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

Last year we identified several key areas as critical to the safety of our children. They included neglect, the need for early help to vulnerable families, child sexual exploitation children’s mental health and the impact of parental mental health on their children. We also identified a need to develop better approaches to our own scrutiny activities and, crucially, to get better listening to children’s own accounts of their experience.

This year has seen some very significant developments in all these areas which I believe will make a positive impact on children’s lives. Partners have adopted a new framework to assess risk and to ensure that children receive the right support from the right agency at the right time. A new Multi-Agency Safeguarding Hub has been launched. There is a new strategy for providing early help to vulnerable children and families and a new approach to tackling neglect is being developed. St Helens LSCB has agreed with other Boards across Merseyside a joint strategy to address child sexual exploitation and this is currently being implemented as a high priority. The operation of child mental health services has been changed and new services are being commissioned. Board Partners have done a lot of work to help us hear the voice of children. Few of these initiatives are yet complete and none is embedded in work across the borough. All will feature as priorities in our work in 2015.

A key task for the Board will be to monitor the effectiveness with which partners implement the changes and to highlight any risks that might arise. We will do this through our improved approach to the scrutiny of the evidence of the impact of changes. We draw evidence most importantly from the testimony of children, young people and frontline professionals but also from performance data, from the audit of cases, from national studies and from detailed inquiry into serious incidents. We have conducted 3 Serious Case Reviews this year together with several reviews of other cases to identify common features. In all these, our focus is to identify underlying causes and to make sure that changes are made to prevent recurrence. These lessons are incorporated into this report.

Lord Laming wrote in his report into the tragic death of Victoria Climbie that safeguarding cannot be done by one profession acting alone; it is a task for all of us who live and work in the borough. There is a particular duty on those who work with children, whether in schools, surgeries or youth clubs. Safeguarding is not just for those who work with the most vulnerable young people such as social workers and police officers; it is for all of us.

This is embodied in the work of the St Helens Safeguarding Children Board and I am enormously grateful to everyone who has contributed. Sadly we know that all our efforts can never be enough; there are still those whose acts or neglect will cause children harm. There is no more worthwhile enterprise than working together to keep our children safe.

Howard Cooper CBE
Independent Chair - St Helens Children’s Safeguarding Board
St Helens has a resident population of approximately 41,100 children and young people aged 0-19 years. Children and young people make up just under 23% of the Borough’s population. In March 2014, 4.1% of school children were classified as being of an ethnic group other than White British.

The health and wellbeing of children in St Helens is generally worse than the England average and 10.2% of children aged 4-5 years and 21.6% of children aged 10-11 years are classified as obese. Infant and child mortality rates are similar to the England average. The level of child poverty is worse than the England average with 25.6% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

A higher than average proportion of children are judged to have achieved a good level of development at the end of the foundation stage, with 57.1% achieving this milestone. This assessment is completed in the final term of the academic year in which a child reaches the age of five and tells us that the majority of younger children get a good start in life.

St Helens has 2 Further Education Colleges and a total of 70 schools. 54 of these are Primary Schools and 10 are Secondary Schools; 1 is a Nursery School and 5 are Special Schools.
3. The Work of the Local Safeguarding Children Board (LSCB)

St Helens Safeguarding Children Board is a statutory body, made up of senior people from a wide range of local agencies such as Merseyside Police, Children Services and health agencies.

The LSCB leads on work that helps professionals to work together and keep children safe. There is guidance in place that tells LSCBs how they must work and what they are responsible for. Every year we identify a range of priorities for all of the partner agencies of the LSCB to work on. Some of these take more than year to complete due to their size and nature. During the year, we often identify more priorities as we are continually learning about the needs of children and how practitioners need to work with them.

The range of work undertaken by the LSCB is broad but mainly falls under the following headings: Policies and Procedures; Training and Awareness Raising; Learning and Improvement (learning through audit and reviews and the work we do to make improvements when we have learnt lessons); Reviewing Child Deaths.

St Helens Safeguarding Children Board agreed its Strategic Priorities in 2012 for a 3 year period.

Our strategic priorities:

1: St Helens Safeguarding Children Board is reassured that children suffering harm, or likely to suffer from significant harm, are managed and supported effectively.

2: Strengthen Quality Assurances and St Helens Safeguarding Children Board Performance Management Framework.

3: Improve the effectiveness of in St Helens Safeguarding Children Board supporting the delivery of Quality Safeguarding Services in St Helens.

4: Ensure a commitment to continuous improvement and learning.

A further 4 priorities are in place for which the LSCB said it would take action to:

5: Help children, young people, their families and communities keep themselves safe and ensure that they know how to get help when it is needed.

6: Monitor how well agencies safeguard and protect children and will challenge them.

7: Use Board Resources effectively to give best results for children and young people.

8: Implement necessary changes that come from research, Serious Case Reviews, Serious Incidents and any national policy guidelines.
To achieve these priorities we undertake a broad range of work each year. For 2013-14 this involved:

**Implementing a Learning and Improvement Framework.** LSCBs need to learn what is happening locally and nationally. To learn about local professional practice and the effectiveness of our safeguarding arrangements we can use a range of methods. Audit, Serious Case Reviews and other reviews, scrutinising how partners work as a single agency or in partnership with other agencies, reviewing child deaths and hearing from people that know what is happening, including practitioners, children and families.

Our Learning and Improvement framework will continue to developing but we have learnt a lot this year from local reviews and audits. You will see more about this in a later section of this report - Learning and Improvement.

**Developing a Multi-agency Safeguarding Hub (MASH).** The MASH model brings a range of agencies together in one place to work alongside each other, share information more easily and make better decisions about what children need as a result. We have already seen evidence that this approach is having a direct impact on the way we work and the quality of help and protection that children receive. The Independent Chair of the LSCB has visited a range of settings including the contact centre and assessment team and spoken to a range of staff. All staff were highly positive about the developments. Staff were also able to articulate how the MASH can improve in the future and this will be taken forward during the forthcoming year.

**Supporting local staff and volunteers to safeguard children from CSE and when Missing from Home and Care.** We raised awareness of CSE and gave clear guidance on how to recognise and respond to this form of abuse to local staff. A reporting protocol was developed and a presentation delivered, to help residential care homes understand local processes and their role within them. Training was developed for practitioners who need more in-depth knowledge. Our partners worked together to develop an understanding of CSE in St Helens by sharing intelligence and information. Operational Multi-agency CSE (MACSE) meetings bring agencies together to ensure that children are protected and perpetrators are identified, disrupted and prosecuted. This intelligence is analysed and turned into useful information for the LSCB, to help us be assured that agencies are working effectively in this area and see what else we need to do.

**Knowing our partners hear the voice of the child and use this to inform their decisions and the support they offer.** LSCBs must assure themselves that agencies meet their responsibilities as laid out in the Children Act 2004, Section11. We made ‘the voice of the child’ a major area of focus within the Section 11 audits during the previous year and found a lot of evidence that our partners not only hear but actively listen and act on the voices of children and young people. We have more to do as a partnership and will create a sub-committee dedicated to this area in the forthcoming year.
Putting in place a Performance Management and Quality Assurance Framework. A set of ‘Herd Indicators’ were developed and used locally, to pull together key pieces of performance data and help the LSCB understand how effective the safeguarding system is. These are regularly reviewed and helps us to focus our attention on particular processes or the support that is provided to particular children.

We undertook a range of thematic audits to closely examine practice, the support children received and the effectiveness of this support. Each time we undertake a multi-agency audit the Board learns a great deal. You can see this in a later section of the report – Learning and Improvement. We also check our learning against statistical information so we are sure of the bigger picture.

Section 11 audits were mentioned above, however, it is important for the LSCB to challenge local agencies to continually improve. To do this, we introduced “Scrubiney and Challenge Panels”. This approach not only helps us to delve deeper into how agencies work to keep children safe but enables a range of agencies to talk together about barriers and opportunities; finding solutions and working together to improve.

Reviewing and revising the way the LSCB and its sub-groups work. You will see the structure of the LSCB later in this report. Our sub-groups have a lot of work to do on behalf of the LSCB. Each group drafted its own plan with clear, timely and measurable targets to be achieved.

This has helped us undertake the right work and we have achieved a lot. These sub-group plans were regularly reviewed at our Executive group and this helped to hold agencies to account, challenge delays, reduce duplication whilst sub-group chairs were able to support each other with ideas and actions.

Action Plans for each individual Serious Case Review (SCR) or other review, were also developed. The Independent Chair and the Executive Group monitors these regularly.
Some more of our achievements

Training

LSCBs need to understand the training needs of the children’s workforce, including those professionals that work with adults who are parents/carers. During the previous year, we updated our analysis of workforce training needs.

How this helps...
Even if training is effective and has the desired impact, it only helps keep children safe if we train the right people. By identifying the training staff and volunteers need, we can modify the training delivered and make sure that the right people attend. We can also monitor how agencies train their own staff and ensure they receive the right multi-agency training.

Child Sexual Exploitation

More than 70 staff and volunteers received training or awareness raising sessions to help them recognise and respond to children and young people who are victims or at risk of CSE. To raise awareness with parents and the wider population, we worked with the local press who published information on this important issue.

How this helps...
More practitioners and members of the public can be alert to the signs of CSE and know how to refer children for help and support.
And some more of our achievements

Electively Home Educated Children

We reviewed a case using Root Cause Analysis techniques that helped us understand more about the reasons for children becoming educated at home, how they feel about this arrangement and how we can help parents help their children achieve good outcomes.

How this helped...

This work helped us to put processes in place to know the needs of children educated at home and crucially over problems early to keep more children in school.

Emotional and Mental Health

A Serious Case Review and other information highlighted that self-harm amongst young people had increased. Frontline staff (including GPs) also highlighted an increase in young people suffering from stress and anxiety.

What we did...

We explored the underlying causes and found that lower level cases were being referred directly to Child and Adolescent Mental Services (CAMHS) for a higher level service. There was a lack of understanding within the workforce of the ‘tiers’ of CAMHS support.

Via our member agencies we disseminated the right messages as to how and when CAMHS support is provided for varying levels of mental and emotional health problems.

How this helped...

We can see that workforce understanding has increased and children and young people get ‘tier 2’ support when they need it.

St Helens LSCB has the people and the skills to learn from practice and local professionals. When we learn as a partnership, we work together to strengthen local safeguarding arrangements. We are good at this and the work we do makes a real difference to how children and young people are safeguarded.
Structure of the LSCB

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

The LSCB Business Plan details the work we need to do and several sub-committees are required to take forward our broad body of work. Each sub-committee has a work plan and the Chair of each group attends Executive Group meetings to report on progress. Membership of each group is drawn from our statutory partners and others organisations. The membership is bespoke for each group, ensuring we have the right people involved in the work. You will see the work of each sub-committee explained later on in this report, along with a summary of what each group achieved during the previous year. The LSCB Chairs meets twice a year with each sub-committee Chair.

Schematic Structure
It is a statutory requirement for the LSCB to produce an annual report and this must be provided to the Chief Executive of the Council, the Chair of the Health and Well-being Board and the Police and Crime Commissioner.

The LSCB works alongside other strategic partnerships in the borough and each has different responsibilities in relation to the same population. The Health and Wellbeing Board is responsible for producing a Joint Strategic Needs Assessment (JSNA). The JSNA helps a number of agencies work together and plan how to best improve the health and wellbeing of people in St Helens and reduce health inequalities. The work of the LSCB informs the JSNA, as what we learn in our work, is important for others when they plan what services are required for the local population and how those services should be designed. Each year the LSCB Annual Report is presented to the Chair of the Health and Well-being Board.

The LSCB is the lead strategic decision making body to help people work together to keep children safe. This ranges from putting things in place, such as policies or training, to help frontline staff understand their roles and work together to keep children safe; right through to conducting Serious Case Reviews if children are seriously harmed and abuse was factor. The LSCB Chair meets with the lead individuals for LSCB member agencies once per year. We have recently introduced an Annual General Meeting to provide the time for Board members to formally approve local reports and arrangements; and enabling Board meetings to focus on the work to achieve agreed priorities.

It is important for these partnerships to work together and inform each other. In St Helens, there is an agreement as to how these partnerships will do just that. This is known as a Memorandum of Understanding and it describes the activities each Board undertakes to support and challenge the other Boards in their work.

St Helens LSCB has an Independent Chair. This helps to bring challenge to the work of the Board. The Independent Chair reports to the Chief Executive of the Council and regular meetings take place between the Chief Executive, Leader of St Helens Council and the LSCB Chair. Separate meetings are held between the LSCB Chair and the Director of Children’s Services.
The Work of the Sub-committees

This section explains what each sub-group does and the work they have undertaken during the previous year.

Critical Incident Panel

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

The purpose of a Serious Case Review is to:

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

If the criteria for holding a Serious Case Review has not been met but the LSCB feels that the case may provide an opportunity to learn about and improve practice, a different type of review will be initiated. Six cases reviewed were considered by the Panel and three Serious Case reviews were initiated as a result. Child W (SCR1) is now published.

To see the Learning and Improvement from completed SCRs and other reviews, please see the relevant section on Page 44

During this reporting year, the Critical Incident Panel undertook an annual review of our functions and revised our terms of reference in line with Working Together 13. This review process assisted us in determining our role to support the implementation of a local Learning and Improvement Framework using a systems methodology to undertake SCRs and other reviews. The form to refer cases to the Panel was revised and communicated to local agencies.

The most important part of our work is how we learn from cases and lead on improving local safeguarding arrangements across the partnership as a result of this learning. Nevertheless, there remain important aspects in the way we undertake our work that we need to continually develop and build upon. During the forthcoming year we plan to:

- Communicate the role of the group and the referral process more widely.
- Undertake an Annual Revision of our Terms of Reference, Membership and Governance arrangements
- Development further the Learning and Improvement Framework so that we can evidence improvement has occurred following lessons being learnt
- Report more robustly into the LSCB to increase the awareness of risk and also offer assurance of mitigation where possible
- Improved our communication links into professional networks to help us cascade learning from reviews
Training and Workforce Sub-group

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

This sub-group had 4 key priorities during the previous year:

- Understand the Impact of LSCB training.
- Committee members to support with the Review of, and Root Cause Analysis of relevant cases that are referred to the Critical Incident Panel.
- Members to review their agency level Training Needs Analysis and feed this into the sub-group to inform the Training Programme.
- Understand what training is taking place at a single-agency level and arrange a programme of Quality Assurance.

This year, the LSCB provided training to more than 2000 local staff and volunteers!

Training included:
- Safeguarding Children
- Domestic Violence
- Fabricated and Induced Illness
- Harmful Practices
- Child Sexual Exploitation
- Briefings on Serious Case Reviews
- Various courses focusing on issues for young people
More of our work

St Helens LSCB provided a bespoke training package at Level 3 (a more advanced level of training) to General Practitioners. The Clinical Commissioning Group commissioned the LSCB to work alongside their staff to develop this package and deliver it to all GP's across the St Helens Area. This method of development delivery proved highly effective with excellent feedback from GPs following their attendance. So effective that a neighbouring borough requested that this be package be delivered to GP's in their area.

The LSCB set up a task and finish group to focus on equipping staff and carers, who work with looked after children, with a range of CSE resources to ensure that safe messages are being shared with our looked after children population. Sessions have begun to be delivered and we will know more about the impact of this work in the forthcoming year.

A number of St Helens practitioners attended training on how to undertake Root Cause Analyses. This method of analysis assists professionals to get to the root cause of why a child was harmed or put at potential harm. Many cases were referred to the LSCB for a decision as to whether a review of some sort was required. A decision was made that Root Cause Analysis would be the most effective way to achieve learning for three of those cases. You can read more about this work in the Learning and Improvement Section of this report.

In light of the findings from Rochdale, a Child Sexual Exploitation training programme was devised and targeted at staff who work with young people, particularly those who are most vulnerable to CSE. This training is facilitated by a number of professionals from partner agencies including the police, social care and support services. The LSCB recognises that reflecting on the voice of the child is an imperative part of learning, we were able to ask a young adult to share her experiences of being a looked after child who experienced CSE, this proved to be extremely powerful and enabled professionals to consider how they could change their practice in order to safeguard children and young people who are at risk.
Impact of LSCB Training

To gain an understanding of how LSCB training is having an impact upon practice, sub-group members spoke with professionals who had attended training courses. Below are some examples of how our training is making a difference:

- Delegates have held team meetings to share content of training with wider members of their team.
- Information packs given to service users and residents have been reviewed and revised following staff attending our training.
- Assessment tools were amended by individuals who attended our training to incorporate questions concerning DV and CSE and other safeguarding aspects.
- Professionals have left our training and felt more equipped to challenge the views of others during meetings.
- One attendee explained that they had built in a more robust recording system on a secure shared drive in their agency to improve access to safeguarding information for relevant staff.
- Professionals are more able to escalate their concerns.
- Attendees report that the training stays with them in their work and helps them to recognise risk factors.
- Social Care staff reported that they are clearer on how to prevent female genital mutilation.

Information we have received from the single agency training needs analysis has helped us to identify gaps in those attending and gaps in the training offered to the workforce. This is helping the LSCB to ensure that the training offered meets the local needs of all staff and volunteers.
Child Sexual Exploitation (CSE) Sub-committee

Tackling CSE is a major aspect of St Helens LSCB’s work. Membership is drawn from a wide range of local agencies including, Police, Children and Young People’s Services, Health agencies and the Voluntary and Community Sector. This has enables us to have a good understanding of the problem, the needs of victims and those at risk and how best to combat those who want to sexually exploit children and young people. During the previous year we worked on the following priorities:

- To work with neighbouring LSCBs on a Pan Merseyside/Pan Cheshire level to tackle CSE
- To implement systems and procedures that will protect children and young people resident in St Helens, from the risks of CSE
- To raise awareness of and embed the new police procedures for child sexual exploitation across agencies e.g. ALARM (Multi-agency CSE) meetings.
- To gather intelligence and assess the risk of child sexual exploitation to children and young people resident in St Helens
- To identify cases of good practice and ensure learning from these cases is rolled out
- To introduce a training programme that targets partner agencies, the local community and local businesses
- To identify hotspots
- To ensure that through single points of contacts in key agencies, identified priorities are actioned

The Merseyside CSE Protocol has helped to put systems and pathways in place for reporting CSE concerns and ensuring that a range of agencies share information, whilst lower level cases are also considered in a multi-agency way.

We know that our efforts have had an impact and this is demonstrated in the increased number of cases being referred and the increase in intelligence being reported to the Police. Merseyside Police responded to this by setting up a dedicated team; prioritising this highly important area of work.

A training programme was introduced to raise awareness of CSE with the aim of helping professionals to recognise CSE and understand the risk factors associated with this form of abuse. The training also helps staff and volunteers to be clear on how to respond to CSE. Below are some of the comments from those who have attended this training.

- ‘I am more aware of the risk factors to look for’.
- ‘I already have an understanding of CSE, however listening to the young person relate her story it brought it home how important it is that we listen.’
- ‘It has improved my knowledge of the new CSE protocol that is in place.’
Quality and Performance Sub-group

The role of this group is to gather and examine data and other information that helps the LSCB to know if children are safe and the safeguarding system is effective. The group looked at a wide range of information during the previous year from partner agencies including Children’s Social Care, Police and Health providers. The LSCB looked at this information closely as it tells us important facts about the safeguarding system and how effective it is. You can see more of this in the Performance Information and Learning and Improvement sections of this report.

Our priorities for 2014-15

- Continue to promote the CSE protocol and procedure and their implementation across agencies in St Helens
- Ensure that CSE is prominent and an agenda item in key meetings
- Each agency will have a Single Point of Contact for communication and for awareness raising within their agency
- All staff and volunteers to be trained to the appropriate level in CSE
- Produce a Communications Strategy that will inform a number of sectors and interest groups including Voluntary and Community Sector and our local Business Sector of CSE and raise their awareness of how to recognise and respond to this abuse
- Raise awareness of CSE with staff and students in schools and colleges
- Review the support available for victims and ensure that there are clear support pathways for the victims of CSE
- Effectively utilise available powers to restrict the risk of CSE and tackle perpetrators
- Develop a comprehensive problem profile
- Audit practice and the use of the Protocol and Procedures
- Ensure that the Protocol and Procedures are effective

We will monitor the impact of our work by:

1) Undertaking a multi-agency audit of practice on CSE cases, early in 2015

   This will help us assess the quality of practice within agencies and how professionals from a range of organisations work together. It will also help us understand if our processes and interventions are effective.

2) A set of performance indicators will be agreed and regularly reviewed by the sub-committee.

   This is will enable us to spot and respond to emerging problems and gain a fuller understanding of the nature of CSE in the borough and how to tackle it.
The role of CDOP is to review all deaths of children and evaluated information from a range of agencies so we can identify lessons to be learnt. Our main objective is to look for modifiable factors that may assist professionals and organisations in preventing the deaths of children. The learning gained from our work is included in our Learning and Improvement Framework and you can see more about this in a later section of this report entitled Learning and Improvement.

Learning and Review Committee

The LSCB Executive group considered a range of information and approved a plan for the Learning and Review Committee to undertake four thematic audits. These were:

Self-Harm - this was identified as a theme for audit through data performance from an Acute Trust and case review undertaken by the Critical incident Panel. This audit was completed.

Supervision - the findings of case reviews highlighted the need to undertake an audit in this area of practice. This audit is nearing completion.

The impact of adult mental health upon children - a previous audit and a review led us to revisit the experiences of children living with a parent/carer with Mental Health problems. This work is ongoing.

Travelling Community: our safeguarding approach - the Travelling Community is the largest minority group within St Helens and the way in which we design and deliver services was not understood. We had also uncovered issues in the application of thresholds for this Community through undertaking a case review. This work is in progress.

Section 11 audit cycle was completed: The Children Act 2004 requires agencies working with children and young people and their families, to have effective safeguarding arrangements in place. We use a range of methods to assess these arrangement locally and this year was the last in a cycle of 3 years. We undertook challenge and scrutiny sessions with local organisations to highlight areas for improvement and solutions. Our work to review Section 11 arrangements provided assurance for the Board that organisations are safely discharging statutory duties with regard to safeguarding.

Section 175 of the Education Act 2002 requires Local Authorities to seek assurances of the quality of safeguarding arrangements in local schools. We co-ordinated a Section 175 audit.

Other audits undertaken include Electively Home Educated Children and a review of restraint practice and procedures within a local setting.

Additionally, we challenged Merseyside Probation Service in relation to practice standards; and the quality and oversight of risk assessments of young people, who are a danger to children and young people.

The learning gained from our work is included in our Learning and Improvement Framework and you can see more about this in a later section of this report – Learning and Improvement.
Engagement and Empowerment Committee & the E-safety and Anti-bullying Sub-group

The focus of each of the above two sub-groups is to help organisations and families support safe internet use and behaviours for children and young people in the borough; and to tackle bullying, providing safe environments for children to learn and play. The groups worked hard to undertake a range of activities and initiatives during the year:

We organised digital safety training and a conference. The voices of children and young people drove the content of each and gave participants a greater understanding of the benefits and opportunities of internet use balanced against threats and consequences.

**How this helped...** The training was positively received and the learning outcomes were achieved. As a result of the conference, recommendations were drawn up and this has assisted the LSCB to identify what it needs to do next.

Throughout 2013-2014 over 300 staff accessed training on how to challenge derogatory bullying language in their school.

**How this helped...** A high percentage of those attending stated that the training has significantly changed their individual and school practice.

3000 young people in two High schools received interventions as a result of Ofsted comments regarding the use of unsafe language by students towards other students and staff.

**What did this achieve?** Follow-up inspection visits have indicated that young people are much more aware of the risks and consequences of using unsafe language, especially homophobic, racist or disability.

Digital safety information packs were distributed to social care staff working with Foster Carers. The packs gave the key worker and/or foster carer the opportunity to increase their knowledge and discuss important safety messages with children.

**Here is some of the feedback we have received from Foster Carers...**

“"It has reassured me that I am doing the right things"; “I found the setting of parental controls useful"; “Being able to update my knowledge about technology has helped”

Through the St Helens Teaching Schools Alliance - the CEOP Ambassadors have provided training for 7 Schools and 40 Newly Qualified Teachers.

**What did this achieve?** NQT’s have commented that this training has made them more aware of their professional role and online reputation and they feel more confident to discuss the emotional impact of digital safety alongside the technical aspect of the digital world.

Community based library staff are active participants in the Neighbourhood Action Group meetings in respect of inappropriate use of technology within the libraries. This year libraries have implemented a new firewall and have been involved in providing information on users who have breached the rules.

**The impact of this work...** This information has been used within police investigations to safeguard children and young people in St Helens
Some more achievements of the sub-group:

- Significant digital safety developments have taken place within St Helens College, which include: the development of a policy, young people as digital ambassadors, whole college digital safety education and launch of new website. The changes have been driven by young people, endorsed by the senior management team and incorporated within the college development plan.

- Over 400 children and young people have been trained as peer listeners/anti-bullying ambassadors. Impact case studies have been produced for all schools who have introduced the programme.

Pupils reported....

At the beginning there were lots of problems, but the more confident we got, the playground calmed down

Chapel End Primary School

The zero tolerance to bullying is well known amongst pupils and staff

Rainford High School. (This was also recognised during a recent Ofsted monitoring visit)

- The Behaviour Intervention Support team have trained over 1400 teaching and support staff to manage bullying behaviour. Training included restorative justice, managing challenging behaviour, team teach and de-escalation techniques. 98% of staff have reported that the training has been relevant to their role and has helped them to manage behaviour more effectively.

- Over 1000 children and young people have been supported to improve their behaviour, especially, bullying behaviour. 70% of pupils who received restorative justice interventions reported that it had made a difference to their circumstances.

- The Chair of this sub-group facilitated the 2013 and 2014 annual pupil health and wellbeing survey, which included a range of ‘feeling safe’ questions. The information has been used in a range of actions and interventions, including strengthening the JSNA and informing commissioning intentions.
Democracy debates were held involving all schools in St Helens. The theme was ‘Safety First’ and pupils debated how their safety in St Helens could be impacted and discussed ideas of how their schools, communities and the borough could help them to stay safe. The impact report featured examples of ‘you said, we did’ and was circulated to all school councils across the borough. Children and young people have gone on to vote for the 2014 theme which they felt was important. Therefore the 2014 events will focus on mental health from a young person’s perspective, ‘happy to be me’, ‘what stops me from being happy’ and ‘what services/activities do I need to be happy again’.

Development of an evidence repository to highlight that services have both listened and acted upon the voices of children and young people has been implemented and shared across the partnership. Over 40 pieces of evidence have been included within the repository and best practice is shared via the LSCB subcommittee, executive committee and Voice of the Child newsletter.

NYAS (National Youth Advocacy Service) were commissioned by St Helen’s Children’s Services, to provide support for children and young people to attend initial and review child protection conferences. Protocols have been developed and communicated to relevant staff to ensure the process is supportive and that they are able to manage expectations both from a practical and emotional perspective. Children and young people will be prepared for this by their social worker and have the option of attending. Evidence of impact will be recorded and the LSCB will examine this in the forthcoming year.

Following a challenge from the Chair, the Voice of the Child subcommittee has incorporated a targeted focus in relation to drugs & alcohol, neglect and domestic violence. Services have been strengthening how they work alongside children and young people to find out how they are affected by the ‘toxic trio’. Examples include: the commissioning of the ‘breaking the cycle’ programme to work with families impacted by substance misuse and Helena Housing working more closely with Troubled Families team and the Women’s refuge to ensure that the feelings and wishes of children are taken into consideration as part of the support plan.

We have developed a plan to take forward work in a co-ordinated way so we can all better hear the voice of children in our work and use this to inform case by case decisions, our understanding of the effectiveness of our work; and also to plan and design local services. This will commence in the forthcoming year and enable the LSCB to challenge partners to demonstrate the difference that children and young people’s voices are having on service development and delivery.

Priorities for 2014-15

- Strengthening the Voice of the Child within social care practice to the extent that children receiving a service and looked after children report that they are effectively listened to.
- Introduce a child and young people forum across the borough enabling them to opportunities to work alongside decision makers and be involved in projects that affect their lives.
- Extend the health & wellbeing questionnaire to include vulnerable groups of young people, enabling self-reported health behaviours to be reflected within commissioning arrangements.
- Facilitate the 2015 Anti-Bullying conference with a focus on safeguarding and Ofsted.
- Develop the multi-agency E-safety strategy and launch in 2015.
- Formally establish the digital safety ‘alerts’ communication alongside Merseyside Police.
- Ensure children and young people are involved in the development of borough wide child friendly anti-bullying policies.
Policies and Procedures Sub-group

During this reporting year the functions of the Policies and Procedures sub-group were reviewed and refreshed. Clarity was sought from the Executive Group as to the purpose of this group and its activities were streamlined to reflect the core business of the Board. Terms of Reference were drawn up reflected the honed focus on reviewing, quality assuring and developing multi-agency procedures.

Governance and accountability for the group have also been improved. Progress and concerns are reported to the LSCB Executive Group; strengthening oversight and the involvement of senior staff where there are delays or barriers to completing the work. Work is referred to the group by the LSCB main Board. Additionally, when the recommendations from Serious Case Reviews and Critical Incident panels pertain to policies and procedures, the work is undertaken by this group.

During 2013-14 the group’s membership was reviewed and revised, ensuring that the partnership is fully represented and all relevant agencies are able to contribute to the development and improvement of our policies and procedures. Regular review of written guidance is crucial so we have introduced a timetable to enable us to maintain an up-to-date suite of multi-agency policies and procedures.

Our biggest piece of work during the previous year was revising the LSCB Continuum of Need document. This enables local practitioners to understand the level of support that should be provided to a child, depending on their level of need. This work should improve the consistency of practice across all levels of the continuum. We can already see that the work undertaken during the previous year is making a difference. Additionally, having a broader membership on the sub-group has enabled procedures to be reviewed more robustly, whilst revised documents are reflective of the operational needs of a wide range of multi-agency practitioners.

During the forthcoming year we will quality assure and ratify key policy and procedural documents, including:

- Elective Home Education Policy and Procedure
- Early Help Strategy
- MASH Operation and Governance document
- Neglect Strategy
- Children and Young People’s Services – Threshold Guidance
- LSCB Continuum of Need Guidance

The LSCB will gain an understanding of the impact of this work via:

- Multi-agency and single agency audit activity evaluating if procedures and the expectations within local guidance are reflected in practice.
- Analysis of performance information
- Section 11 assurance activities such as S11 self-assessment and LSCB scrutiny activities

Continuum of Need 2014
Developing New Local Guidance

“Think Child, Think Adult, Think Family”

We brought together a range of professionals from several different agencies to undertake this big and important piece of work. This document help professionals understand the level of support required by children depending on their needs.

You can see the Continuum of Need 2014 guidance here
5. Performance Information

Referrals

A referral is defined as ‘a request for services to be provided by children’s social care services.’ This is in respect of a case where the child is not previously known to the council, or where the case was previously open but is now closed. A referral cannot be received on an already open case. A referral can be made by a professional from one of many different agencies (typically in the health and education sectors) but the term as used here is a broad one which encompasses referrals from any source, including self-referrals.

Table 1. Total Number of Referrals to St Helens Children’s Social Services

The table below provides a direct comparison between the numbers of referrals to Social Care in each of the previous four financial years.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Referrals to St Helens</td>
<td>1973</td>
<td>1772</td>
<td>2385</td>
<td>2950</td>
</tr>
<tr>
<td>Year on Year change</td>
<td>-10%</td>
<td>+35%</td>
<td>+24%</td>
<td></td>
</tr>
</tbody>
</table>

Percentages of referrals going on to initial assessment – Trend over time

An initial assessment is defined as a brief assessment of any child who has been referred to children’s social care services with a request that services be provided. An initial assessment is deemed to have started either at the point of referral to a social care services department, or when new information on an open case indicates that an initial assessment should be repeated. The expected timescale for the completion of an initial assessment is a maximum of 10 working days. Initial assessments may lead to three types of outcome:

- no further action
- the immediate provision of services
- a more detailed type of assessment (known as a ‘core assessment’) being carried out. This may be carried out even where there is immediate provision of services

Table 2. Numbers of referrals to Social Care that led to an Initial Assessment being undertaken.

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>72.5</td>
<td>66.0</td>
<td>59.7</td>
<td>88.6</td>
<td>92.4</td>
<td>90.1</td>
<td>91.5</td>
</tr>
<tr>
<td>North West</td>
<td>62.3</td>
<td>64.3</td>
<td>-</td>
<td>77.3</td>
<td>77.9</td>
<td>77.9</td>
<td>tbc</td>
</tr>
<tr>
<td>England</td>
<td>59.4</td>
<td>63.8</td>
<td>65.5</td>
<td>71.5</td>
<td>74.6</td>
<td>74.4</td>
<td>tbc</td>
</tr>
</tbody>
</table>

90.2% of Initial Assessments were completed within the 10 working timescale (2013-14)
Core Assessments
A core assessment is defined as an in-depth assessment which addresses the central or most important aspects of the child’s needs. There are several junctures at which a core assessment may start, depending on the child’s circumstances, and the existence of child protection concerns (‘risk of significant harm’) is not a pre-requisite. The expected timescale for the completion of a core assessment is a maximum of 35 working days, recognising that where specialist assessments are required they may not take place within this timescale.

Rate per 10,000 of children (<18 years) for whom a core assessment was undertaken was 388.3, compared with an England rate of 204.2 and a North West rate of 214.4 per 10,000. The 2012-13 rate was 299.9. The LSCB will monitor rates in the forthcoming year, following the conflation of the initial and core assessments into a single assessment – in line with statutory requirements. 91.3% of core assessments were completed within the 35 working days timescale.

Section 47 Investigations
At an initial assessment the local authority should ascertain if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm (section 47 of the Children Act 1989). If this is suspected then the local authority should carry out a section 47 investigation to determine if it needs to take steps to safeguard and promote the welfare of the child. If concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference will be convened.

An initial child protection conference should take place within 15 working days of the strategy discussion which decided whether Section 47 enquiries should be initiated. The conference will result in a decision on whether the child will become the subject of a plan or not.

Table 3. Rate of section 47 enquiries per 10,000 children

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>60.2</td>
<td>73.7</td>
<td>102.5</td>
<td>111.6</td>
<td>215.9</td>
<td>258.6</td>
</tr>
<tr>
<td>North West</td>
<td>72.2</td>
<td>76.3</td>
<td>90.4</td>
<td>95.2</td>
<td>112.5</td>
<td>tbc</td>
</tr>
<tr>
<td>England</td>
<td>76.4</td>
<td>79.6</td>
<td>101.1</td>
<td>109.9</td>
<td>111.5</td>
<td>tbc</td>
</tr>
</tbody>
</table>

This rate, when compared to regional and national rates is very high. The LSCB will monitor this figure carefully during the forthcoming year and consider this information against data that describes the caseload sizes of key safeguarding staff, such as Social Workers and Health Visitors.

Child Protection Conferences and Plans

Initial Child Protection Conferences
Rate of Initial Child Protection Conferences per 10,000 children for 2013-14 was 92.5 compared to a rate for the previous year of 77.4. Comparable data is available for the previous year (2012-13); the rate across England was 52.7 per 10,000 children and 63.4 for the North West region. This rate, when compared to expected regional and national rates is very high. The LSCB will examine accurate comparable data when available (end Oct 2014) and undertake further work to understand more about the child protection system and why this rate is so high for St Helens.
Rate of children who became the subject of a child protection plan during 2013-14 per 10,000 children was 80.7. **In the previous year (2012-13) this rate was high when compared to national and regional rates and it is expected to higher still for 2013-14.** The LSCB will examine comparable data when it becomes available (end Oct 2014) and request and analysis of this data from Children’s Social Care.

Table 4. **Children subject to Child Protection (CP) Plan at period end (per 10,000)**

As at the 31 March 2014 a total of 239 children in St Helens were subject to a CP plan. In terms of a comparison to the previous year, at the 31 March 2013 a total of 156 children in St Helens were subject to a CP Plan. Please note, the table below displays the rate of children who were the subject of a child protection plan at 31 March (per 10,000 children).

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>31.0</td>
<td>51.5</td>
<td>59.5</td>
<td>48.7</td>
<td>43.0</td>
<td>63.6</td>
</tr>
<tr>
<td>North West</td>
<td>35.0</td>
<td>-</td>
<td>42.5</td>
<td>42.6</td>
<td>41.4</td>
<td>tbc</td>
</tr>
<tr>
<td>England</td>
<td>31.0</td>
<td>35.5</td>
<td>38.7</td>
<td>37.8</td>
<td>37.9</td>
<td>tbc</td>
</tr>
</tbody>
</table>

Table 5. **Percentage of children who became the subject of a child protection plan during the year ending 31 March who became the subject of a plan for a second or subsequent time**

In the recent 2013/2014 financial year a total of 293 children became the subject of a CP Plan at some point during the year with 61 of the children having previously been the subject of a CP Plan.

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>10.2</td>
<td>19.8</td>
<td>19.0</td>
<td>17.1</td>
<td>14.0</td>
<td>20.8</td>
</tr>
<tr>
<td>North West</td>
<td>12.7</td>
<td>-</td>
<td>13.4</td>
<td>15.3</td>
<td>14.9</td>
<td>tbc</td>
</tr>
<tr>
<td>England</td>
<td>13.5</td>
<td>13.4</td>
<td>13.3</td>
<td>13.8</td>
<td>14.9</td>
<td>tbc</td>
</tr>
</tbody>
</table>

The LSCB will seek to understand why more than 20% of child protections are not effective in the longer term at reducing the risk of significant harm to child. We will request additional data from St Helens Social Care on the timescales between one child protection and the next. We will audit practice in relation to the child protection system to gain a deeper understanding of the quality and effectiveness of multi-agency support and protection provided at this level.
Private Fostering

It is a legal requirement that anyone directly involved in making a private fostering arrangement must notify the local authority. This means that the parents of the child, the carers and anyone else involved in making the arrangement must tell the local authority at least 6 weeks before the arrangement is due to start, or within 48 hours if it is due to start sooner or has already started. The purpose of the publicity within St.Helens has been to increase the rate of notifications. Although non-notification is an offence, there have been no prosecutions within St.Helens.

St.Helens CYPS received 15 notifications between April 13 and March 14. There are currently seven children in a private fostering arrangement, whereby the carers have been registered. There are five children who are in a private fostering arrangement, whereby the private foster carers are undergoing assessment. Thirteen children are White British, one young person is over the age of sixteen and has a disability. This number can fluctuate as children move in and out of placements. We undertake an assessment of the private fostering arrangement to ensure it is appropriate and children are safeguarded and well cared for.

The table below illustrates key data in relation to privately fostered children:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of enquiries</td>
<td>3</td>
<td>9</td>
<td>10</td>
<td>28</td>
<td>17</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Number of notifications</td>
<td>15</td>
<td>27</td>
<td>19</td>
<td>22</td>
<td>14</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Number of new private fostering arrangements starting during the year</td>
<td>14</td>
<td>23</td>
<td>16</td>
<td>15</td>
<td>12</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Number of arrangements ending during the year (including any historic arrangements)</td>
<td>14</td>
<td>27</td>
<td>14</td>
<td>15</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Number of private fostering arrangements still in place at the end of each March</td>
<td>13</td>
<td>12</td>
<td>16</td>
<td>11</td>
<td>11</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

In Summary:
- St.Helens CYPS has received 15 private fostering notifications between 1st April 2013 to 31st March 2014
- 14 new private fostering arrangements are recorded as starting during the year from these notifications
- St.Helens CYPS had 12 ongoing arrangements that began before 1st April 2013
- 24 private fostering arrangements came to an end between 1st April 2013 and 31st March 2014
- Of the 24 new arrangements between April 2013 and March 2014, 14 had visits of intervals of no more than 6 weeks.
Our Private Fostering work promotes good outcomes:

- All privately fostered children are registered with a GP
- Privately fostered children are encouraged to attend regular dental and optical check ups
- There is increased awareness of private fostering among health professionals
- Signposting young people to information regarding sexual health, mental health, drugs and alcohol, smoking and children’s rights
- The child's health is monitored via 'family action meetings' and formal supervision with the private foster carers
- All carers are encouraged to promote a healthy diet and lifestyle choices
- Positive contact with birth family is encouraged to promote emotional wellbeing

The reasons for private fostering situations vary:

- Parental capacity to care for the child
- Family breakdown
- Parent receiving prison sentence
- Deceased parent
- Young people attending Liverpool football academy

Private Fostering arrangements ended for a range of reasons:

- Returned home (12 returned home)
- Obtained legal orders (2 private foster carers obtained a residence order)
- Become looked after by this authority (4)
- Reached their 16th birthday when the private fostering arrangement is deemed to have ended although the young person may remain in the placement.

In 2014, inclusion at Private Fostering Network Meetings and/or awareness training will be targeted/delivered to:

- Children services teams – inclusive of the first response team
- Schools (both secondary and primary)
- Housing officers
- Probation service.
- Youth offending teams
- Youth service
- Citizen advice bureau
- Drug and alcohol projects
- Private day nurseries
- Health visiting and school nursing

There is an ongoing awareness raising programme coordinated by the Service Manager of front line services.

St. Helens has established effective systems and procedures to safeguard and promote the welfare of privately fostered children.

Written information for children, parents, private foster carers and professionals is regularly distributed and also made available at public buildings throughout the area.
Local Authority Designated Officer

Managing Allegations against Professionals and Volunteers who work with Children

It is a statutory requirement for all Local Authorities to have a Local Authority Designated Officer (LADO). The role of the LADO is to manage allegations against staff, paid and unpaid, who work with children and young people.

An allegation may relate to a person who works with children who 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 they may pose a risk of harm to children.

The LADO does not investigate allegations against staff but co-ordinates the response to the allegation; enabling agencies to understand their own role within the investigation. The LADO is also responsible for monitoring outcomes and timescales of investigations.

Allegations by Category of Abuse

<table>
<thead>
<tr>
<th>Category</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Sexual</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Emotional</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Online</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>49</td>
</tr>
</tbody>
</table>

This table illustrates the numbers of allegations made, by category of abuse and in which month the allegations were made.

As can be seen from the figures, the majority of allegations are in respect of physical abuse. The ‘safeguarding’ allegations where those that did not fall into a specific category, ranging from a member of staff sending inappropriate texts and offering a lift to a young person, to a member of staff misusing alcohol.

This year we included “Online” as a category to reflect the increasing use of social media, and it is likely that more allegations under this category will be made in the future.

We can see here that during July, there were no allegations. It is likely that this was in part due to school holidays.
The table above illustrates the agencies reporting allegations, broken down into each month of the reporting year.

Here we can see that the majority of referrals to the LADO were made by Children and Young People’s Services.

Given the nature of some of our young people, it is not surprising that Children’s Social Care has been the highest referrer, including referrals from other Local Authorities. Education providers and independent residential establishments are also high, which is to be expected.

However, the number of referrals from other agencies is low, and this may be due to limited awareness, better management of concerns or fewer incidents.
A high number of referrals have been made in respect of residential care staff. Some of the allegations have been in connection with two or more members of staff during a restraint, and others who have allegedly been involved in accessing a young person’s Facebook account inappropriately. Although we acknowledge that these staff work with challenging children and young people it is important for every allegation to be investigated thoroughly and overseen by the LADO.

Teaching staff have again featured highly, alongside foster carers. Again this is not surprising as teachers are the largest profession in the children’s workforce and teachers have the most contact with children and young people.

A robust process is needed to monitor and reassess carers where necessary.
### Allegations by Final Outcome

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Further Action</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>32</td>
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<tr>
<td>Management Advice</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Training and Support</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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The majority of allegations resulted in no further action; some after a police or an internal investigation. **The LSCB will request that additional scrutiny is undertaken in this area to assess the quality of investigations given the low number being substantiated.**

When a professional is dismissed (or ceases to be contracted) by an organisation following an investigation into an allegation, the individual must be referred to the Disclosure and Barring Service for a decision on whether they will be placed on a 'Barred List' – containing the names of those individuals barred to work with children. One investigation led to a referral to the Disclosure and Barring Service (DBS) by the Local Authority, while an independent agency referred a member of their staff to the DBS.
LSCBs consist of a number of agencies and the work we do collectively helps practitioners work together and families to get the help they need when they need it.

Some of the work we undertake leads to changes in how local agencies work. The LSCB must continually strive to challenge local agencies, whilst supporting and encouraging them to improve.

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

This section describes the work of our partner agencies during the previous year

**Merseyside Police**

Our organisation investigates crimes against children and this is well known. However, we also play an active role in the multi-agency response to children who may be suffering abuse or neglect. It is our agency that often has the information about what happens in a household at night, when other professionals don’t see the child.

By providing information to partners and our attendance at multi-agency meetings, including Child Protection Conferences, all involved agencies are able to develop a more complete picture of what life is like for a particular child or children. This enables comprehensive plans to be put in place for children and young people that meets their needs and improves their outcomes.
During 2013-14 we had a particular focus on two LSCB Priorities and we want to focus on this work for this report.

The most significant development has been the introduction of the St Helens Multi Agency Safeguarding Hub (MASH). The concept involves the co-location of a number of agencies such as Police, Health, Education, Housing, Catch 22, and CYPS to improve information sharing and streamline processes thereby enhancing the services to children subject to child protection concerns, at risk of Child Sexual Exploitation, subject to Domestic Violence and those who are regularly reported as Missing from Home.

The second, and perhaps more tactical development has been the response to the increased profile of Child Sexual Exploitation locally. Through our drive to gather and understand intelligence we learnt more about the risks of Child Sexual Exploitation (CSE) and the profile of this abuse in St Helens. In response to the identified risk, we established a team to specifically tackle CSE. The team comprises of one sergeant, two Detective Constables and two uniform Constables. A member of staff from Catch 22 works alongside the team, supporting children who go missing and helping us to prevent and combat CSE.

This specialist team is situated within the Multi-agency Safeguarding Hub (MASH) team alongside the Children and Young People’s Services at Atlas House. Tackling CSE is one of the LSCB priorities and our CSE team has the objective of reducing CSE, disrupting CSE and developing intelligence around the problem.

This work is helping the LSCB to understand specific risk factors that leave children vulnerable, including internet use whereby children can come into contact with people that want to harm and exploit them; and children who are vulnerable, including those in care.

By improving the intelligence picture for our organisation and partners, the local response to CSE has significantly improved. This work is making the lives of children safer and is also informing the investigation process. Several offenders have been successfully prosecuted and received custodial prison sentences as a result of the work of the CSE team and in the forthcoming year we will move to a greater proactive approach; disrupting offenders and preventing them from committing offences against children in St Helens.
NHS England

Some of our safeguarding children achievements

NHS England works with NHS staff, patients, stakeholders and the public to improve the health outcomes for people in England. We also directly contract some of the health staff and services that deliver primary care to children and families; including General Practitioners (GPs), Dentists, Optometrists and Pharmacists. We also commission specialised services, offender healthcare and services for members of the armed forces.

Below is some of the work we did during the previous year that helps with the multi-agency task of keeping children safe:

- Named GPs are in place across Merseyside. These are GPs with particular responsibilities for safeguarding children and protected time to undertake this work.
- There is a robust Serious Untoward Incident system and process in place to monitor Child Deaths, SCRs and Domestic Homicide Reviews.
- We provided safeguarding reports to the Merseyside Quality Surveillance Group twice during this year.
- We secured funding to train independent contractors (GPs, Dentists, Optometrists and Pharmacists) on key topics.
- Our 1st National Safeguarding Conference was held in October 2013 and hosted in Merseyside.
- A Safeguarding Forum for Designated Professionals was established
- Development of a Merseyside Health Key Performance Indicator framework.
- We have undertaken a baseline audit across a section of GP surgeries
- All NHS England Merseyside staff have undertaken Level 1, 2 or 3 training dependent on the position held.
Children and Young People’s Services (CYPS)

In 2013-14, St Helens Children and Young People’s Services focused on a number of key areas of work and redesign to maintain a high standard of support for children and young people, at all levels of our service.

**Our key priorities were to:**

1. Restructure our statutory social work teams to align with the requirement of the revised public law outline.
2. Implement a Multi-agency Safeguarding Hub (MASH).
4. Improve practice in relation to neglect
5. Review arrangements for Electively Home Educated children

Three of the above priorities arose directly from challenge and discussion at LSCB meetings.

We can already see the difference this work is making upon how professionals work together and outcomes for local children and young people.
The work around CSE, the Multi-agency Safeguarding hub and Electively Home Educated Children (EHE), arose directly out of discussions at the LSCB and reflect LSCB Priority 1. The EHE project in particular looked at the situation of individual children through the lens of safeguarding alongside whether the quality of the educational arrangements meets the needs of this group of children.

The revisions to the LSCB Continuum of Need and the CYPS threshold documents arose out of an ongoing debate at the LSCB in relation to the respective responsibilities of agencies to take action at universal levels of the welfare continuum of need.

The LSCB has continued to scrutinise the performance of children’s social care and in doing so acted as the catalyst for the regular review of service effectiveness in the interests of improving outcomes for children and young people.

We have monitored the rates of young people detained in police cells following denial of bail and the extent to which the LA responded to police request to transfer young people to LA accommodation. Our Director of Children and Young People’s Services led the work to develop a protocol and improve local authority arrangements across the five Merseyside local authorities.

**The Impact of our Work in 2013-14**

- Restructuring the statutory social work teams has enabled us to create smaller teams with reduced caseloads.
- It has also reduced the span of management control, assisting us in providing better quality management oversight.
- At the time of producing the LSCB Annual Report, the restructure also appears to be improving the quality of case work and outcomes for children. We have evidence of this from an extensive case file audit recently completed by an external consultant.
- The MASH is still in an early stage of implementation and development, however we can already see the signs that it is enabling better quality multi-agency decision making.
We will continue to work on the priorities of the LSCB in 2014-15, including:

- Developing the MASH further with a view to bringing Health agencies and other partners on board
- We will implement the MASH workspace to support a truly integrated business process for all involved partner agencies.
- Continuing to improve our performance around permanence and in doing so bring our LAC population more in line with regional norms.
- Implementation of the Special Educational Need and Disability reforms.
- Continuing to improve our practice in respect of neglect in order to prevent families coming to the attention of statutory social care services and children becoming accommodated.
- Deliver an extensive programme of training on the Graded Care Profile in order to support our revised early intervention model.

**CYPD - Challenging ourselves and LSCB partners to improve the approach to child neglect**

Our department recognises the need for all partners to improve the local approach to neglect cases. We support the LSCB by providing evidence for why it is important to help these families early; particularly during the earlier stages of neglect when concerns are at a low level and/or confined to a single agency. It is important for all LSCB member agencies to act earlier so that matters are not left to escalate leading to the need for Children’s Social Care involvement.

We want to continue to work with partners on this area during 2014-15; making this a shared priority and making a big impact on improving outcomes for these children.

Let’s ‘Think Family’ and help earlier.
Safeguarding children is always a priority for our organisation. Mental health staff often influence decision making processes in safeguarding children due to their knowledge and information sharing around how the mental health of a child, young person or adult carer can impact on a family.

The Trust has a named Doctor for Safeguarding Children, a newly appointed Head of Safeguarding who will lead and manage the safeguarding children and adults teams, and all teams have a safeguarding champion that staff can speak to if they have concerns. Our newly appointed Assistant Director for Child and Adolescent Mental health Services represents our organisation on the LSCB. This year we have been involved in a number of activities and introduced new initiatives in this area.

- There have been a series of audits led by the Learning and Review Group which the Named Nurse attends. Some of these are continuing and include 'self-harm in young people', 'safeguarding children supervision' and ‘parental mental health'
- We have helped to develop and provide multi-agency training around compromised care. This includes issues around parental mental health, substance misuse and domestic abuse.
- We have introduced a new safeguarding training lead in our organisation. The Intercollegiate Document provides statutory requirements in relation to safeguarding training to staff that work in health settings. The introduction of this new role alongside the initiative that sees staff only able to receive their pay increment when they are fully compliant with training expectations, has seen training at all levels (1, 2 and 3 – Core and Specialist) improve during the previous year.
- The Child and Adolescent Mental Health Service is now continually monitoring data on families open to service to ensure all cases are allocated, have a key worker and that there is no drift.
- Within Clinical and managerial supervision CAMHS staff are specifically asked about safeguarding concerns
- CAMHS documentation now includes specific questions about other agency involvement and has specific questions in relation to safeguarding including domestic violence. The documentation includes a robust risk assessment.
- Group supervision is delivered to all CAMHS and Early Intervention Teams every 3 months.
- The 5 Boroughs has developed a Single Point of Access for all CAMHS referrals, the service is known as CART (CAMHS Assessment and Response Team). This has resulted in an improvement in waiting times for assessment for children and young people. The service operates seven days a week 9am until 9pm for urgent referrals and also provides 24/7 response for psychiatric emergency.

In 2014-15 we will focus on improving the knowledge and skills of our staff that work with children and young people particularly in relation to Child Sexual Exploitation and the PREVENT agenda.
Public Health Department

Public health is about helping people to stay healthy, and protecting them from threats to their health. Our work aims to enable people in St Helens to be able to make healthier choices, regardless of their circumstances, and to minimise the risk and impact of illness. Many of the choices people make impacts upon their safety and well-being; this includes children and young people and also adults who are parents and carers. Our Public Health department has been involved in a broad range of initiatives to support effective arrangements to keep children safe. These include:

- A review of Addaction drug and alcohol services to ensure that joint safeguarding audits are completed and the transition between young person and adult services is seamless. From this we introduced ‘breaking the cycle’; a family centered programme to ensure that the voices of children and young people are included in the overall care package for the family.
- We re-aligned existing service delivery within the Health Improvement Team, TAZ (sexual health service for young people aged 13 to 19) and the young people’s drug and alcohol team. This is helping to strengthen the provider arm of Public Health, enabling a consistent and planned approach towards addressing risky health behaviours amongst young people, such as drugs & alcohol use, sexual health, sexual exploitation, self-harm and suicide awareness.
- Whilst the Tier 2 CAMHS review is in progress, an interim service has been commissioned to safeguard young people with mental health conditions.
- Development of a multi-agency suicide prevention action plan, which includes an audit of what is currently being done to address self-harm and suicide prevention education programme for schools.
- We successfully launched a campaign to encourage parents/carers to sign a pledge to support smoke free homes and cars to protect and safeguard children against the damaging effects of second-hand smoke inhalation. Over 1000 people signed the pledge.
- We developed and implemented school nurse care pathways to support better safeguarding.
- The LSCB requested that questions relating to safety should be included in the annual pupil health and wellbeing survey, questions on self-harm, feeling safe in communities (including weapon crime), bullying and digital safety were included. These results inform the JSNA and commissioning of needs led services.
- The 2013-2014 Joint Strategic Needs Assessment (JSNA) provided an evidence base for informing and commissioning of services. This included risk taking behaviours which could negate safe and healthy lifestyles amongst children and young people and has provided the evidence for commissioners as to why these matters remain priorities.
- Our department contributed to the self-harm report. This included A & E attendance for under 18’s and qualitative patient accounts of their behaviour and experience of the system. The report has been used to inform the Suicide Prevention strategy.
- The service specification for the Specialist weight management programme has been strengthened to reflect neglect and hungry children. Specialist nurses focus on family engagement and retention model and will work alongside social care to support complex cases.
Our work as a member of St Helens LSCB involves us in the partnership's priorities and we make these matters our priority. The LSCB challenges us all to improve local arrangements and services. Often, our department helps to uncover and present the evidence clearly for Board members. Child Sexual Exploitation, Neglect, Drugs & Alcohol, Compromised Parenting, Self-Harm, Domestic Violence, E-Safety & Anti-Bullying – we worked on all of these priorities during 2013-14.

- Public Health investment and strengthening of tier 2 CAMHS service has been in response to service gap raised by LSCB. The review of CAMHs includes identifying self-harm and putting a care pathway in place. This was in response to concerns raised from the LSCB and Head teachers.
- Bridgewater Community Healthcare Trust has been commissioned to develop awareness training in respect of self-harm and suicide prevention.
- We developed and implemented an action plan to address the key recommendations emerging from the Serious Case Review in relation to co-sleeping. Priority actions have been embedded within existing work streams and include; messages to new parents via midwifery and health visitor services, the ‘real life’ alcohol campaign, developing training for frontline practitioners (including social workers) and other work aimed at ‘de-normalising’ cannabis use as the ‘soft option’.
- As part of the Pharmacy review and issuing of emergency contraception (EHC), stronger risk assessment thresholds for under 18 year olds have been introduced as part of safeguarding against CSE. For example, as part of the training, pharmacists and counter assistants will be alerted to young people, especially females, who may be accompanied by older males or who have been issued with repeated emergency contraception medication.
- The Teenage Advice Zone Team have responded to increasing concerns about CSE and teen domestic abuse by initiating and delivering a range of interventions, such as embedding the ‘Face Up’ (domestic abuse) resource in all High Schools, training over 80 delegates on the importance of tackling pornography with both children and young people and increasing the exploitation aspect of the Healthy Body, Healthy mind programme for young people.
- Established a Tier 2 alcohol worker within the Young People’s Drug & Alcohol Team to work with schools to strengthen alcohol prevention and harm reduction education.
- Over 4000 children and young people from Years 6, 8 and 10 participated in the 2014 pupil health & wellbeing survey. The Pupil Survey covered a broad range of health and wellbeing issues including diet, physical activity, tobacco, drugs and alcohol, dental health, mental wellbeing and staying safe. The information from the borough survey will be used to help us to understand the health and wellbeing needs of children and young people in St Helens, so commissioners and service providers are better able to target interventions that improve health and wellbeing of children and young people, especially those families who experience health inequalities and poverty.
- Our department provided under 18’s health data to support local understanding against safeguarding priorities; such as A & E attendance, deaths, teenage pregnancy and child accidents.
- Through a recent scrutiny review of breakfast club provision within schools, which featured a strong emphasis on the impact of the ‘hungry child’, a guidance document was produced and shared with schools and other settings. The guidance provided advice to schools on how best to ensure that children start the learning day with adequate food provision.
• The LSCB CSE Sub-committee outlined the need for greater education in schools about sexual exploitation, particularly for vulnerable groups. This has been delivered via Teenage Advice Zone (TAZ) in schools and over 400 young people have received targeted education through the healthy body/healthy mind programme.
• The Public Health Annual Report reflected the LSCB expectation to ensure that the health of looked after children (LAC) is central to activities and interventions.

The LSCB informs and influences our work

The LSCB CSE Sub Committee outlined the need for greater education in schools about sexual exploitation, particularly for vulnerable groups. This has been delivered via the Teenage Advice Zone in schools and over 400 young people have received targeted education through the healthy body/healthy mind programme.

The LSCB requested that questions relating to safety should be included in the annual pupil health and wellbeing survey, questions on self-harm, feeling safe in communities (including weapon crime), bullying and digital safety were included. These results inform the JSNA and commissioning of needs led services.

The LSCB has influenced us to ensure that the Voice of the child is stronger within both the commissioning and provider elements of the Public Health service; for example within the Healthy Child review.

We are currently reviewing all Public Health service specifications and performance monitoring frameworks to ensure that there is a stronger emphasis on safeguarding children.

We took forward recommendations for the prevention of co-sleeping arising from a Serious Case Review.

LSCB members informed the development of the Suicide Prevention Strategy.
Merseyside Probation Trust has safeguarding children at its core. Our work is perfectly placed to support this agenda and our key responsibilities to prevent further offences are aimed at keeping our communities safe, including the children within those communities.

During 2013-14 we undertook many activities to strengthen local safeguarding arrangements. You can read about these below.

- The learning gained from Serious Case Reviews and Domestic Homicide Reviews was disseminated to all of our staff. HMI Probation undertook an Inspection on arrangements for violent offenders in Liverpool, which was published in September 2013. The findings were relevant for all staff members, including those in St Helens, so we shared them with all staff members alongside a Practice Improvement Project launch. This project launch had a specific focus on Safeguarding.
- The above project required new guidance, so we devised practice guidance and launched this across our workforce.
- Our staff attended specifically commissioned training on child sexual exploitation.
- The Youth-to-Adult transition period can be one of increased problems so we worked with our colleagues in the Youth Offending Service to develop a joint working protocol.
- We developed an information sharing procedure with local police in relation to domestic violence and police call outs.
- With a spotlight upon CSE and neglect – there has been a renewed focus on substance using offenders and the impact upon children and families.

In the forthcoming year training for staff and managers on safeguarding issues will be a focus of our attention.

Also in the forthcoming year, Merseyside Probation Service will be disbanded and there are will be two organisations delivering Probation Services across Merseyside. The National Probation Service will be work with the highest risk of harm offenders, whilst the Community Rehabilitation Company will work with the remaining offenders. It is a statutory requirement for both organisations to be members of the LSCB.
Clinical Commissioning Group (CCG)

The CCG, as with all organisations, must be assured that we are fulfilling and safely discharging our statutory safeguarding responsibilities. As commissioners we are required to be assured that all commissioned health services, promote the safety and welfare of children and young people and continue to improve safeguarding practice within the NHS.

To gain assurance the CCG, amongst other processes, has a contractual agreement with all Providers. This includes the adoption and compliance with the Safeguarding audit tool and with key performance indicators (KPI's) held within the Quality Schedule. The safeguarding audit tool is a regionally adopted method for gaining assurance about compliance with statutory safeguarding standards. This tool reflects the requirements of all organisations to have effective safeguarding arrangements in place, as stated within Section 11 of the Children Act 2004.

The Safeguarding Service of the CCG, has a role and function across the Merseyside footprint and is required to lead the health economy on the learning and review process. This aims to ensure that cases meeting the criteria for review as per Working Together 2013 have the learning extracted. This learning is then disseminated and areas for improvement are identified and the improvement embedded into practice across commissioned health organisations.

The CCG currently supports the St Helens LSCB infrastructure by the provision of resource within a number of the sub committees; supporting the Board’s work across a number of priority areas. This includes chairing the Critical Incident Panel and the Learning and Review group. We also support the wider quality/audit function on behalf of the LSCB. The model of the CCG safeguarding service enables full support to the wider sub group network, which in turn, fully contributes to the Board’s priorities.

Challenge is a core function of the CCG Safeguarding Service demonstrated through the contracting process with all commissioned services and the investment of time and leadership into the LSCB and its sub committees.

Focusing on LSCB Priorities

The Key Performance Indicators (KPIs) against which we monitor standards within commissioned health providers, have been established by the Safeguarding Service. In developing these, we considered, and subsequently included, Board priorities, specifically in relation to the Early Help agenda and applying thresholds in line with the St Helens Continuum of Need Guidance. These KPIs are adapted and updated accordingly.

Hearing the voice of the child is an area that needs further strengthening within the CCG and commissioned services. It is vital that the process is made more comprehensive and the information gained used to inform service redesign and further commissioning. The LSCB is making this a priority as is St Helens CCG.

Any learning from reviews, audits and service user feedback will be communicated back through the CCG quality committees and will positively impact upon future service delivery; by means of contractual amendments, the redesign and commissioning of services within the Borough.

The CCG will continue to support the LSCB priorities by working in partnership with all commissioned providers to ensure a response to agendas such as CSE, implementing the MASH, embedding the continuum of need guidance and early intervention. We have agreed to increase our financial contribution to the LSCB for 2014-15 to further support the Board’s work. This increased contribution will support the development of a Quality Assurance post for the Board to further enhance learning from reviews and multi-agency audit.
We recognised progress against a range of priority areas during 2013-14:

- Training was devised and rolled out on a range of topics and the commitment of the LSCB to train the workforce is evident.
- The structure of the Board was revised assisting in driving the right work in the right way. Clear terms of reference are in place.
- The development of the Multi-agency Safeguarding Hub and subsequent evidence of improved multi-agency practice are notable achievements.
- Child Sexual Exploitation work is a clear priority for the LSCB. MACSE meetings are established for CSE operational matters and a LSCB sub-committee leads on implementing the strategy. Work is ongoing to raise awareness in the community of CSE.
- A Neglect Strategy was developed this year and Neglect Tool Kit is being established with clear channels of communication across local agencies.
- There is increasing evidence that agencies hear the voice of the child and this has an impact on the way professionals work with children. A Children in Care Council has been established and staff have heard messages of the importance of listening to the voice of the child and received training to help them do this effectively.
- The LSCB Constitution, Terms of Reference and Induction Pack have been updated.

Knowing the effectiveness of local arrangements

Herd Indicators are analysed and these focus on key priorities. The Quality and Performance Group gather evidence concerning the impact of actions taken by agencies and alerts the Executive group to any indicators where St Helens performance is below National levels or deteriorating. Evidence is gathered after training events – for example questions are asked about the impact training has had on the individual and their future professional practice. One response identified the raised awareness of health professionals to female genital mutilation.

Our contribution to the work of the LSCB

We fully participate in meetings and are committed to attending as many training events as we are able. We are all involved in various Sub Groups. We see that our role is to be the voice of the general public and to ensure that the relevant steps are taken to improve outcomes for children and young people.
Pauline Henderson

I am a member of the Child Sexual Exploitation Sub Group, Critical Incidents Panel, and attend Serious Case Review Meetings. I have been involved in the task group to update and revise the Constitution, Terms of Reference, and Induction Pack. I am involved in the work of the Learning and Review Sub Group. I also attend as many training events as possible including Development Days, and the Serious Case Review (report presentations).

Tina Bradley

I am a member of the Executive Board and the Training and Workforce Sub Group. I attend as many training events as possible which include Development Days, the Serious Case Review (report presentations) the Practice Learning Reviews and more recently the Digital Footprint Conference.

Beth Turton

I am a member of the Quality and Performance Sub Group. I attend all relevant training and Development event days. I also attend the Serious Case Review report presentations and the Practice Learning Reviews.

Developing our role further

We have no doubt that the role of the lay member of the LSCB will continue to develop. We are particularly interested in how the voice of the child will impact the service that the children and their families receive. We are interested in raising public awareness in the work of the LSCB and reviewing systems in place to promote it. We would be willing to attend Sub Groups on behalf of each other when lay member representation is required. We are concerned about the safeguarding of ‘hidden’ children in the community i.e. Traveler children and children educated at home. We would be interested in being involved in the monitoring of this issue in the future.

A suggestion

We would suggest that it would be very beneficial if minutes of meetings i.e. Sub Groups and the Main Board are circulated as soon as possible following the event.
Learning from Practice Audits and Reviews – what difference has this made?

St Helens LSCB becomes aware of areas requiring improvement via a range of mechanisms. It is important that we not only act, but that our action has a positive impact. Here are some of the areas where we had a big impact:

**Restraint**

Alder Hey Rainbow Unit reported a higher level than expected of children presenting to them who required medical treatment following physical intervention. Absolute numbers are low but the perception is that they are higher than other institutions. Data from national comparable institutions was however, hard to find. Following being made aware of this, a case audit of the children’s files was commissioned with a focus on particular cases.

Young people that lived in the setting or had lived there quite recently were interviewed and a multi-disciplinary team commenced an investigation of practice. This involved a pediatrician, nurse, police officer, social worker, a teacher and a secure unit manager. A number of staff from the provision were also interviewed.

The investigating team produced a written report which made recommendations to the owner and leadership within the organisation. Recommendations included better supervision procedures, better training, better engagement with the LSCB, use of CCTV and action in relation to specific members of staff.

The implementation of the recommendations was monitored by the LSCB and a report from the leadership of the setting indicates that there has been a reduction in the number of restraints.

**Self-Harm**

Whiston Hospital reported an increase in presentations of young people for Self Harm at their A&E department. It was reported that in the first six months of 2013/14 the numbers of children and young people who had presented had doubled when compared with 2012/13 figures. The Board also noted that St Helens now has a higher rate of self harm than the England average and neighbouring areas. Linked to this, other data showed us that emotional abuse is the second highest cause of referral in the borough at 41%.

The learning and review group were requested to perform a multi-agency audit by the performance and monitoring sub-committee following recognition that the numbers of children and young people who were presenting at St Helens and Knowsley Teaching Hospital with self-harm had substantially increased.
We linked our learning above with the learning we had gained from undertaking a review on a case of a young person who attempted suicide. This highlighted that Child and Adolescent Mental Health Service (CAMHS) provision was needed, was not easily accessed and the case had been closed after missed appointments. Sadly, a second, similar case resulted in death and is now subject to Serious Case Review.

Staff helped us understand more of the situation; Headteachers reported difficulty in accessing appropriate CAMHS services at Tier 2 (though not at 3 and 4). CAMHS staff reported poor understanding of mental health across universal professionals. Our Health and well-being Board has mental health as a priority and health commissioners, CCG and Public Health, recognise that there has not been comprehensive commissioning at Tier 2 of CAMHS.

LSCB Executive Group scrutinised performance data and the LSCB Chair raised this issue with the Board, Council, CCG, 5 Boroughs. Following the pulling together of the picture and highlighting this to relevant bodies and people, CAHMS revised their approach to stepping down to Tiers 1 & 2 of the service. 5 Boroughs Partnership revised their delivery model so that they “triage” T2 cases and subsequently put in place the most appropriate provision.

A Practice Learning Event, based on the learning review, was organised to raise understanding of the issue across partners and to launch the new 5 Boroughs Partnership model. Public Health, through Children’s Commissioning, developed a plan to commission extra Tier 2 services for 2014/15.

**Electively Home Educated Children**

Safeguarding applies to all children. It is not just a case of intervening when a child is at risk of harm and needs protection, nor is it only when a child needs additional services or support to achieve good outcomes. Prevention and early intervention is an important component of the safeguarding continuum. Knowing that children are seen and safe is a fundamental part of safeguarding.

A root cause analysis revealed that children who are electively home educated, do not fit neatly under the safeguarding banner. However, young people when interviewed, revealed that they did not always want to be educated at home and felt they did not have a voice. Staff explained that they did not feel equipped to assess safeguarding on home visits.

As a result of our learning, the approach to assessing children when they are withdrawn from school was changed; procedures were reinforced with schools and a vulnerability matrix was introduced. Relevant staff were trained in safeguarding and this entire area received additional management oversight

This work has had a very positive impact. All Electively Home Educated Children have been visited and a safeguarding assessment undertaken. Crucially, more families have been persuaded to keep their children within the school system.
Learning from practice and practitioners

- We know that communication is the cornerstone of safeguarding children and practitioners told us that poor record keeping impacts negatively upon how information is communicated. Also, if minutes of meetings are not circulated this can lead to a lack of clarity for involved practitioners. We have found that poor communication can lead to decisions being made in isolation.

  The LSCB will continue to work with agencies to improve record keeping, timely sharing of minutes and good communication. Our plans to develop the MASH further this year, will assist with this at the front-end of the safeguarding system.

- Staff changes can cause delays and in some circumstances may lead to ‘drift’ in case management. Drift can also come about when chronologies are not analysed and where there is a lack of management oversight.

  The LSCB will monitor staff numbers, caseload sizes and vacancies of specific posts, within our multi-agency dataset.

- Parental Issues such as domestic abuse and health issues that impact upon the parents’ ability to care for their child, coupled with feigned compliance, can make it difficult for professionals to maintain their focus on the child and hear the child’s voice. Additionally, when one or more parents display domineering or aggressive behaviours, professionals may be less able to challenge, leaving parents able to manipulate the situation.

  The LSCB will support our workforce to recognise and work with these issues, including the specific traits of resistant families. We will continue with our work to enable practitioners to place the child at the centre of our work.

- Professionals can be reluctant to escalate their concerns when they disagree with case management decisions and the threshold applied to a case.

  We will continue to promote and embed use of the Escalation Procedure within local agencies.

- If professionals are not provided with sufficient information when first introduced to a case, this can lead to ‘start again’ syndrome.

  Social Care and other agencies are continuing with their work in relation to case file chronologies and supporting staff to understand the history of a family and parental capacity to change.
Learning what is working well

- The tenacity and determination of staff was noted in a local review.
- Various agencies recognise Domestic Violence incidents.
- We have seen evidence that professionals are persistent in their attempts to maintain contact with a family and see the child.
- Multi-agency working has been seen to be strong.

Learning – What do we need to do next?

- We will complete the outstanding elements of the 2013-14 audit cycle.
- Year 1 of the 3 yearly cycle of Section 11 assurance will commence in the forthcoming year.
- Root Cause Analysis training will be accessed by relevant sub-committee members
- We will develop a framework to capture learning and themes from single agency audits.
- Dissemination and communication of the National learning from SCR’s
- We will devise a programme of audit to test how well the learning from reviews is embedded.
- We will identify a case to learn how the system supports good practice
- Work will be commenced to ensure that agency representatives within the sub-committees and on the Board, disseminate the Board messages and expectations and the learning gained from reviews, audits and other activities.
- We will undertake additional learning methods to support our scrutiny of local services; eg. Board member visits to the frontline.
- We will strengthen our Learning and Improvement Framework so that it becomes a ‘living’ document, regularly updated and in line with the requirements of Working Together 2013.

The Learning and Improvement Framework will clearly illustrate

1. What we have learnt
2. Our improvement plan/s, including the methods we will employ to know we have made a difference
3. Evidence of the impact of our work
Here is the key learning from the Child Death Overview Panel

Trends in Child Deaths Reviewed on Merseyside

Figure 2: Child deaths reviewed 2013 - 2014 by LSCB area and presence of modifiable factors

The modifiable factors identified in the 12 cases included:

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

On occasions panel members have not felt able to conclude that there were modifiable factors identified but felt the situation warranted issues being identified.

Below is a summary of the issues raised:

- Delay in bereavement support;
- Admission/observation policy desirable for vulnerable patients;
- Auditing of practice requested with a resource when a child death in similar circumstances occurred despite a previous Root Cause Analysis report recommending changes to address;
- Dietary input for patients with low BMI;
- Difficulties obtaining post mortem reports;
- Care pathway for cardiac babies;
- Alcohol and parental responsibility;
- Medical record transfer;
- Risk taking behaviour;
- Flawed categorisation due to DfE documentation not being sufficiently specific.
## 1) Governance Arrangements

The structure of the LSCB and its sub-committees are aligned to the work undertaken by the Board.

The Board plans its structure in line with the tasks it needs to undertake to develop and improve safeguarding arrangements and to evidence the impact of this work.

A Memorandum of Understanding (MoU) between the LSCB and H&WB is in place.

There is clarity across each partnership of the respective roles and accountabilities.

This area of work is **GOOD**

### Next Steps

We will strengthen further the voice of the child and how this informs interventions at the individual child level, service level and strategic planning.

We will do this by

- Establishing a multi-agency group working under the direction of the LSCB
- Devising and implementing a multi-agency action plan
- Learning more about how the voice of the child is influencing local practice

We will provide further clarity on the respective roles of partnerships in relation to Looked After Children

## 2) Evaluating multi-agency front-line practice

Qualitative and quantitative performance information has regularly been provided by Children’s Social Care and other partners. This enables the LSCB to recognise areas for further scrutiny and improvement.

The IRO service produced a comprehensive performance report. Multi-agency quality assurance information is available for the LSCB

This area of work is **GOOD**

### Next Steps

Develop further the Learning and Improvement Framework to enable the LSCB to plan multi-agency audits and other scrutiny activities; and evidence improvement following previous audits and case reviews.

Learn more from single-agency audit activities.

Establish and recruit to a LSCB Quality Assurance Co-ordinator post

Further develop multi-agency performance information and LSCB dataset
### 3) Challenge and accountability

**S11 audits** are undertaken and challenge sessions are held. There is significant evidence of challenge by Board members and the LSCB Chair in relation to specific safeguarding arrangements and individual agencies within LSCB meetings. This challenges arises from evidence (eg. learning from reviews); and there is evidence that this challenge consistently leads to improvement.

Partners make themselves accountable by engaging in multi-agency quality assurance activities and providing qualitative data to the Board.

This area of work is **GOOD**

#### Next Steps

We will take this area to ‘OUTSTANDING’ by:

Introducing more structure to our single agency scrutiny work.

To give us a robust understanding of the work of individual agencies, we will combine the learning from

- reviews
- audits
- S11 returns
- challenge sessions;

and also establish a programme of Board member visits to the frontline to hear directly from the workforce in order to triangulate our hypotheses and findings.

### 4) Local Learning and Improvement Framework (LIF)

The LSCB has a Learning and Improvement Framework in place.

We undertake a broad range of learning reviews, including those that do not meet the threshold to initiate a Serious Case Review.

Our audit activity and performance information helps us to triangulate findings with other evidence and track the expected trajectory of change and improvement.

This area of work is **GOOD**

#### Next Steps

We will strengthen our Learning and Improvement Framework so that it becomes a ‘living’ document, that is regularly updated and in line with the requirements of Working Together 2013.

The Learning and Improvement Framework will clearly illustrate:

1. What we have learnt
2. Our improvement plan/s, including the methods we will employ to know we have made a difference
3. Evidence of the impact of our work

St Helens LSCB will work with other Merseyside LSCBs to ensure the learning from CDOP is maximised and supports our LIF

### 5) Policies and Procedures

The group has good multi-agency representation and has shown itself to be effective in undertaking complex policy work (eg. Continuum of Need 2014).

A timetable of policy and procedure review is in place and the group has refocused its priorities.

This area of work **REQUIRES IMPROVEMENT**

#### Next Steps

This group has a large portfolio of work to undertake and rightly prioritised the CoN guidance in 2013-14. To go to **GOOD** this group will:

- Review and revise LSCB Procedures.

To go to **OUTSTANDING** the group will:

- Enlist the support of relevant sub-committees to be assured that practitioners follow local guidance and procedures as intended.
### 6) Influence

The LSCB understands its statutory powers and responsibilities and there is learning available to the LSCB that enables the Board to influence the priorities of other partnerships.

The LSCB has strong evidence that it influences partners, through robust evidence to engage in multi-agency improvement work; this in turn leads to evincible improvement.

Improvements to scrutiny and Learning & Improvement activities will enable the Board to have yet further evidence of the sufficiency and effectiveness of local services in order to provide greater challenge.

The LSCB identifies local priorities with rigour and there is substantial evidence that the Board has a big impact upon local safeguarding arrangements, within which its ability to influence plays an important part.

This area of work is **GOOD**

### Next Steps

To go to **OUTSTANDING** the LSCB will:

- Produce a good quality Annual Report to inform lead members, H&WB Board members, Chief Executive of Council and Police and Crime Commissioner of the key safeguarding priorities, learning and improvement activity and the effectiveness of local safeguarding arrangements in St Helens.

- Be more actively involved in the development of the Joint Strategic Needs Assessment (JSNA) and be consulted with during the drafting of this. The LSCB will use its influence and the robust evidence it gathers to influence the priorities of the JSNA and consequently wider local commissioning plans.

### 7) Training

The LSCB delivers a wide range of training to front-line staff, managers and senior staff.

The training delivered is aligned to LSCB priorities and learning gained by the Board through review and audit.

There is an emerging understanding of the impact of training.

Following a Workforce Needs Analysis there is a growing understanding of the training needs of the workforce.

This area of work **REQUIRES IMPROVEMENT**

### Next Steps

LSCBS have three responsibilities in relation to training. LSCBs are not responsible for the direct delivery of training but many Boards feel they are best placed to do this. LSCB responsibilities in this area are to:

- Understand the safeguarding children training/learning needs of the workforce
- Be assured that those needs are met
- Evaluate the impact of training upon frontline practice to be assured of its effectiveness

**These 3 areas will be prioritised within an action plan for the sub-committee.**

The LSCB will devise a Level 1 single-agency course and be assured by all local agencies of the expertise and credentials of those delivering this course. This will standardise local learning objectives for the workforce and free up valuable time of the LSCB Training Officer from quality assuring all single-agency training, in order to focus on the core responsibilities highlighted above.
Effective LSCBs prioritise and this Board has worked hard to know what our priorities are for the forthcoming year. We examined a number of areas and a wide range of evidence. This helped us to understand what we need to focus on the most in the forthcoming year and beyond. The priorities we decided upon are explained below:

1) Organise our systems of management and governance to make sure that we are well fitted to keep children safe and to comply with all relevant regulations. The section above 'A Summary of our Effectiveness' provides much of the basis for this and the actions we need to undertake.

2) Reduce the incidence of neglect in families and, where it where we discover it, to reduce the impact on children’s lives. Evidence gained locally helped us to understand the size and nature of the problem and how we need to support the workforce to provide the right support to these families at the right threshold dependent upon need.

3) Work across partners to provide help early, reducing the impact on children of compromised family circumstances and making it more likely that families thrive. Where this proves not to be possible, to intervene quickly robustly in support of children. Local learning has highlighted to us the importance of providing support to families when problems arise. Our partners in St Helens Children and Young Peoples Services have also highlighted the reasons why we must all provide help earlier, particularly where neglect is a feature of a child’s life.

4) Identify the extent of CSE and to tackle it across all agencies in order to protect children. From our local knowledge we know that this must extend from preventative and protective work across the whole child population to support for child victims and prosecution of perpetrators. Conscious of the risks to children who are alone, we will pay particular attention to work with those who go missing from care, home, education or health provision.

5) Ensure that children in public care are kept safe and can make a successful transition into adult life. Our learning from local and national information tells us that children in care of one of the most vulnerable groups.

6) Ensure that partners commission a more comprehensive and accessible set of services for children with low to moderate mental and emotional health needs so that these issues do not impact on their future lives. Learning from a Serious Case Review and scrutiny of other evidence has shown this to be an area that needs continued development, building on our previous work.

7) Make access to child protection services easy, clear and secure. We will make sure that all those with responsibility for safeguarding children understand the Continuum of Need, how needs are assessed and the role of each professional in keeping children safe.
The Voice of the Child

During the forthcoming year we plan to build on our work to hear the voice of the child and ensure it informs the work of partner agencies at all levels. Here is a snapshot of our plans. We will:

- Develop standards of practice around the involvement of children and young people at case conference.
- Collate the views of children and young people involved in case conferences to improve their experience.
- Review and improve the recording mechanisms for case conferences, both paperwork and ICS.
- Review the role of the Independent Reviewing Officer (IRO) in relation to the involvement of children and young people in case conferences to ensure that there is a level of challenge.
- Ensure there are formal opportunities for young people to make their views known to decision makers.
- Children who are in receipt of home education have the opportunity to contribute and inform their education plans.
- Seek the views of children and young people as to whether they feel safe.
- Enable children to influence our strategies, plans and services.
- Enable actions and decisions to be informed by the voice of the child and their family.
9. Messages for our Stakeholders

**Children and Young People**
There are lots of professionals ready to listen to you. If you need help with something, please speak to someone you trust. This includes help with school work, help if you feel bullied and help if you feel sad or unsafe.

**Parents and Carers**
Families can encounter problems at any time. We want to work with you to find solutions to problems and we want to help you earlier before a small problem becomes crisis. If you need some help at an early stage please speak to a professional you have a good relationship with. This might be a health visitor or teaching assistant at school. They can signpost you to other services or might ask if they can undertake a ‘CAF’. This will help them identify the support you need.

**Elected Members**
Please examine our priorities and the role of the Council in furthering these. We have extensive evidence that this is the work we need to undertake. When making difficult budget decisions please consider our priorities.

**Police and Crime Commissioner**
We hope you enjoy our Annual Report and find it informative. When making your decisions on your own priorities, we ask that the Annual Reports of all Merseyside LSCBs inform your planning; and in particular that the issue of CSE remains high on your agenda. We would like to work more closely with you on this shared priority during the forthcoming year.

**Commissioners** - If you have control of a budget, this means you. Please consider how the voice of the child has informed your plans and when commissioning a particular service, consider how the provider will work to ensure that children are seen and heard within every day practice.

**Managers** – Please support your staff when they have attended training by finding out what they have learnt. You can come along too!

**Board Members**
When we say ‘this is a job for the LSCB’ this means you. You are the Board and it is only through the work of you and your agencies that we can get all of the work done. We have a great LSCB Team to co-ordinate the work and support us but it will take ‘all hands on deck’ to deliver on our priorities.

**Elected Members**
Please examine our priorities and the role of the Council in furthering these. We have extensive evidence that this is the work we need to undertake. When making difficult budget decisions please consider our priorities.

When scrutinising local authority activities and receiving reports from officers, we ask that you support our efforts to increase how the voice of the child is listened to and informs local decision making.

**Front Line Staff** – without you, we could not fulfil our objectives. We want to thank you for your work with children and families during the previous year and for engaging with our work so readily when we have asked for your help and views. If you are contacted in relation to a Serious Case Review or another review, please know that this is to help us learn and is not to catch you out or to tell you what you didn’t do.
We have identified a number of local and national factors that could have an impact on the ability of the LSCB to safeguard children and young people in St Helens. The Board is taking steps to reduce the impact of each risk or concern.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Effect of the risk</th>
<th>Action to be taken to reduce the impact of the risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geography/cross border issues</td>
<td>Duplication of efforts or gaps in intelligence and information in relation to CSE</td>
<td>Shared Merseyside CSE Strategic group</td>
</tr>
<tr>
<td></td>
<td>Duplication of efforts, missed opportunities for economies of scale and added value</td>
<td>Exploration &amp; development of joint commissioning arrangements where possible (eg. CSE and LSCB training)</td>
</tr>
<tr>
<td>Membership of LSCB</td>
<td>Potential for statutory Board members to not be able to carry out their responsibilities whilst they do not have membership on the main Board</td>
<td>Review membership in line with statutory guidance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audit the engagement in key safeguarding initiatives of; and challenge of and from, Health partners who are no longer members of the LSCB if they are to remain non-members</td>
</tr>
<tr>
<td>LSCB – Capacity of Support</td>
<td>Increased expectations upon LSCBs due to Ofsted Inspection Framework; and growing number of reports and guidance documents making recommendations for LSCBs</td>
<td>Assess support needs of the LSCB</td>
</tr>
<tr>
<td></td>
<td>Potential for skills and knowledge to be lost due to temporary nature of support posts</td>
<td>Agree and secure the long term funding needs of the LSCB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruit additional Quality Assurance post</td>
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<tr>
<td></td>
<td></td>
<td>Secure permanent staff within LSCB support posts</td>
</tr>
</tbody>
</table>
Education developments: Academies/Free Schools/LADO arrangements

Following changes to the relationship between individual schools and the Local Authority schools may find it more difficult to engage with the LSCB and understand their role in the multi-agency safeguarding agenda.

LSCB to build on support offered to schools, including academies and free schools by evaluating the S175 returns for trends and themes which can communicated to schools.

LSCB to receive reports from LADO that clearly disaggregates data re. the education sector.

LSCB to request that LA School Improvement Partners assist the Board in understanding safeguarding issues within schools; both generally and in specific schools.

Appendix 2

LSCB Budget Information

Contributions from Partner Agencies 2013-14

<table>
<thead>
<tr>
<th>Agency</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens Council</td>
<td>73,450</td>
</tr>
<tr>
<td>St Helens CCG</td>
<td>50,000</td>
</tr>
<tr>
<td>Whiston Hospital NHS Trust</td>
<td>5,100</td>
</tr>
<tr>
<td>5 Borough Partnership NHS Trust</td>
<td>5,225</td>
</tr>
<tr>
<td>Bridgewater NHS Trust</td>
<td>5,100</td>
</tr>
<tr>
<td>Merseyside Police</td>
<td>19,500</td>
</tr>
<tr>
<td>Merseyside Probation Service</td>
<td>2,225</td>
</tr>
<tr>
<td>NHS England</td>
<td>10,000</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>550</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>171,150</strong></td>
</tr>
</tbody>
</table>

Priority areas of expenditure 2014 – 15

- Training and Events
- LSCB Support posts and Chair
- Quality Assurance and co-ordination of the Learning and Improvement Framework
- LSCB Member Development
- Serious Case Reviews and other reviews
- Pan-Merseyside CDOP
## Membership of the Local Safeguarding Children Board (at end March 2014)

<table>
<thead>
<tr>
<th>By Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services – St Helens Council</td>
</tr>
<tr>
<td>Children and Young People’s Services – St Helens Council</td>
</tr>
<tr>
<td>CAFCASS</td>
</tr>
<tr>
<td>Merseyside Police</td>
</tr>
<tr>
<td>National Probation Service</td>
</tr>
<tr>
<td>Community Rehabilitation Company</td>
</tr>
<tr>
<td>5 Borough Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>Secondary Schools Representative</td>
</tr>
<tr>
<td>Primary Schools Representative</td>
</tr>
<tr>
<td>Whiston Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>St Helens &amp; Knowsley Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>NHS England</td>
</tr>
<tr>
<td>Legal Services – St Helens Council</td>
</tr>
<tr>
<td>Public Health – St Helens Council</td>
</tr>
<tr>
<td>St Helen’s Clinical Commissioning Group (CCG)</td>
</tr>
<tr>
<td>Independent/Other Persons</td>
</tr>
<tr>
<td>Independent Chair</td>
</tr>
<tr>
<td>3 x Independent Board Members</td>
</tr>
<tr>
<td>Lead Member for Children’s Services (Participating Observer)</td>
</tr>
</tbody>
</table>

**Appendix 3**
The Annual Report writing process

This year’s St Helens LSCB Annual Report was written by the Business Manager of Sefton LSCB who was also commissioned to write the Annual Report of Liverpool LSCB and tasked with writing the Sefton Annual Report as part of her substantive role. Each report is distinct and focuses on the progress and impact against the individual LSCB’s priorities; however, many of the areas of work are similar and this provided additional opportunities for shared learning. eg. What is working well elsewhere? The independent element of the report writing process enabled a fresh perspective and external challenge to be brought to the process. Additionally, the process enabled comparisons to be made across the three areas and the potential for future joint work is more easily highlighted.

The table below illustrates the areas each of the LSCBs would benefit from working more closely together and a plan to assist with this.

<table>
<thead>
<tr>
<th>AREA OF WORK</th>
<th>SHARED ACTIVITES</th>
<th>POTENTIAL BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluating the impact of LSCB training</td>
<td>Implement Kirkpatrick model of training evaluation across Sefton, St Helens and St Helens LSCBs with each LSCB Training Officer receiving and analysing the evaluation returns from another LSCB</td>
<td>Addition of independent oversight is brought to the evaluation process. Training evaluation is planned and prioritised more effectively</td>
</tr>
<tr>
<td>CSE Specialist Training</td>
<td>Commissioning CSE Specialist Training for practitioners involved in assessing or delivering interventions to victims or children at increased risk.</td>
<td>Potential for reduced cost due to increased numbers/spending power</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pool of skills developed across a broader footprint.</td>
</tr>
<tr>
<td>Learning and Improvement Framework</td>
<td>Each LSCB Learning and Improvement Framework is shared across the LSCB Chairs and Business Managers quarterly.</td>
<td>Practice and systems issues noted within agencies that serve more than one LSCB area are known by all relevant LSCBs. Activities to evidence improvement are not duplicated when more than one LSCB is required to monitor and evidence improvement. Shared training opportunities are highlighted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Problem solving and sharing good practice is enhanced.</td>
</tr>
<tr>
<td>SCR and other Reviews</td>
<td>Business Managers training in systems review methodology with commitment to undertake 1 review per year for another LSCB.</td>
<td>Significant spend across each LSCB on SCR and Review authors – savings would be generated. Delays in sourcing authors reduced. Local expertise developed (shortage nationally of trained authors)</td>
</tr>
</tbody>
</table>