or behaved towards a child or children in a way that indicates she/ he may be a risk to children in the work place.

This applies when the allegation of concerns arises within the adults own work setting, their own children making allegations, other children living outside the family and non-recent (historical) allegations.

The LADO (Service Manager Child Protection and Allegations Service Safeguarding and Quality Assurance Unit) oversees the Allegations Service which is provided by an Allegations Independent Chair lead (full time) and additional capacity provided by .5 of a Child Protection Independent Chair. There is designated administrative support.

The LADO and allegation leads provide advice and guidance to employers and voluntary organisations about the thresholds of harm and unsuitability. They liaise with Police, Social Care and partner organisations as necessary and ensure a consistent, fair and thorough process for child and adult.

Leicester City also has two Investigative Officers, experienced social workers based within Duty and Advice, Fieldwork Service. They support the allegations process by attending strategy meetings, assist in investigations and where there is a need for risk assessments in respect of adults about whom allegations have been made.

The Safeguarding in Education Development Officers (based within the Safeguarding and Quality Assurance Unit) work closely with the Allegations Service regarding any referrals where education staff or resources are identified as requiring safeguarding input to enhance practice, to increase compliance with procedures and to improve outcomes for children.

The service delivery, including the provision of training, advice and guidance, is underpinned by the following principles:-

- Sits within an effective cycle of good practice
- Robust systems for dealing with allegations reduces harm
- An open and transparent system that is fair to all
- Supports the development of a safer workforce
- Ensures children are listened to

Referrals by type of employment
Between April 2013 and March 2014 the Allegations Service worked with 302 referrals, an increase over the previous year of 11 %. The employment settings of those against whom allegations were made were as follows:

Education settings	107
Children's Social Care	88
Health settings	22
Criminal justice settings	4
Others including volunteers	81
	302

How well did we do it?

The outcomes of the referrals to the service during the period of reporting are:-

- 60% did not meet the threshold for risk of harm
- 16 % were unfounded - there was sufficient evidence to disprove the allegation (this is sometimes referred to as a false allegation or malicious – where there is evidence of deliberate act to deceive).

- 12% were substantiated – there was sufficient evidence to prove the allegation.
- 11% unsubstantiated - there was insufficient evidence to either prove or disprove the allegation.
- 1% of referrals are ongoing investigations post April 2014.

The number of substantiated cases is relatively low, although the proportion of cases which have been substantiated has increased slightly. In those cases, the relevant employer took appropriate remedial action. Actions and recommendations were made in respect of all of the cases where the outcome was unsubstantiated and unfounded. Of the referrals substantiated, over a third were referred to the Disclosure and Barring service.

There has been an increase in referrals involving the use of digital technology and these referrals often include concrete evidence; however the substantiation of forensic evidence can be a lengthy process. The number of referrals not meeting the threshold for risk of harm is a slight decrease.

This cohort includes:

- Cases where there has been an evaluation meeting to inform that decision and to prevent drift, where the Allegations Manager is waiting for more information from the referrer - 10% of referrals had evaluation meetings
- Cases that have been referred to Leics. County or another Local Authority (LA) LADO service-as, after consideration, an agreement was reached regarding the most appropriate LA to deal with a referral
- Whilst the referral does not meet the threshold for harm, there will have been advice provided regarding training needs, disciplinary processes and monitoring and supervision of staff.
- All referrals involve a strategy discussion and decision between the Allegations Lead, DAS Team Manager and a Child Abuse Investigation Unit (CAIU) Police Sargent.
- If there are three or more repeat referrals involving the same adult of risk or young person as a victim or the same provider/resource, consideration is given to convening an evaluation meeting or a specific professionals only meeting to consider the history of concerns and relevant chronologies.

It is too early to say whether the slight decrease in this cohort is as a result of the Thorpe work (referred to in section 2.5.4) and re-configuration of the 'front door' dealing with referrals into Social Care. It may be as a result of growing confidence of employers in dealing with this area of work.

Timeliness of activity

We aim to hold strategy meetings and complete the process within recommended timescales. During the period of this Annual Report a themed sample audit of

meeting timescales was undertaken. 51 referrals were considered. Of the referrals where it was assessed that the concern did not meet the threshold:

- 37% outcome was decided within 2 working days
- 49% outcome was decided 0 - 4 weeks
- 14% outcome was decided in 4 -12 weeks
- 12 weeks to 24 weeks - 0
- Over 24 weeks - 0

Therefore timescales have been timely in the cases subject to this audit and have met safeguarding standards.

Where there has been an outcome meeting, the Independent Chair of the strategy process ensures that there is an outcome letter for the employer to share with the employee so that information shared is consistent and accurate and based on the information shared within the allegations process.

Training

The service provides training to LA staff and partners via the LSCB training programme. This year 4 sessions were planned and delivered, offering 60 places. The service has also provided bespoke training to groups of staff within a health setting, transport and specific Faith groups.

The Operational lead for Safeguarding in Madrasahs project is also the Allegations manager and continues to deliver joint training with the Safeguarding Project Officer to Madrasah staff. The Allegations manager has also delivered joint training with the Duty and Assessment Manager regarding working with Madrasah's to police.

Between April 2013 and March 2014, 153 staff who are Designated Safeguarding Leads from 79 schools received training from the Safeguarding in Education Development Officers. In addition 26 primary schools, 2 secondary schools and 2 special schools received whole school Safeguarding training.

The training includes LSCB and LA policies and procedures, including procedures about allegations against adults who work with children, the whistleblowing policy and signposts to the Allegations service. The training also incorporates reference to serious case reviews published elsewhere which contain learning for school staff working with children.

A Safeguarding in Education Development Officer is also a lead in E Safety for Children's Services and has delivered 2 training sessions regarding the risks associated with digital technology and working with children for the LSCB- and he has delivered bespoke training to foster carers and supervising social workers.

The training delivered via the LSCB is evaluated by attendees and the feedback from the Allegations against Adults course attendees was good (with overall satisfaction

rate of 4.3 out of 5). The feedback from the risks associated with the use of digital technology was good (with overall satisfaction rate of 4.7 out of 5).

Responding to learning

Our processes and procedures are subject to review following new information from Serious Case Reviews and new policy and legislation. For example, the agenda for all evaluation, strategy and outcome meetings ensures each meeting covers the vulnerability of the adult of concern and of the child that may be a victim. This implements learning from a Serious Case Review regarding the vulnerability of a young person who had made allegations against a member of staff working with him.

The Independent Chair also writes directly to the child/young person where this is appropriate regarding the outcome of the allegations process, (sometimes allegations are historical or involve children where it is deemed this is not age appropriate).

The allegations service with Human Resources has also developed a leaflet explaining the Allegations process for City Council employees.

What difference have we made?

There has been an increase in referrals overall and a small increase in referrals that are substantiated.

The Allegations processes are embedded within the Local Authority's and partner agencies' safeguarding processes, as illustrated by the breadth of type of employees referred and by the number of own children referrals.

The Investigating Officers, based within the Duty and Assessment Service (DAAS), add value to assessments within evaluation and strategy meetings and their experience and expertise in this area of work informs risk assessments of adults of concern-they also provide advice and guidance to employers.

There is a bi monthly meeting between Allegations manager DAAS Team Manager and a Detective Inspector within the CAIU that tracks open cases to ensure that there is no drift, timely outcomes and proportionate responses to concerns. The police are involved in every strategy discussion regarding threshold and are invited to strategy and outcome meetings. If there is not a named officer involved, a designated officer attends and the continuity of the involvement of this officer, the development of their expertise in this area of safeguarding, has been very useful.

We are aiming to capture evidence regarding the difference we have made with the implementation of our new database and with the systematic use of post meeting evaluation/ feedback.

Last year there was one complaint about the allegations service from an adult subject to the processes.

The following developments are in progress :-

- The database will be changing to Liquid Logic, with safety and security of information assured. The system being developed will provide more reliable, sophisticated, management information to inform the quality assurance of the service and provide evidence of outcomes.
- Evaluation feedback surveys have been developed for professionals/partners involved in the delivery of the service and for children and adults, subjects of the service. These have been used from March 2014- and will be reported on in the next LSCB report.
- Feedback evaluation forms will also be sent to children and young people, where it is appropriate. These will be in an age appropriate, child friendly format.

Training will continue to be available, the following groups will be targeted :-

- Day care - particularly day nurseries.
- Faith groups
- Sessional staff/youth workers
- Transport services.

10. How safe are children and young people in Leicester?

Quality and effectiveness of the safeguarding system and of work with families

LSCBs have a duty to monitor and challenge the effectiveness of local safeguarding arrangements (Working Together, 2013). This work is undertaken in Leicester by The Safeguarding Effectiveness Group (SEG), which is responsible for monitoring and challenging the effectiveness of safeguarding arrangements of the partners of Leicester Safeguarding Children Board. This activity enables the LSCB to reach a judgment based, on the work submitted to SEG, about the effectiveness of the local safeguarding arrangements.

The work of SEG can be divided into four interlocking domains:

- Performance Framework – monitoring statistical data about service delivery
- Co-ordination of Audits – undertaking multi-agency case file audits and Section 11 audits to provide a qualitative perspective on the statistical data
- LSCB Effectiveness – reviewing the work and effectiveness of the Board itself
- Embedding Learning from Review processes – tracking the recommendations of case reviews

The SEG has adopted the priorities agreed by the Leicester Children's Trust in the local Children & Young People's Plan and amplified in the partnership's Stay Safe group

The following activity was completed by agency partners, supported by the Board Office, during 2013/14:

- Section 11 Audit - satisfactory assurance was received in regard to members safeguarding arrangements. No concerns were noted. (See the next section).
- Serious Case Review action plans were reviewed and assurances obtained in relation to implementation of case recommendations.
- Clarification and refining of safeguarding indicators – which are aligned to the children and young people's plan.
- Development of data and commentary reporting sheet.
- Safeguarding Babies – multiagency review in-depth of three cases (two in detail)

Impact on safeguarding and children

The role of the SEG is to support improvement in services for children, young people and families by gathering evidence about the quality of the local safeguarding

arrangements. The quality assurance activity that SEG has either commissioned or received indicates that safeguarding and child protection arrangements are safe in Leicester. SEG has laid the foundations for a strong framework of quality assurance and critical challenge, which will be further developed in the year ahead.

Impact on partner agencies

SEG has a wide remit across the whole safeguarding system in the city. The engagement of partner agencies has been strengthened during the year. Partners are submitting information to SEG in relation to key performance indicators and reports summarising their internal quality assurance work.

Impact on community awareness

In the last 12 months the Safeguarding Effectiveness Group has coordinated a range of activity to assure the board of the effectiveness of safeguarding arrangements in Leicester, and through the Board the community of Leicester:

- Section 11 audit – assurance was received in relation to agency partner's safeguarding arrangements. No concerns were noted.
- Serious Case Review action plans were all reviewed and assurances with evidence from agencies was obtained in relation to recommendations.
- Regular reporting on the safeguarding indicators which are based around the child's journey and are aligned to the Children and Young People's Plan
- Systematic programme of multi-agency case file audits, carried out monthly, and based on themes aligned to learning from serious case reviews and priorities in the Children and Young People's Plan
- Safeguarding quality assurance work/audits undertaken by agencies reported through to the Safeguarding Effectiveness Group as further assurance of the quality and impact of safeguarding activity.

The outcomes of this work are reported annually to the City Mayor, chief executives of partner agencies, the city council scrutiny committee, the City Health and Wellbeing Board, the Police and Crime Commissioner, the Clinical Commissioning Group and other boards and agency managers. The annual report is published on the website. The main messages from the Board are publicised through the year to staff and the wider community.

10.1 Monitoring pressures and vulnerabilities in the arrangements

The Board receives reports twice a year by partner agencies, analysing service trends, pressures and vulnerabilities, including the consequences of service and budget changes. These reports are intended to help partners to strengthen joint planning and take account of wider system in changes in service development. They also provide evidence of strengths and weaknesses in the system and feed into the SEG overview of safeguarding arrangements in Leicester. From 2014 the reports integrate the overview of children's and adults services across the City and are reported to both Boards..

10.2 Section 11 audits 2013-2014

The Children Act (2004) requires named agencies and individuals to co-operate to safeguard children and promote their welfare. Section 11 of the Act makes clear to whom this duty applies and indicates that they must make arrangements for ensuring that:

> "*their functions are discharged having regard to the need to safeguard and promote the welfare of children*;"

The same Act established the roles and responsibilities of the Local Safeguarding Children Board, with Section 13 describing their functions as:

- to co-ordinate what is done by each person or body represented on the Board for the purposed of safeguarding and promoting the welfare of children in their area
- to ensure the effectiveness of what is done by each such agency

The 'Section 11 Audit' is designed to allow the LSCB to assure itself that agencies placed under a duty to co-operate by this legislation, are fulfilling their responsibilities to safeguard children and promote their welfare. The outcomes from the audit contribute to the monitoring activity of the Safeguarding Effectiveness Group and the Board's overall judgement about the effectiveness of the safeguarding arrangements in the city.

Agencies/organisations required to comply with the duty

The key people and bodies that are covered by the duty are:

- local authorities, including district councils;
- the police;
- the probation service;
- Youth offending teams;
- Governors/ Directors of Prisons and Young Offender Institutions;
- Directors of Secure Training Centres;
- The British Transport Police.

- Organisations (currently the Connexions Service) providing services under section 114 of the Learning and Skills Act 2000;

Leicester, Leicestershire and Rutland LSCBs have adapted and extended this process to include all of the statutory members of the Board.

Health agencies will continue to complete the Safeguarding Quality Indicators, the Safeguarding Adults Framework and the Markers of Good Practice for Safeguarding Children as agreed in their Quality Schedules with the Clinical Commissioning Groups (CCG).

From October 2013 these assurance documents have been revised to include additions, and relevant questions from the Section 11 Audit as required by the LSCBs Performance Management Framework.

Standards to safeguard and promote the welfare of children

Chapter 2 of 'Working Together' (2013) details the common features which must be demonstrated by agencies in order to fulfil their commitment to safeguard children and promote the welfare of children.

The standards listed below (and on the template) correspond with the standards in the statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.

Standards tested

- Senior management commitment to safeguarding and promoting children's welfare
- A clear statement of the agency's responsibilities towards children is available for all staff
- There is a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
- Service development takes account of the need to safeguard and promote welfare and is informed by the views of children and families
- Staff development to support safeguarding and promoting the welfare of children
- Safer recruitment
- Effective inter-agency working to safeguard and promote the welfare of children
- Information sharing

Findings

East Midlands Ambulance Service and CAFCASS are not subject to the Section 11 duty, but were willing to submit evidence of their own compliance arrangements using the assurance systems they already have in place.

The main issues raised by the audit are as follows:

- All agencies stated that they were compliant against the standards
- Agencies identified that they need to do more to take into account the views of children and families
- There is further work required to embed a wider family approach in agencies where the focus of their work is mainly on adults
- Information sharing is a standard for which some agencies did not feel confident they could demonstrate full compliance. Information sharing protocols need revisiting.

Actions to become fully compliant

Those organisations that declared that they were fully compliant against the standards (Police, University Hospitals of Leicester and Social Care) were not required to submit an action plan.

Those organisations that declared that they were either partially or mostly compliant against the standards were asked to submit an action plan to show how they would move to a position of being fully compliant. Leicestershire Fire and Rescue, NHS England, Leicestershire and Rutland Probation Trust and the CCG all submitted action plans.

The Board convened a special meeting of statutory partners to review the outcome of the Section 11 audit process for the first time. Senior officers presented their audit statement, reported on progress with their action plan, where relevant, and were questioned by partners. This process was welcomed by all agencies and will be repeated. It was also agreed that we should develop a more sophisticated audit tool and seek to involve more agencies on a voluntary basis.

Process issues arising from audit

- Some agencies are only able to supply National returns
- The completion of both the Section 11 and the Adult strategic audit at the same time was a difficulty for some agencies
- As the Section 11 process matures, there are other agencies that have been identified as being able to contribute to future audits

Recommendations for future Section 11 audits

- Develop a more sophisticated audit tool for next year, in partnership with Leicestershire and Rutland.
- Find a better way to better incorporate the findings from national returns for relevant agencies
- Reconsider the timing of future strategic audits so not to clash with the Adults safeguarding audit.
- Continue to complete a joint Section 11 audit process with Leicestershire and Rutland Safeguarding Board office.
- Explore a secure method of completing the audit 'on line' for easier completion and analysis
- Consider other contributors for future audits

What went well?

- Good response from agencies.
- Very few difficulties were reported in completing the audit
- Positive response to the joint LLR Section 11 audit. This was well received by agencies that work across LLR.
- Commitment to peer scrutiny of audit returns and developing a more sophisticated audit tool.

10.3 Case Review function

The Board oversees a number of processes which review individual cases, including the Child Death Overview Panel, Serious Case Reviews and other forms of case review. The outcome from reviews feeds into the work of the Safeguarding Effectiveness Group and informs the overall judgement about the effectiveness of safeguarding arrangements in the city and the wellbeing of children.

The only Serious Case Review conducted by the LSCB during 2013-14 was the case of an eight month old baby girl, known as Baby Z, who had suffered fractures to her skull, ribs and legs. The girl was severely brain damaged and as a result of her injuries is "severely visually impaired". The injuries represented "multiple episodes of non-accidental injury".

Baby Z's mother admitted causing grievous bodily harm and was jailed for two-and-a-half years. She was later returned to India as she had overstayed her student visa.

The review, which was published in February 2014, found there were missed opportunities when a referral to social services could have been made, which would

have led to further assessment of the child and possibly to a safeguarding investigation. Baby Z was seen by health visitors and GPs when she was six months old and her mother pointed out marks on the baby's back. At this point children's services should have been informed.

The learning from the review was shared in a series of briefings to multi-agency audiences. The briefings were delivered by the Consultant Paediatrician and the Named Nurse for Safeguarding.

10.4 Child Death Overview Panel (CDOP)

One of the duties of the LSCB is to ensure a review is undertaken into the deaths of all children, whatever the cause, who are normally resident within their area (*Working Together 2013*, chapter 5*)*. During this period, 47 cases were reviewed by Leicester, Leicestershire and Rutland (LLR) CDOP and 8 panel meetings were held. Two of these meetings were used as developmental sessions and six were utilised to review cases. The child death overview process is not an investigation and does not supersede the need for organisations to undertake their own reviews following the death of a child. It is intended that the child death overview process will incorporate issues identified within case review processes to ensure shared learning.

CDOP has a permanent core membership of the appropriate level of seniority, including public health, child health, police and social care. The LLR CDOP was chaired during this period by Dr. Tim Davies, (Consultant in Public Health, NHS England). CDOP currently meets 6 weekly for 2-3 hours. The Child Death Reviews (CDR) Manager provides information to HM Coroner for Leicester City and South to allow for cross reference of notifications on a weekly basis.

The Service Level Agreement for CDOP provision within LLR was reviewed in January 2014 and supported the current working arrangements. CDOP has effective data management systems in place to record, analyse and monitor childhood deaths and meet its intended purposes and outcomes.

As part of the review of all of the cases, the panel monitors the appropriateness of professionals' responses to each unexpected child death to ensure thorough consideration of how such deaths might be prevented. It also monitors the support and assessment of services offered to the families of children who have died. Alongside determining if modifiable factors can be identified which might have resulted in a different outcome to each case, CDOP members are also asked to consider if there are additional actions, learning points or recommendations that can be drawn from the review. The panel seeks to help identify and report on any public health issues that may pose risks to children's health or development.

Learning that has taken place within partner organisations as a result of CDOP cases has led to a range of actions and improvements, including:

- Working with partners to seek clarity on the protocols associated with the transportation of children pronounced 'dead at the scene'.
- Close work with the Joe Humphries Memorial Trust and also the Heart Start initiative, resulting in a number of consultants committing to teaching (in their own time) basic life support skills to school children.
- Feedback from the perinatal mortality review panel to neonatal staff has continued and three sessions were completed in 2013.
- A series of infant mortality road-shows in each District bringing together children's centre staff and service providers to highlight the risk factors and promote awareness of the services available to tackle them.

10.5 External inspection findings

Partner agencies have formal inspections undertaken by a number of national inspectorates. The inspectorates are proposing to undertake joint inspections of safeguarding. External inspections provide an external check on the effectiveness of services and contribute to our understanding of the local systems. Their findings are taken into account by the Safeguarding Effectiveness Group.

Ofsted did not inspect safeguarding or looked after children's services in 2013/14. The last full inspection was carried out in December 2011, when safeguarding services were judged adequate overall with good capacity to improve.

In 2013 Ofsted revised and introduced a new inspection framework for the inspection of services for children in need of help and protection, children looked after, care leavers with a review of Local Safeguarding Children Boards. The focus of the inspection is on the journey children and young people make through early help, safeguarding and looked after children/care leaver services. Inspection activity includes exploring a sample of children's cases in order to judge the quality of front line practice and management and the difference this makes to the lives of children, young people, their families and carers. This includes inspectors meeting directly with children, young people, parents and carers, as well as directly observing front line practice.

Ofsted will undertake a review of the effectiveness of the Local Safeguarding Children Board at the same time as the inspection of the local authority, and will be evaluating the effectiveness of the board in meeting its statutory functions. Inspectors will consider how effectively the LSCB evaluates and monitors the quality and effectiveness of the local authority and statutory partners in protecting and caring for children.

Throughout the year the LSCB has undertaken and maintained a self-assessment against the criteria Ofsted will use when they review the Leicester Safeguarding Children Board. The self-assessment has been co-ordinated by the Executive Group and reported to each board meeting.

HMIC have not specifically inspected police work on child protection, but other inspections have included a reference to child protection. For example, the domestic violence inspection found that Leicestershire Police was identifying and safeguarding children and making appropriate referrals and the data integrity inspection looked at sexual offences and highlighted a very positive victim led approach.

Following its inspection of Leicester's hospitals on 13-16 January 2014, the Care Quality Commission found that "the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led".

The national inspection of CAFCASS by Ofsted in January 2014 found that outstanding leadership has led to a wholesale transformation in organisational culture, radically improving the services children and families receive, and has steered the organisation to receiving an overall grading of good. The inspection found that the CAFCASS social workers consistently work well with families to ensure children are safe and that the court makes decisions that are in children's best interests.

11. Conclusion and recommendations for future priorities and Business Plan

This annual report has identified a substantial range of safeguarding activities, the involvement of a wide range of partner agencies and some significant achievements, such as the Children's Summit, improved evaluation of service delivery, implementation of an agreed threshold policy, a range of training opportunities and a new system of evaluation, effective scrutiny of child deaths, new initiatives to address child sexual exploitation and the situation of children who go missing from home or care, a new Early Help Strategy, a new assessment protocol and effective management of allegations made against professionals. The Board reviews its governance arrangements and its own effectiveness and engages with a range of multi-agency strategic structures in the City.

The report also identifies areas for continuous improvement, but with a specific focus on sustaining and strengthening our efforts to ensure the voice of children and young people is heard clearly in case reviews and also in service monitoring and planning discussions; developing performance monitoring and a more robust analytical approach to information which is collected; monitoring implementation of the Early Help arrangements and ensuring that staff in all agencies are aware of the opportunities for early help; monitoring of support for staff to enable them to deliver more consistent, quality work; strengthening responses to child sexual exploitation and trafficking, developing new approaches to prevention and disruption of this activity; ensuring that victims of non-recent abuse have access to services they need; completing the governance review of the Board; encouraging partner agencies to sustain partnership working and strengthen joint planning of services; and ensuring that children, young people and adults in Leicester know where to get help when they are concerned about a safeguarding issue and that they are heard respectfully.

12.Glossary of terms

Acronym	Stands for
C&YP	Children and young people
CAFCASS	Children and Families Court Advisory and Support Service
CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CDR	Child Death Review
CICC	Children in Care Council
CMHC	Children Missing from Home and Care
CSE	Child Sexual Exploitation
CUSAB	Children who Use Sexually Abusive Behaviour
DAAS	Duty and Assessment Service
DBS	Disclosure and Barring Scheme
DfE	Department for Education
HM CORONERS	Her Majesty's Coroners Service
HMIC	Her Majesty's Inspectorate of Constabulary
HSE	Health & Safety Executive
ISA	Information Sharing Agreement
L&R LSCB	Leicestershire & Rutland LSCB
LA	Local Authority
LADO	Local Authority Designated Officer
LCC	Leicester City Council
LLR	Leicester, Leicestershire & Rutland
LSAB	Leicester Safeguarding Adult Board / Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board / Leicester Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
PVI	Private, Voluntary and Independent
QA	Quality Assurance
SCRs	Serious Case Reviews
SDMT	Senior Departmental Management Team
SDSA	Schools Development Support Agency
SEG	Safeguarding Effectiveness Group
STOI	Safe Transfer of Information
SUDIC	Sudden Unexplained Death in Childhood
YOS	Youth Offending Service

Appendix A: LSCB membership

Agencies/Organisations/Roles represented on the Board are as follows:

Statutory members

Independent Chair
Director of Children's Services
Lead Member for Children Services and Assistant City Mayor
Lay Members
Leicester City Council:

- Youth Offending Service
- Children's Social Care & Safeguarding, Leicester City Council
- Adult Social Care & Safeguarding

Leicester City Clinical Commissioning Group

- Designated Nurse
- Designated Doctor

University Hospitals Leicester
Leicestershire Partnership Trust
Leicestershire Constabulary
Children and Family Court Advice and Support Service
Youth Offending Service
Leicestershire & Rutland Probation Trust
Education Improvement Partnership
City Primary Heads
Further Education Colleges

Non statutory members

Leicestershire Fire and Rescue Service
East Midlands Ambulance Service
Child Death Overview Panel
Barnardo's CareFree Young Carers Service
National Society for the Prevention of Cruelty to Children
Leicester City Council:

- Legal services
- Learning, Quality & Performance

FreeVA
GP consortia, National Health Service

Appendix B: Attendance of statutory members at Board meetings

Organisation/Agency/ Role	Record of attendance			
	June 2013	October 2013	December 2013	April 2014
Independent Chair	✓	✓	✓	✓
Director of Children's Services	✓	✓	✓	X
Leicester City Council	✓	✓	✓	✓
Leicester Partnership Trust	✓	✓	✓	X
Clinical Commissioning Group	✓	✓	✓	✓
University Hospitals Leicester	✓	✓	✓	✓
Leicestershire Police	✓	✓	✓	✓
Lay Member	✓	✓	✓	✓
Lead Member for Children's Services	✓	X	✓	✓
Leicestershire & Rutland Probation Trust	✓	X	✓	✓
CAFCASS	X	✓	✓	✓
Further Education Colleges	✓	✓	✓	✓
Schools representation	✓	X	✓	X
Youth Offending Service	X	✓	X	✓

Appendix C: Values statement

JOINT LSAB/LSCB VALUES STATEMENT

The values that the Leicester Safeguarding Boards are committed to are as follows:

1. All people of Leicester have the right to:
    - dignity, choice and respect
    - protection from abuse and/or neglect
    - effective and co-ordinated work by all agencies to ensure a holistic child/person centred response
    - the best possible outcomes, regardless of their age, gender, ability, race, ethnicity, religion, sexual orientation and circumstances
    - high quality service provision
2. Safeguarding the wellbeing of children, young people and adults is a responsibility we all share.
3. Openness, transparency and sustainability will underpin the work of the Boards.
4. Participation by children, young people and adults is essential to inform services, policies, procedures and practices.
5. Services to meet the individual needs of children, young people and adults aspire to reach the highest standards.
6. Constructive shared learning to protect children, young people and adults will be integral to the Boards' business.
7. Celebration of strengths and positive achievements is important to the Boards, as is the commitment to a process of continuous development and improvement.

Appendix D: LSCB sub group structure