Durham Local Safeguarding Children Board

Annual Report 2013/14
Safeguarding our Children in County Durham

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This report is available on the LSCB website
www.durham-lscb.org.uk

Section 1: Foreword by Independent Chair

Welcome to Durham LSCB's 2013/14 Annual Report. This is intended to give local people and staff an account of the Board's work over the past year and that of the partner agencies, to improve the safety and wellbeing of children and young people across County Durham.

The LSCB now includes more than 25 members from 17 different agencies; nine of whom contribute to funding the Board and the LSCB team. This helps deliver shared priorities and support new and ongoing work to safeguard children in many different settings.

Our vision continues to be that every child and young person in County Durham grows up safe from maltreatment, neglect and crime. We aim to sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting early help and support.

At the heart of our plan is a strong integrated approach to early intervention and prevention underpinned by the Children & Families Partnership's 'Think Family' Strategy. This is set in the context of the need to target resources in the most effective and efficient way. The Board has set the direction and commitment by agency partners to this vision which is evidenced in the breadth of work outlined in this report - closer links between adult and children's services, improved performance in some key areas and sustained funding, despite the financial and demand pressures on all partners.

In 2013/14 the LSCB has responded to major changes in Public Health, NHS, Durham Constabulary, Probation Service and Local Authority. Time has been made to learn more about each other's priorities and challenges and to further strengthen partnership working, which is central to our approach. This is reflected also by a balance between directive activity and strategic influencing of partner agencies. So this report reflects both the activity of the Board and its Sub-Groups as well as some of the major changes and improvements in the delivery of services which have been made in a way which is consistent with the Board's overall strategies.

The Board itself has focused attention on families where there is domestic abuse, parents who have mental health needs, alcohol or drug issues. Another key priority has been on building awareness and systems to tackle child sexual exploitation, in its many forms.

Durham LSCB has also embraced the Government's emphasis on alternative methods of investigating serious incidents. The emphasis has been on sharing and embedding learning through the LSCB's well developed multi and single-agency training programme.

In this, my final report before standing down as Chair, I would like to thank the LSCB team for their very effective working and sustained commitment through recent changes. We also say goodbye to Bill Worth, our Lay Member, who sadly had to retire, but who has made an important contribution to the work of the Board.

I would also like to thank and recognise the contributions of the LSCB Sub-Group Chairs and members who play a huge role in delivering the Board's priorities and in supporting and challenging agency practice.

Fran Gosling-Thomas
Independent Chair

Section 2: Executive Summary

The purpose of this annual report is to evaluate and report on the effectiveness of safeguarding arrangements for children and young people in County Durham and the contribution made by Durham LSCB, partner agencies and services in the County to improve the quality of services for vulnerable children.

The report also recognises the achievements and the progress that has been made in the last year as well as providing a realistic assessment of the challenges that still remain. It sets out how the Board's work is being developed and strengthened in 2014/15 and beyond to address these challenges.

This year's report also builds on learning from national research[1] including guidance on what makes a 'powerful' annual report and the 'Facets of an Effective LSCB'. It is intended to address three fundamental questions:

1. What did we do?
2. How well did we do it?
3. What difference did we make to improve outcomes for children, young people and families?

It is drawn from a wide range of sources from across the Children and Families Partnership and reflects the County's ongoing 'improvement journey' following the Ofsted Inspection in early 2012 that rated services as 'outstanding'. Embedding and sustaining best practice at the frontline 24/7 and 365 days each year, across the agencies, presents considerable ongoing challenge and commitment, particularly, in the current financial and organisational context. This requires a high degree of multi-agency collaboration at every level.

The report demonstrates the extent to which the functions of the LSCB as set out in 'Working Together' are being effectively discharged. In particular we focus on the priorities we agreed as a board:

Child Sexual Exploitation - our report describes a comprehensive strategy to address this highly charged and distressing issue. This includes the provision of a series of multi-agency events across the county training over 500 staff on the issues and new procedures. The LSCB has taken a lead role in relation to work on sexual exploitation and child trafficking and feedback from frontline staff across statutory and voluntary sector partners has confirmed the importance of this work.

Information Sharing - we highlight developments in our protocols compliance with which will ensure that agencies work together in the best interests of children.

[1] National Association of Independent LSCB Chairs

Early Help and Think Family – we describe major changes in the strategy and delivery of services in this county which take the recommendations of the Munro report and subsequent versions of Working Together to their logical conclusion. We expect that in time, these changes will lead to reductions in the number of children who are Looked After and an increase in the number of children and families whose needs are met through early help.

Parental Mental Health and Hidden Harm (primarily substances, but also recognising the effects of alcohol and links with domestic abuse) - we describe how we now have embedded these themes into all aspects of training and planning.

Policy Review - changes include introducing a Single Assessment process and the Assessment Intervention and Moving On (AIM) tool which relate to children and young people who sexually harm other young people. The impact of these developments are reported to the LSCB and will be outlined in our 2014-15 Annual Report.

Training - training remains a high priority and there is now a closer focus on the 'impact' of training for both children and for partner agencies. We describe the scope and reach of our training programme and the way that it supports our priorities and forms a coherent whole with that provided by partner agencies.

Performance and Audit - testing the quality of frontline services has had a high profile over the last year with an expansion of the Quality and Performance Framework to ensure a more coherent approach to quality. A number of thematic audits have taken place in areas identified by the Board as requiring further examination. This has included quality audits of children subject to more than one Child Protection Plan and scrutiny of compliance with Child Sexual Exploitation processes. Single-agency practice audits have also been completed to ensure the Board is informed of the learning from these and issues requiring further attention; for example an audit of cases deemed as requiring 'No Further Action' at the point of referral to children's services; GP's response to referrals of injuries to pre-mobile children; and the conduct of Core Groups following the outcome of an Initial Child Protection Conference.

We describe how we monitor the safety of children in a number of settings including secure establishments and plans to monitor the use of restraining techniques with young people by the Police.

Performance is a focus for us in terms of key performance indicators. One that we closely watch is the timeliness and robustness of Child Protection Plan reviews. In 2013/14 we saw a significant improvement in timescales from 92.4% last year to 95.6% of reviews being completed within target.

Another indicator which we focus on is the number of children being relisted onto a Child Protection Plan for a second or more time. During 2013-14, despite the number on Child Protection Plans increasing there has been a 2% reduction in second time on a plan.

Child Death Reviews – we summarise the scale of the problem and identify the difficulties encountered in conducting these in a timely way. However we also highlight learning points which we hope may help reduce the number of modifiable factors in the future.

Stronger Families and Youth Justice – we highlight the excellent performance on these themes which is consistent with our strategy and complimentary to the work of the wider partnership.

Ways of working

Engagement of GPs in Child Protection Conferences has improved significantly and in some localities practitioners were able to achieve very good levels of attendance. Almost all agencies improved their performance in providing reports to Review Child Protection Conferences.

Engaging children and young people about safeguarding matters and their own care has remained a key priority during the year. This has included specific meetings between Board members and groups of children and young people supported by Investing In Children. Significant improvements continue to be made in obtaining the views of young people as part of the assessment and review conference process. There is scope for further work to be done in this area in the next year.

Wider Community - the LSCB has also supported the raising of awareness and promotion of safeguarding standards in the voluntary, community and faith sectors through sponsorship of the local 'Never Say Nothing' campaign jointly with Community and Voluntary Organisations Service (CAVOS) and VCCS.

The Future - embedding service change on Early Help, closer working with adult services and recruiting a new Chair are all priorities for the year ahead.

As the Durham Children and Families Partnership strategy states

"In an era of decreasing resource services must be offered first to those who need them, when they need them. To an extent universal services have already started to target needy populations, and children's centres are increasingly required to target individuals more than they have in previous years.

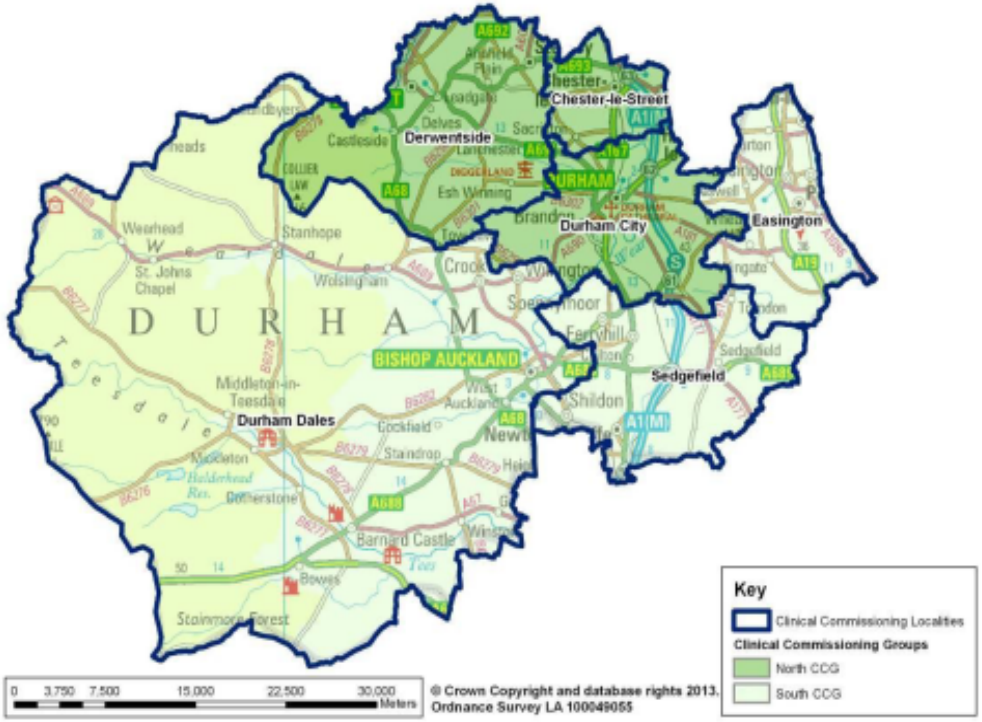
The focus in Durham has been on battling with the symptoms of high need and risk rather than tackling cause at an earlier stage. In an era of decreasing resources we need to ensure that we target what we have at the families who need it most in the most effective and efficient ways."

Section 3: The Local Context

3.1 Our Community

In 2011, there were an estimated 513,000 people in the County (251,000 males and 262,000 females), of which 96% were from a white background. In 1991 only 0.6% of the population in the county were recorded as having a non-white ethnic background, which increased to just over 1% in 2001 and then to 1.8% in 2011. The main concentrations of people from non-white ethnic backgrounds appear to be from the Durham City area, in particular the student population. The adult population is ageing. However, trends in the birth rate indicate that there will be many more children in the County in the future, with perhaps as many as 8,600 additional births by 2031 when compared to current projections.

The county “stretches from the remote rural North Pennine area of outstanding natural beauty in the West to the more densely populated Easington heritage coastline. Commonly regarded as a predominantly rural area, the county varies in character from remote and sparsely populated areas in the west to former coalfield communities in the centre and east, where villages tend to accommodate thousands rather than hundreds of people”



3.2 Our Local Challenges

Services in County Durham face similar challenges to those elsewhere in the UK, but a significant key feature, is the scale of the challenge relating to alcohol and rate of teenage conceptions. An estimated 5% of the population in County Durham are believed to be dependent on alcohol, with a further 20% drinking at increasing risk levels:

- Alcohol specific admission rates for under 18's are higher than the regional rate with County Durham ranked 12th worst out of 326 Local Authorities.
- In 2012/13 alcohol was seized from 785 children across County Durham.

Teenage conception rates are 43.2 per 1,000 population of 15-17 year olds, which is higher than the national average (Source: Joint Strategic Needs Assessment 2012 and Public Health performance data). Updated needs checking with JNSA team

The main parental risk factor leading to a child being made subject to a child protection plan is domestic abuse (see below). In County Durham the Levels of domestic abuse related incidents reported to the police have seen a continuous but small increase over recent years, with 10,425 in 2010/11, 10,865 in 2011/12, 11,084 in 2012/13 and 11,550 in 2013/14. In 2012, the Victims' Services Advocate was commissioned by the Victims' Commissioner to look at which services are available and what victims need from local services. The report found that within County Durham, victims of domestic abuse felt that they were not always taken seriously, especially if there were no signs of physical abuse. The first response was also considered to be the most important in terms of influencing outcomes relating to engagement with criminal justice processes, referrals for holistic needs assessment and subsequent development of appropriate pathways of support including support for children and young people.

The LSCB takes these factors into account in its work to support the needs for services to support children, young people and their families. For example in its delivery of the annual training programme which focuses not just on awareness raising but improving understanding of the impact of risk factors, equipping practitioners with knowledge and skills to undertake effective risk assessments; leading development work to ensure practitioners and managers are clear about referral pathways and key points of contact; and the development of new and existing procedures.

3.3 Our Children

Our approach is to ensure that each child is considered as the unique individual that they are, and no child is therefore reduced to a statistic. However, in planning, resourcing, designing and managing our work there are some key facts that are of importance to us:

- **The number of cases classified as Children in Need**

3,038 - this is a significant reduction from 3,970 last year

- **Children being cared for in the Looked After system**
  611 – a continued and significant reduction since April 2012

  The numbers of children Looked After has been reducing over recent years and continues on a downward trajectory. When children become Looked After there are significant challenges in providing them with placement stability and improved outcomes and in equipping for life beyond care. We know that by understanding the reasons children become Looked After enables agencies to target better their early help and family support services. Reduction in the number of children Looked After is a good indicator of the impact of our early help strategy.

- **Children on a Child Protection plan**
  455 – a significant increase from 409 last year (this represented a rate of 45 per 10,000 children and young people).

  Although higher than the national rate of 42, it was significantly lower rate than that for the North East which was 59 and its statistical neighbours, which was 54.8.

- **Reasons for Child Protection Plans**

  1. The most frequent reason for children being place on a child protection plan was **Neglect** (63.1%)

  2. The second most significant reason for child protection plans was for **Physical Abuse** (20.1%)

  In response, the LSCB developed a comprehensive strategy to respond to the issues of neglect and its impact on children and young people's wellbeing and outcomes. This has resulted in the provision of specialist training, assessment tools and new procedures for multi-agency practitioners to enable them to better support children identified as at risk or subject to neglect by their parent/carers. Specialist training continues to form a significant part of the LSCB's training programme. In 2014-15 this will be further developed so that the training offered focusses more on child development and the long term impact on children of neglect, learning from recent research, improved national guidance and lessons from Serious Case Reviews. As a Board we also recognise the need to better understand the links between the impact of our training on children's outcomes.

- **Parental Risk Factors**
  Domestic abuse is the main parental risk factor leading to children becoming subject of a Child Protection Plan - for 45% of child protection conferences. Second to this is problems linked to parental mental health and alcohol misuse, accounting for 25% and 24% respectively. Substance misuse accounts for 19%. In 2011/12, domestic abuse was identified as a priority for the LSCB and is now embedded into the Board's core activities. This year's domestic abuse figure represents a significant reduction on the previous year which was 59%. Specialist training continues to be provided for multi-agency practitioners and includes awareness raising sessions as well as more in-depth specialist sessions presented by specialist workers.

- **How old are these children?**

2013-14

Age	Total	%
Unborn	16	3.5
< 1	57	12.5
1 to 4	132	29.0
5 to 9	125	27.5
10 to 15	119	26.2
16 to 17	6	1.3
TOTAL	**455**	**100.0**

As shown in the table above 45 % of children who were made subject of a Child Protection Plan were under five years old, indicating how vulnerable this age group is and indicating the importance of the Early Help strategy in engaging with families as early as possible before things escalate.

The LSCB has for a number of years supported the voluntary and community sector thorough the provision of targeted safeguarding training to Early Year's providers which has led to better identification of vulnerable families and children at risk. We have also incorporated into our training the learning from serious Case and Learning Lessons Reviews so that practitioners and managers can improve their understanding and assessment skills.

Section 4: What is an LSCB and how does is work in County Durham?

Each local area is required by Law to have an LSCB. The LSCB is a statutory body established in legislation (Section 13 of the Children Act 2004) and works according to national guidance, the most significant being the latest version of "Working Together" .

Our primary responsibility is to provide a way for the local organisations that have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children in the locality, and to ensure that they will do so effectively.

The functions of the LSCB are:

- **To develop policies and procedures** for safeguarding and promoting the welfare of children in the area. These could include:
  - the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
  - training of persons who work with children or in services affecting the safety and welfare of children;
  - the recruitment and supervision of persons who work with children;
  - the investigation of allegations concerning persons who work with children;
  - the safety and welfare of children who are privately fostered;
  - having clear strategy in place for tackling Child Sexual Exploitation;
  - co-operating with neighbouring children's services authorities and their Board partners.

- **To raise awareness of both the need to safeguard and promote the welfare of children and action to so do.**

- **To monitor and evaluate the effectiveness** of what is done by the local authority and their Board partners individually and collectively to safeguard and promote the welfare of children **and advise them on ways to improve.**

- **To participate in the planning of services for children in the area of the authority.**

- **To undertake reviews of serious cases and advising the authority and their Board partners on lessons to be learned.**

The LSCBs does not commission or deliver direct frontline services and does not have the power to direct other organisations, which retain their own existing lines of accountability for safeguarding. However, the LSCB does have a role in making it clear where improvement is needed and in providing challenge.

To discharge this role, the LSCB uses data to:

- Assess the effectiveness of the help being provided to children and families, including early help;
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned;
- Monitor and evaluate the effectiveness of training, including multi-agency training.

4.1 Membership and governance

The LCSB is a partnership of local agencies and in Durham there is a longstanding and high commitment amongst them to share responsibility and accountability for the arrangements to protect and safeguard children from harm. A list of members is attached at Appendix 2.

Durham LSCB has a robust Governance and Memorandum of Understanding in place that is reflective of the new NHS landscape. It forms the formal agreement between the Board and all partner agencies. It outlines the accountability arrangements; key purposes; functions and tasks of the LSCB; membership; and agreed standards and expectations of LSCB services. The document sets out the arrangements for the LSCB to link with key strategic groups; such as the Children & Families Partnership and the Health & Wellbeing Board. This document is kept under review.

In line with national requirements, the Board continues to be chaired by an independent person, an arrangement that has been in place since 2011. The Chair has a crucial role in making certain that the Board operates independently and secures an independent voice for the LSCB. The postholder is due to stand down in August 2014 and a replacement will be secured in September. The Vice Chair has operated in the role of chair until the new chair commenced in post.

4.2 Ways of working

Agreeing priorities

The LSCB held its annual development day on 21st June 2013. Whilst the role of the Board as set out above is prescribed in statute, the development day was an opportunity for this Board to consider how best to conduct itself in the context of local issues and concerns. It is also the process for which our primary objectives are agreed for the year ahead in the context of the local issues. These are set out in Section 3. In addition, the Board takes into account a range of performance and quality assurance activity; including analysis of child protection statistics, audits, case reviews, national development and guidance and taking into account the views of children and young people to inform the business development.

Meetings

The main Board is made up of the strategic leaders of the local agencies. This is where priorities are agreed and agencies hold each other to account. Durham LSCB meets every two months. Attendance is monitored and reported annually to the Board as part of the Board's review of the governance and effectiveness arrangements. Throughout 2013/14 the Board has been well supported by partner agencies despite budget cuts which place pressure on capacity.

Research

Durham LSCB is also kept up to date with national research and guidance through regular reports which summarise national and regional implications. The local implications for the LSCB are considered and progressed through business planning and the work of sub-groups for example the work undertaken by the Missing and Exploited (MEG) sub-group to strengthen local policies and processes in relation to Child Sexual Exploitation; the adjustments made to the content of training in relation to neglect by the Training sub-group; and work undertaken by the Serious Case Review Monitoring group to consider the relevance of findings from Serious Case Reviews published nationally and regionally.

4.2.1 Sub and Other Groups

LSCB has in place a well-established number of standing sub-groups, each of which have clear terms of reference for taking forward the priorities of the Board. The current groups can be seen in the diagram in Appendix1, and are listed below:

Policies and Procedures - reviews and develops the local multi-agency safeguarding procedures to ensure they are current, up to date and address issues that have been identified through Serious Case Reviews, Learning Lessons Reviews and complaints as well as national and regional guidance.

Training - delivery of multi-agency training and monitoring of quality and consistency of that provided by agencies.

Performance Management - oversees the quality and standards of safeguarding practice across the partnership to ensure that the LSCB fulfils its statutory function under Regulation 5 of The Local Safeguarding Children Boards Regulations (2006).

Routinely, the Durham Performance Management Group receives reports which provide information and analysis of the effectiveness of the multi-agency child protection procedures relating to the operation of child protection conference and review arrangements. Agencies are challenged to improve performance through a number of recommendations which are monitored at each meeting and where necessary further scrutiny is provided through the LSCB audit programme which is detailed in the LSCB Quality and Performance Framework.

Three Performance Management Locality Groups - each locality group has membership across the LSCB partnership and has a shared work plan, overseen by the main Performance group to deliver the Board's priorities and to address practice and standards issues identified at a locality/practitioner level. The areas covered are: Durham City and north of the county; East of the County and South and west of County.

Missing and Exploited Sub-Group (MEG) – focusses on monitoring activity and improving services to tackle child sexual exploitation and missing children and is supported by an Operational Group to manage cases.

Serious Case Review Monitoring Sub-Group – considers serious incidents, commissions reviews, oversees and monitors progress on agreed actions for specific local cases. Also monitors issues arising from cases across the country with a view to improving practice in the County. Meets as the Serious Case Review Sub-Committee to consider whether cases meet the criteria for a Serious Case Review or other form of review.

Child Death Overview Panel (CDOP) - is a sub-committee of both Durham and Darlington LSCBs. It is responsible for reviewing the available information on all child deaths and is accountable to the LSCB Chair.

Each sub-group provides regular progress reports to the Board and is required to produce an annual report setting out progress on agreed actions. From time to time, time-limited task groups are set up to take forward specific pieces of development work, for example parental mental health and child sexual exploitation.

Activities and achievements of the Board and its constituent groups are covered in Section 6.

4.3 Linkages across other partnerships and services

The LCSB aims to ensure that safeguarding and the welfare of children is central to all aspects of public and voluntary sector activity. The County Durham Partnership has a number of sub-groups: The Children and Families Partnership, the Health and Wellbeing Board, the Economic Partnership, the Safe Durham Partnership and the Environment Partnership. A number of subgroups also have work in common with the LSCB, such as the Domestic Abuse Forum Executive Group, Multi-Agency Risk Assessment Conferences and Multi-Agency Public Protection Arrangements and the Sexual Violence Group.

Through their membership of these partnerships, LSCB members have the opportunity to ensure that safeguarding issues are represented in the most efficient way across the broad agenda; they cascade learning to their respective agencies; and bring experience and evidence to the sub-groups to ensure the Board is aware of key challenges and achievements in keeping children safe.

The LSCB is also represented at practitioner groups such as the Think Family Operational Group and Alcohol Harm Reduction and Intelligence Groups so that the work of the Board informs and influences the work of these groups and that the Board in turn also take account of what these groups are also working on.

The key linkage between adult and children's services are strong strategically and operationally – through the Think Family approach. The Board intends to strengthen this further, when it recruits its next Chair. This will be done in tandem with the recruitment for the Chair the Local Safeguarding Adults Board. It is the intention that a single individual will hold both posts.

4.4 Equality and Diversity

The LSCB strives to promote equal access to safeguarding services, particularly for those children who are unable to communicate with those who are able to protect them, arising from their age, disability or first language. Durham's population is primarily white ethnic with just over 1% in 2011 being from a non-white background. All policies and procedures of the LSCB are subject to an equality impact assessment to ensure that new policies and procedures do not discriminate on any basis. The implications for equality and diversity are routinely discussed at Board and Sub-Group meetings.

Specifically in relation to sexual exploitation, the LSCB is proactive in the audit of sexual exploitation cases and domestic abuse cases to ensure that there is no evidence of discrimination given the under-representation of male victims.

Equality and diversity, challenging discrimination and values underpins the delivery of all LSCB training. LSCB training considers a broad range of issues such as parental mental illness, parental learning disability, substance misuse and children who are deaf or disabled. It also recognises the impact of social disadvantage such as poverty, poor housing and worklessness.

Durham LSCB also strives to ensure that its courses are open and accessible to all and create an environment where participants feel able to challenge and be challenged in a safe and constructive way.

The LSCB has a complaints review system in place, which has recently been revised and designed to ensure that where there is concern raised by parents and carers and young people, they will be treated with respect, are not discriminated against, are listened to and their views taken into account..

4.5 Involving Young People

The LSCB has continued to actively better engage with and seek the views of children and young people on wider safeguarding issues. During the year the LSCB worked collaboratively with 'Investing in Children' to set up a Young People's Reference Group for the LSCB. The group has met with members of the LSCB on a number of occasions. Their views have been taken into account in the LSCB work plan to deliver priorities which include parental mental health and child sexual exploitation.

4.6 Working with other LSCBs

Durham LSCB works collaboratively with other LSCBs in the North East so as to share learning and agree safeguarding policies and procedures which impact on children and families; for example cross border issues, child deaths and Serious Case Reviews. The LSCB Business Manager led on one of the regional priorities during the year which led to the very successful conference on Early Help, attended by over 100 delegates. The conference was supported by the regional Association of Directors of Children's Services Improvement Grant from the DfE. Delegates had the opportunity to hear about innovative practice and developments in the region and used the occasion to network with others working on similar projects. There is invaluable work across the region to share good practice and developments in relation to training, policies and procedures and to share the learning from Serious Case Reviews. Over 2014-15 regional priorities will focus on key issues of child sexual exploitation and neglect.

4.7 Board Improvement and Development

The Board recognises that it is on a constant journey of change and that to be effective it needs to continuously learn from its own experiences and that of others. As part of that journey it has used development tools such as “Facets of an effective LSCB” which supported the Board in identifying which areas it needed to work on to improve effectiveness. The outcome of the self-assessment was included in last year’s annual report. These included:

- Revision of the LSCB Top 10 performance indicators and the implementation of a new dataset to better reflect priorities;
- Appointment of at least two lay members;
- Strengthening the scrutiny/challenge role and developing a framework for evidencing impact and difference;
- Strengthening of the engagement and participation of children and young people in the work of the Board;
- Clarifying the Board’s relationship with other partnership forums;
- Visibility and influence of the Board;
- Strengthening the engagement and participation of frontline staff including involvement in audit work;
- Readiness for regulatory inspection/review.

The majority of these issues have been incorporated into the Board’s Business Plan for 2014-15.

It is anticipated that the Board will undertake a range of further steps to develop its practice and values in order to be the most effective it can be. Board development days are planned for 2014/15 which will address:

1. Clarity of our business objectives going forward
2. Greater alignment of LSCB operations and business against our objectives
3. Expected impact of the LSCB to safeguard our most vulnerable - keeping the child’s journey at the forefront of what we do and better evidencing difference and impact.

Section 5: Priorities and Measures of Success

The priorities are driven by an overall strategic approach which has been outlined in the Chair's introduction to this report. This is that County Durham has three distinct policy drivers (a) reducing harm at the earliest possible point – early help, (b) considering the child's needs from the basis of those of the whole family - "Think Family", and (c) focusing scarce resources on those at greatest risk. There are potential tensions between these drivers, particularly when resources are limited, but the Board aims to address these through an intelligent, pragmatic and collaborative approach to its work.

5.1 The Priorities of the LSCB

In July 2013 the Board agreed that there were two main strategic priorities:

1. **Early help, think family approach - taking into account and implementing the Child Centred system – Munro recommendations**
2. **Information sharing**

The Board also agreed to continue its core day to day activities in driving forward action on other key areas drawn from previous years' agreed priorities such as:

- **Sexual Exploitation**
- **Mental Health – impact on parenting**
- **Hidden Harm – primarily substances but also recognising the effects of alcohol and links with domestic abuse**

These priorities have driven both specific activities and have underpinned the way that roles such as policy review and training have been delivered. These priorities correspond to and are consistent with those of individual agencies and other strategic partnerships in Durham. For example one of the priorities for the Health and Wellbeing Board (HWBB) is to "Protect Vulnerable People from Harm". This relates to adults and children and ensures the HWBB is sighted on safeguarding issues and is strategically linked to the LSCB. Additionally the restructuring and redesign of the children's services and high performing Stronger Families programme and Youth Offending Services ensures a stronger focus on early help. These have direct and indirect implications for the safeguarding and welfare of children and young people.

A summary of achievements in these priority areas is included in the next section.

5.2 Performance Framework and Monitoring

The LSCB receives regular reports of performance on all aspects of its business. They cover a wider range of issues including the functioning of the LSCB, the effectiveness of governance arrangements, challenge and improvement/self-evaluation, the well-established Section 11 audit, learning from thematic reviews including Serious Case Reviews and other performance monitoring activity linked to the LSCB priorities. The framework the Board uses has been updated and refined on a regular basis and is now subject to a major review. It will continue to have a focus on themed audits but a stronger emphasis on multi-agency case audits. A number of themed audits have been undertaken in 2013/14 and outlined earlier in the section above and later in this report.

Section 6: What we achieved in 2013/14

6.1 Achievements on our priority themes

Priority 1: Information sharing

The LSCB worked with a range of partners to developed an information sharing protocol called “Collaborative working and information sharing between professionals to protect vulnerable adults and children” which has been approved by both the LSCB and the Safeguarding Adults Board and endorsed through single agency governance arrangements.

The protocol captures the existing guidance on information sharing and signposts professionals that their safeguarding responsibilities carry with it an expectation that information sharing is the norm. It has been recently reviewed and revised in order to ensure that it is complaint with the latest version of “Working Together”. The main emphasis is to ensure information is shared to enable children to be better safeguarded and families offered help early enough. In 2013/14 the government updated and re-issued the 2008 information sharing guidance emphasising that;

“Practitioners recognise the importance of information sharing and there is already much good practice. However, in some situations they feel constrained from sharing information by uncertainty about when they can do so lawfully, especially in early intervention and preventative work where information sharing decisions may be less clear than in safeguarding or child protection situations”.

(Information Sharing Guidance for practitioners and managers DFE 2008)

The Durham protocol is supported by a guidance document for professionals, which is made available as part of LSCB training.

Plans are in place during 2015 to audit the impact of the work on information sharing.

Priority 2: Early Help /Think Family and the Child Centred System

“*Preventative Services can do more to reduce abuse and neglect than reactive services.”*

Munro 2011

The LSCB’s Early Help action plan was developed in response to Munro to enable the LSCB to challenge partners as to what changes they are making to the way they deliver services to children and families to make them more child centred, more responsive and available at a much earlier point to prevent problems escalating.

Partners have responded to the challenge to develop strategies and shape and deliver services in a number of new ways. These include: (i) The Children and Families Partnership has developed an Early Help Strategy, endorsed by the LSCB (ii) a strong continuum of needs framework and (iii) the local authority re-design of children’s services.

(i) Early Help Strategy

Durham's three ambitions for Early Help are to ensure that;

1. Early Help is everyone's business
2. Support will be seamless for families
3. Help will be offered that is known to work.

Within the strategy there is acknowledgement that there has been a longstanding commitment to the Think Family concept within County Durham and this clearly continues to underpin the Early Help Strategy's ambitions. Durham has made significant progress over recent years to build the foundations for providing early help to families through the development of the One Point Service, the Family Pathfinder Service, the continued investment in the Family Intervention Project, initiatives within Children's Care services including Family Group Conferencing and the Pre-Birth Intervention Service. More recently the ambitions of the Think Family Programme and the Stronger Families programme has aimed to transform a range of services to think more holistically about the needs of families at the earliest opportunity.

(ii) The Durham Continuum of Needs Model

The Early Help strategy is underpinned by the local continuum of need framework which sets out clearly the agreed local understanding of levels of need.

It is an integrated services pathway model designed to reflect the fact that children and young people's needs and those of their families exist along a continuum. The model recognises that needs may change over time and is based on the principle that children and young people's welfare and safety is a shared responsibility and should be a seamless positive journey. Regardless of which 'step' children, young people and families are identified on they will be supported at the earliest opportunity and continue to be supported by the relevant services as they move up and down the staircase. (see Figure A below):

The strategy covers three years. If implementation is successful improved outcomes are anticipated for children and families. In terms of safeguarding arrangements these include:

- More families to have received help at an earlier point and be empowered to take control of their own lives, avoiding the need for statutory intervention.
- Reduction in the number of Children In Need and children subject to a Child Protection Plan
- Reduction in the number of children Looked After by the Local Authority
- Reduction in the percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time.
- Increase in the number of assessments completed by a range of partners at levels 2 and 3
- Increase in numbers of assessments at the point of referral to Children's Care

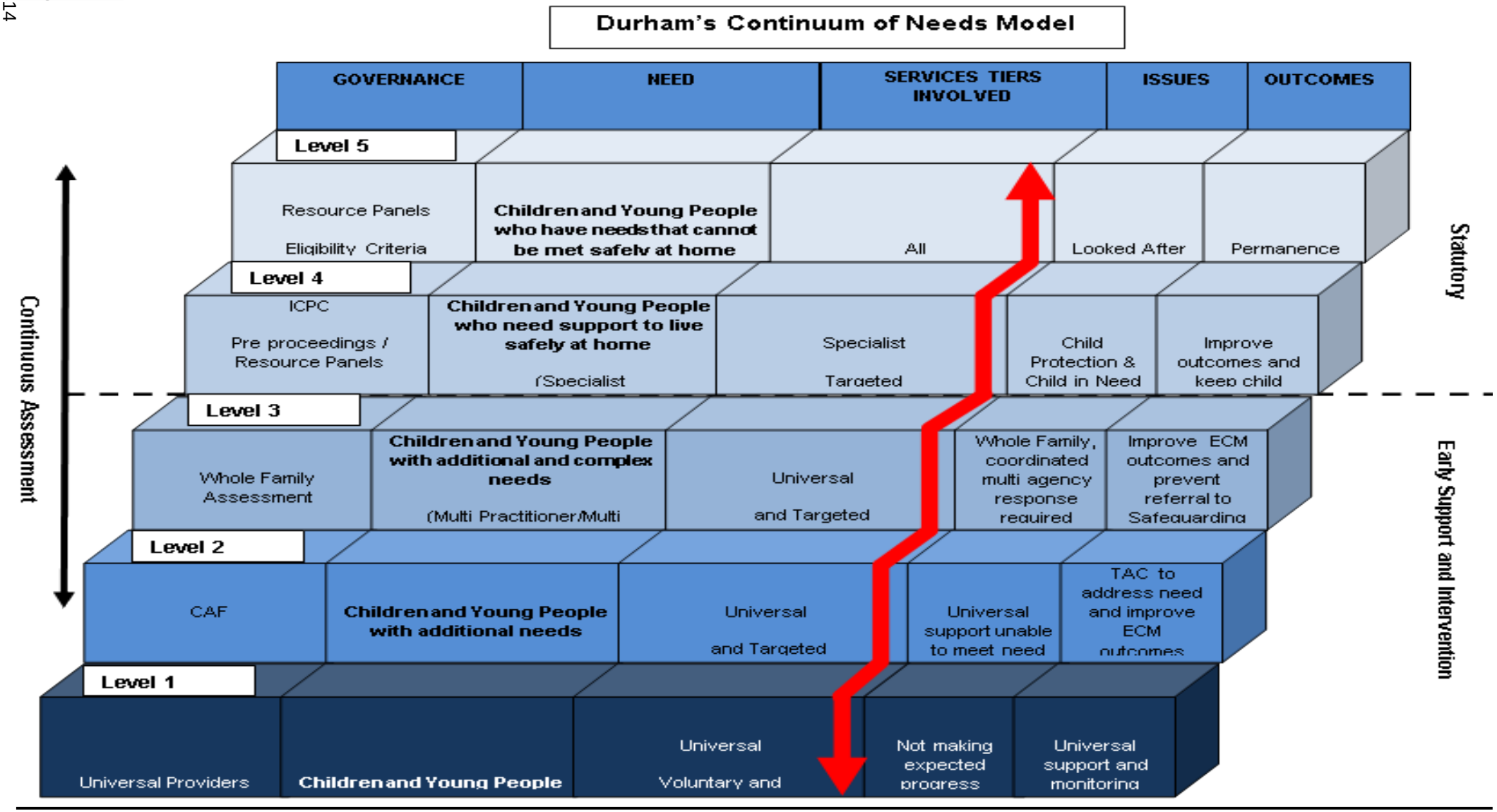
(iii) Service redesign

Delivery of early help and "Think family" rests firmly on recent radical redesign and restructure of Children's Services. There is now one Head of Service responsible for the whole spectrum of Children's Services – early help and intervention through to child protection and adoption. The objectives are to ensure a seamless approach to addressing the needs of children: targeting services at the most vulnerable children and families through early help, ensuring the Think Family approach is embedded and

maximising the opportunity for teams around the family to work collectively at whatever level of need is presented.

A vital part of this new structure is the creation of a single point of contact (First Contact) for all concerns about a child, co-located with the Police Central Referral Unit. New Single Assessment Procedures and Practice Guidance will be launched in April 2014. These multi-agency procedures combined the former CAF and Initial/Core Assessment process into a single, flexible assessment that is designed to address early help interventions and where these are unsuccessful, be capable of being developed into a detailed social work assessment for children in need and in need of protection. The aims of this transformation are to ensure more effective screening of cases referred into children's social care and One Point and; to ensure that services are delivered in a planned, case managed way via teams around the family across the spectrum of need.

Figure A


Durham's Continuum of Needs Model
GOVERNANCE
NEED
SERVICES TIERS INVOLVED
ISSUES
OUTCOMES
Level 5
Resource Panels
Eligibility Criteria
Children and Young People who have needs that cannot be met safely at home
All
Looked After
Permanence
Level 4
ICPC
Pre proceedings / Resource Panels
Children and Young People who need support to live safely at home
(Specialist
Specialist
Targeted
Child Protection & Child in Need
Improve outcomes and keep child
Level 3
Whole Family Assessment
Children and Young People with additional and complex needs
(Multi Practitioner/Multi
Universal
and Targeted
Whole Family, coordinated multi agency response required
Improve ECM outcomes and prevent referral to Safeguarding
Level 2
CAF
Children and Young People with additional needs
Universal
and Targeted
Universal support unable to meet need
TAC to address need and improve ECM outcomes
Level 1
Universal Providers
Children and Young People
Universal
Voluntary and
Not making expected progress
Universal support and monitoring
Continuous Assessment
Statutory
Early Support and Intervention

Child Sexual Exploitation (CSE)

This major priority is the focus of the work the Missing and Exploited Sub-Group (MEG). The scale of the issue and the work undertaken is set out below:

What is the extent of the problem in County Durham?

Multi-agency analysis undertaken by Durham Constabulary has confirmed that CSE is linked to children risk taking behaviours such as going missing, use of alcohol, use of social media and inappropriate relationships. The offender profile tended to be one of "street grooming" and use of social media to exploit children.

Prior to June 2012 there was limited opportunity to monitor the incidence of CSE. LSCB Child Protection Procedures now measure referrals of the potential risk to children of CSE rather than actual exploitation.

Between April 2013 and March 2014, 162 children presented with risk indicators. This is monitored by the Missing and Exploited Group (MEG) During 2013/14 there were 532 missing children reports; going missing is a significant vulnerability factor for CSE. Performance is monitored by the Missing and Exploited Group.

What have we done about it?

- Ongoing analysis of CSE vulnerability factors through police analysis and the Missing and Exploited Group Performance Framework to identify emerging risks
- Recruitment of a Barnardos outreach worker for CSE
- Missing and Exploited Group use of a self-assessment tool to examine the Durham position following Ofsted and national publications around CSE and missing children
- Production of tactical toolkit and criminality notices for use in tackling suspected offenders in CSE and missing incidents
- Refresh of the CSE risk assessment matrix to capture emerging risks from local and national research
- Audit of cases to examine practice through the LSCB Child Protection Procedures – regular dip sampling and one off major exercises.
- Refresh of the CSE procedures recognising CSE audit findings and practice around cross border and local partnership engagement
- Developed IT process for CSE coding on Police and Children's Care systems to aid identification and analysis
- Durham LSCB representation on the National CSE Strategic Co-ordinators Group (NWA)
- Marketing of work in Durham through use of the ERASE brand and production of leaflets/posters added to websites
- LSCB guidance on conditions to be attached to alcohol licences
- Delivered LSCB and single-agency training on CSE
- Provided bespoke training to NHS, One Point staff and education staff linked to behaviour and school exclusion
- CSE resources for use in schools added to Durham County Council's Schools Extranet for delivery in SRE curriculum
- Progress local work on CSE in line with the ACPO police national action plan recommendations
- Strengthened the emphasis on the role that schools and Education Welfare Officers have to play in identifying early, children who are missing from education and setting out clearly the central role the police play in taking responsibility for coordinating information about children who are missing
- Development of a CSE disruption toolkit

What difference have we made?

- Improved training of professionals about CSE and expected practice
- Audit of practice and procedural compliance has led to improvements and in particular increase in number of return interviews with missing children and young people
- Regular analysis of CSE profile in County Durham has identified trends/emerging risks which has been used to inform training and practice
- Analysis of national findings to inform local practice
- Reduced the risks to young people by monitoring their circumstances closely

What are the next steps?

- Development of a new CSE strategy
- Further LSCB audits for both CSE and missing children incidents to assess child protection practice and improve outcomes for children who go missing
- Audit of responses for named suspects
- Development of a CSE toolkit of consistent resources to be used by schools and youth settings across the County
- Further develop prevention and awareness advice on CSE to children, parents and carers
- Developing regional collaboration opportunities
- Develop a CSE marketing strategy

Mental Health- impact on parenting

The LSCB has undertaken extensive process design in recent years to ensure that this key risk factor is addressed in the work of the Board and across the partnership. The work in now fully embedded in the ways of working and partner service delivery. Parental mental health has consistently featured highly in Child Protection Plans. For the period April 2013 to March 2014 parental mental health featured in 28.3% of all Child Protection Plans with parents exhibiting these risks, often also experiencing drug, alcohol and domestic abuse problems. Within the LSCB core training programme mental health is a key theme for training and development of staff. Last year specific work was undertaken to strengthen practitioner's awareness of services to support adults suffering from mental health issues and key points of contact identified and shared with them. The LSCB also monitors the contribution mental health services makes to the Child Protection Conference process which has led to greater involvement in child protection planning processes.

Hidden Harm

Substance misuse, alcohol (and domestic abuse) are known as the '**Toxic Three'**. They have a huge impact on the welfare of our children.

The LSCB aims to ensure that practitioners are aware of warning signs and understand behaviours and the impact on parenting capacity. This is secured through the training programme.

The LSCB aims to ensure that the expertise of specialist services is brought into the child protection conference and review process. It has therefore stepped up its monitoring of the engagement of specialist services. This includes monitoring whether or not specialist services were invited where they were known to be involved, whether or not they provided a report and attended meetings.

Specific work planned by the LSCB particularly around audits to evidence effectiveness of arrangements have been included in the LSCB Performance Framework for 2013-15 and the LSCB Think Family Action Plan and will be cross- referenced in the Think Family Operational Group

Think Family Action Plan. The LSCB audit will focus on assessing whether cases with a hidden harm component are offered effective early help within early intervention and safeguarding services.

6.2 Further Achievements in our core delivery functions

Policy and procedures

Over the year, the LSCB has been rigorous and proactive in the review of policies and procedures. Some improvements are covered within other headings, such as CSE, others include:

- Clarification of the role and contribution of students attending child protection conferences
- Updated the main LSCB procedures in the light of working together and published the new Single Assessment Framework and Thresholds document to support new ways of working and focussing on early help
- Amended and revised the criteria for convening an Initial Child Protection Conference by revising the threshold to take account of situations where a person with 'At Risk to Children status' is seeking to return to a household where there are children
- As a direct result of lessons from a local Learning Lessons Review, developed a new and comprehensive guide for practitioners and managers in conducting multi-agency meetings and working direct with uncooperative and hostile families. This focuses on identifying how and why families might be hostile and uncooperative including issues such as 'disguised compliance,' keeping children safe, undertaking clear and accurate assessments and managing risks
- Revision to the domestic abuse procedures to take account of national guidance regarding the inclusion of younger victims
- Strengthening procedures for social workers undertaking statutory visits to children and young people
- Updated the safeguarding children from sexual exploitation procedures to reflect the wider list of risk indicators

Single and Multi-Agency Training Provision

All agencies working with children either directly or indirectly are required to provide single agency training in order to carry out their own roles and responsibilities. This includes being able to recognise and raise concerns about children's safety and welfare.

The current LSCB training work plan includes a requirement to monitor single-agency training, undertake a training needs analysis and evaluate the impact of both single-agency and multi-agency training. This work is ongoing and due to be piloted in 2014.

Training Programme

For the training programme 2013/14 it was agreed to have a greater emphasis on early help and multi-agency working. The programme included three core courses that provide an essential foundation for working with children and families. The courses were designed to give staff and volunteers an understanding of the processes to safeguard children (including national and local policy context), the skills and confidence to engage with families and improve their knowledge and understanding of how to effectively assess, plan and implement effective help.

The courses were supported by the Think Family - Working Together events which were held four times during the year. This gave an overview of Think Family principles and practice followed by a multi-

agency information sharing event which gave an opportunity for partner agencies to provide information on their services including criteria for accessing services and referral pathways. It also gave an opportunity to improve working relationships, networking and helped to promote a common purpose and language in working with families.

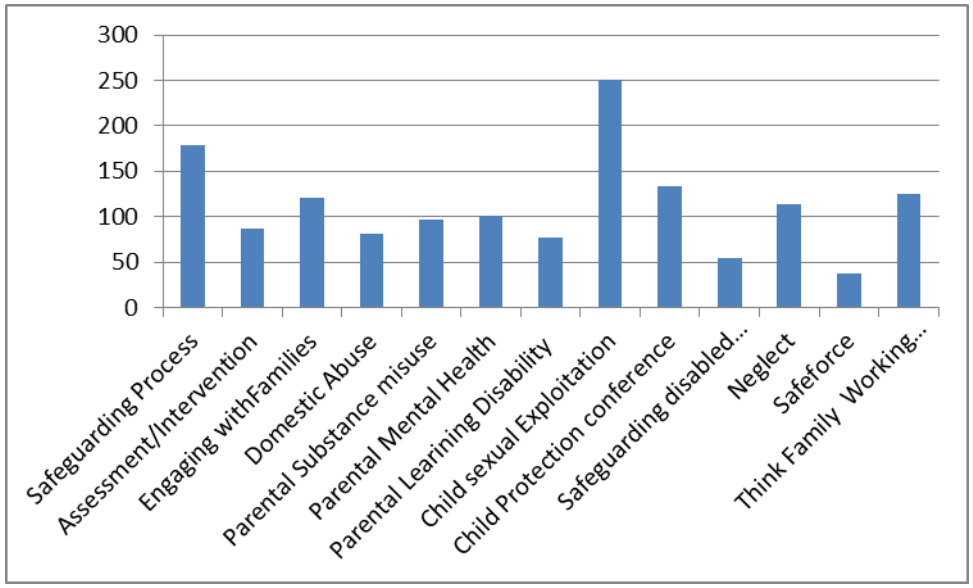
The training programme also included courses to raise awareness and understanding of parental risks factors including parental drug and alcohol misuse, domestic abuse, mental illness and parental learning disability and difficulty; each course included information about the range of services available in order to provide help and support to children and families in these circumstances.

The programme also included more specialist training covering; Child Sexual Exploitation, Safer Workforce, Safeguarding Disabled Children, The Child Protection Conference Process and Child Neglect.

During the year the LSCB training programme was provided through increased collaboration with a range of organisations in the planning, design and delivery of training. This strengthened and enhanced quality, avoided duplication and mirrored the importance of inter-agency working. Valuable partnerships included those with the Children and Adult Services Learning and Development Team, County Durham & Darlington Foundation Trust Safeguarding Children Training Team and the County Durham Think Family Team. There is scope to further develop this in the forthcoming year.

2013/14 Courses delivered

During the year the courses delivered and total number of participants attending included:



The total number of courses delivered throughout the year January 2013 to March 2014 was 84 which were attended by 1,457 staff and volunteers.

A number of courses in Jan 2014-March 2014 were cancelled to enable the delivery of training associated with the introduction of new Single Assessment processes and the transformation programme for children's services. The time was used to develop the training for key managers and practitioners around the new procedures. Some specialised courses still went ahead. These were - Child Sexual Exploitation, Parental Learning Disability and Safeguarding Disabled Children.

The new LSCB Training Co-ordinator who took up post in March 2014 was involved in designing the new courses that will be made available to partner agencies from April 2014. These are focussed on the new Single Assessment Procedures. The courses are as follows:

- Single Assessment Processes
- A New Practice Framework for Assessment and Intervention
- Engaging with Families

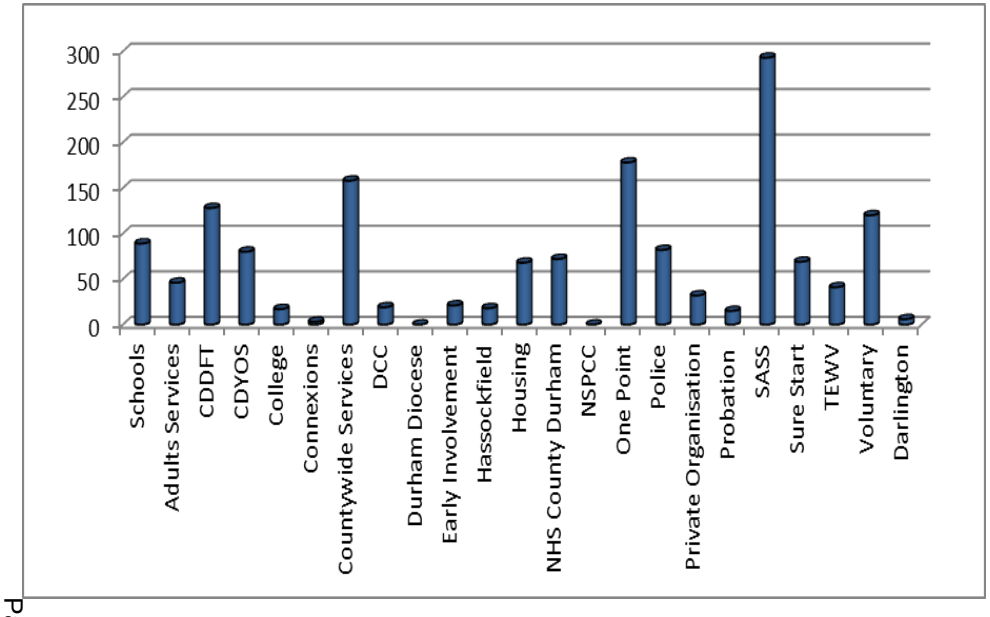
Evaluation of our courses

93% of courses received a good or excellent evaluation and the training programme continues to be held in high regard by the majority of practitioners.

The LSCB has in place plans from 2014-15 to audit and evidence what shift in practice has occurred as a result of attendance on training.

Attendance

Attendance at training was extensive across over 20 agencies as illustrated in the following chart.



Performance Monitoring, Quality & Effectiveness of local arrangements and practice

The LSCB is proactive in assessing the effectiveness of processes that is key to ensure that every child is safe. Some of these are covered in other headings such as CSE. Others include:

- An audit of cases deemed to need 'No Further Action' following referral to the Initial Response Team (IRT). Evidence from this audit showed that honesty and transparency led to a tightening up of recording within IRT, the completion of more thorough assessments as well as ensuring that the outcome of referrals are shared with the referring agency/person where appropriate.
- An audit undertaken by the PCT/Clinical Commissioning Group to assess the impact of training for GPs on responding to bruising to immobile babies and children. This followed the outcome of a Serious Case Review and Learning Lessons Review which concluded that procedures were not being followed and referrals were not being made when an immobile baby who had injuries. Following the audit further training and follow up activity is planned to ensure compliance with agreed standards. In addition further guidance, including leaflets for parents and professionals have also been developed in conjunction with Darlington LSCB.
- A thematic review by Children's Care of cases of children subject to a Child Protection Plan for a second subsequent time was undertaken so as to better understand the reasons, scrutinise decisions and assess impact of interventions on outcomes for children. The audit evidenced that children became subject to a subsequent plan usually for different reasons and in some cases domestic abuse re-occurring. As a result challenges have been made to the decision making process at child protection conferences and the conduct of Core Groups in monitoring and implementing of Child Protection Plans.

- An audit of multi-agency chronologies to check out the evidence that there is very good compliance with procedures. This led to ongoing challenges across the partnership to ensure partner contribution to the production multi-agency chronologies. There is continued monitoring of this issue to ensure improvements are maintained.
- An audit of Core Groups. As a result of this new guidance has been developed for the conduct of Core Groups and developing of Child Protection Plans.

In terms of key performance indicators, one that we most closely watch is the timeliness and robustness of Child Protection Plan reviews. In 2013/14 we saw a significant improvement in timescales from 92.4% last year to 95.6% of reviews completed within target. In Appendix 4 we have reproduced a number of our indicators to illustrate the level of local activity in respect of some groups of vulnerable children.

6.3 Safeguarding Privately Fostered Children

The Board monitors the local arrangements for safeguarding children who are privately fostered. The Board includes specific data in its 'Top Ten' performance indicator list and on an annual basis is provided with a full report setting out the Local Authority's strategy and specific arrangements to raise awareness in the community, monitor and support children and young people who are in such placements.

6.4 The Use of Restraint – Safeguarding Young People in Secure Settings

County Durham is among a small number of Councils who have secure services within its boundaries. The LSCB also monitors the use of restraint in two secure settings for children, many of whom are placed by Councils outside the area and by the criminal courts. Since 2011 an annual report outlining the use of restraint in the two secure settings in relation to young people who have been placed by the criminal courts has been submitted by the LSCB to the national Youth Justice Board (YJB).

Hassockfield Secure Training Centre

Monitoring arrangements including a six monthly update is submitted to the Board outlining any trends and issues identified in relation to the use of restraint and injuries following restraint. The LSCB Quality and Performance Manager/Business Manager regularly attends local meetings and is able to raise issues of concern regarding the use of restraint or any wider issues that might be brought to the notice of the LSCB. Hassockfield staff have access to the LSCB multi-agency training programme and regularly makes use of it.

In the period, April 2013-March 2014 there were 648 incidents of restraint – mainly due to assaults/attempted assaults on staff and young people and young people causing damage. **This is an increase of 76 incidents or 28% from the previous year. A number of actions have been taken in an attempt to reduce the overall figure**. These include a number of changes in the admission process, including allocation of beds on enhanced and cadets unit and bringing young people in on highest league status.

Despite this increase injuries to young people following restraint have remained virtually the same (69 as compared to 70 the previous year). However, the number of young people involved in restraint leading to some injury has increased from 28, for the period April 2012 to March 2013, compared to 39 for April 2013 to March 2014.

Aycliffe Secure Children's Home

The LSCB monitors the use of restraint across the whole population and receives regular updates with regard the whole population. It is particularly focused on increases in the use of restraint and ensures that the centre has appropriate steps in place to minimise its use.

In this reporting period (April 2013 – March 2014) there were 457 incidents of restraint. This is a reduction of 10 restraints compared to the corresponding period for 2013-2014 (467). The annual reduction in restraints continues, although only a slight reduction for this period. The total of 457 for this period compares favorably to the 508 incidents recorded for the period April 2011 to March 2012.

During this reporting period there were 62 incidents of restraint which coincided with some injury to young people. These injury incidents (62) involved a total of 23 young people over a 12 month period.

The number of young people involved in restraint leading to some injury has increased by 8, from 15 young people for the period April 2012 to March 2013, compared to 23 for this period.

The total number of injury incidents has also seen a significant increase of 40 from 22, for the period April 2012 to March 2013, to 62 incidents for this reporting period. These have been mainly due to assaults on staff and damage to property.

6.5 LSCB monitoring the use of restraint in other settings

The LSCB has considered the implications of the Winterbourne View report and the use of restraint. Whilst this had implications for adult safeguarding settings, the LSCB considered the implications of the report for children. As a consequence, in addition to monitoring restraint in secure settings the LSCB has also sought to identify where restraint of young people is also used and to identify how this is reported and monitored.

This has resulted in work with Durham Constabulary to examine how the LSCB can obtain more information and oversight of the use of police restraint. One development has been the completion of a "use of force" report by all police officers when restraint is used on a child or equipment such as handcuffs or incapacitant spray. The report is submitted irrespective of whether there is an injury. The report is submitted initially through the officer's supervisor and then on to the Professional Standards Department of Durham Constabulary, where a manager monitors trends and also assesses the actions of the subject officer to ensure the actions are justifiable.

The Professional Standards Department now produce a six-monthly report to the LSCB.

Over the next year there will further work to better understand the arrangements in relation to education settings

6.6 Serious Case Review Function

There have been no Serious Case Reviews or Learning Lessons Reviews in the 2013/14 period. Recommendations from local Serious Case Reviews and Learning Lessons Reviews both in County Durham and nationally are robustly monitored on a quarterly basis by the Serious Case Review Monitoring Group and an escalation process is in place if progress on the actions is not being achieved in a timely manner.

6.7 Child Death Review function

There are two interrelated processes for reviewing child deaths:

1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death; *and*
2. An overview of all deaths up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) in Durham and Darlington areas, undertaken by a panel.

Child Death Review Notifications

29 children living in Durham and 6 children in Darlington died between 1 April 2013 and 31 March 2014.

Of the 35 child deaths there were:

- 19 Rapid Responses.
- 19 deaths that have been or will be considered at a Local Case Discussion meeting.
- 33 deaths reviewed at Panels during 2013/14
- 30 child deaths that remain outstanding and will be brought forward to 2014/15.

Child Death Overview Panel (CDOP)

Between April 2013 and March 2014 there were five Child Death Overview Panels in which 33 cases were reviewed. At each Child Death Overview Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

The CDOP were of the view that there were 11 deaths in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

Out of the 33 Child Death Reviews completed, 12 Local Case Discussions and two Serious Case Review reports were presented at the Child Death Overview Panel.

The delays in completing the reviews detailed above were due to several factors:

- The long delay for final results of post-mortems to be available, this is still the major cause of delay in review.
- The complexity of the police investigation, it takes many months after road traffic accidents for the final police report to be completed.
- Previously, there have been long delays in receiving requested information from Newcastle upon Tyne Hospitals NHS Foundation Trust but new arrangements are in place which has substantially improved and facilitated communication.
- Cross boundary issues have occasionally led to delay in determining which Child Death Overview Panel is leading the process but measures have been put in place to improve communication. One of which is inviting all CDOP coordinators to be part of the Paediatric Professionals group.
- One case is ongoing in which a child died in another geographical area. Numerous requests have been made for information from that area but as yet this has gone unanswered.
- Two case discussions from 2010-11 were subject to Serious Case Reviews and were published in 2013.

Timescale for Child Death Review Completion
Out of 33 completed reviews, only 9% were completed in less than six months. This is a significant decrease particularly on the figure of 50% in 2010/11. However these figures also reflect the far higher percentage of older cases which were considered in 13/14 meaning that there are far fewer outstanding older cases. The vast majority of 'carried forward' deaths took place during 2013/14.

We will continue to work together to complete reviews in a more timely way.

Key Learning from child deaths 2013-14
From the Child Death Reviews held in 2013-14 some of the learning points included:

- **Coroner Issues**
  The coroner issued a Section 28 letter to a visitor centre after the death of a child in an accident to improve child safety.

- **Care Plans**:
  Where a child who is looked after is known to have life limiting conditions the care plan should include details of how birth parents will be contacted in case of an emergency.

- **Regional Issues:**
  CDOP wrote to Durham County Council to ask them to put up a warning sign, life belt beside the riverbank on the Wear explicitly stating that the river is deep with dangerous currents and that swimming is prohibited, or alternative fill in the hole.

- **Communication & Recording**:
  Communication to be improved to ensure Rapid Response nurse is notified promptly of any RTA deaths.

- **Police**
  The Police to consider whether it should be a legal requirement to declare any modifications to a motor vehicle at the time of sale.

- **Education**
  Raise awareness regarding swimming in rivers via schools. Drowning prevention week is taking place from 21st to 29th June, this is organised by Royal Lifesaving Society and Sunderland CDOP are carrying out an awareness raising campaign using their resources.

Two Durham cases considered were subject to Serious Case Review. These have been published on the LSCB website.

A copy of the Child Death Review Annual Report 2013-14 can be accessed at www.durham-lscb.org.uk

6.8 Further Achievements in the wider partnership

Stronger families

Another aspect of work which is consistent with the aims of the LCSB is the way that it is implementing the Stronger Families programme:

- As at the end of 2013/14 (year 2 of the 3 year programme), County Durham Stronger Families Programme claimed results for a total of 676 families 'turned around'. This represents 51.2% (676 out of 1,320) of the total number of families to 'turn around' by March 2015.
- County Durham was ranked 16th highest nationally based upon the total number of 'turned around' families (as at end of 2013/14).

- County Durham's performance (51.2%) was higher than the national average (44.8%), the region (49.8%) and (50.4%) across statistical neighbours (as at end of 2013/14).

Youth Justice

Effective action to reduce offending by young people has both direct and indirect links to welfare and safeguarding. Key achievements in Youth Justice in 2013/14 include:

- improving performance in two of the three national outcome measures (First Time Entrants and Re-offending) and maintaining the previous year's good performance in the third (Use of Custody)
- Reducing re-offending by 13.1% (binary rate) and 15.6% (frequency rate). (Source: PNC data; MoJ, March 2014). This improvement is better than the North East and England performance
- implementing our Reducing Re-offending by Young People Strategy to further reduce re-offending
- Achieving our lowest ever number of first time entrants (FTEs): 210**.** A 16.3**%** reduction compared to 2012/13 (251 FTEs) and a 81.4**%** reduction since 2007/08 (1129 FTEs)
- having only 25 custodial sentences (same as 2012/13)
- Winning The Youth Justice Award, Children and Young People Now Awards 2013 with our Intensive Employability Programme - the third time in four years that the service has won this national award. (The PRD won in 2010; Fully Integrated Pre Court System won in 2012)

Clinical Commissioning Groups (CCGs)

The two CCGs have become fully integrated into the work of the LSCB and the impact of this close working is beginning to deliver results. For instance, ongoing practice and professional development, supported by the CCGs, has enabled 100% of GP practices to have an identified practice safeguarding lead. The safeguarding leads have been supported in their role by the named GPs and designated professionals through a programme of quarterly development sessions.

In the last year a total 72 safeguarding leads have attended these sessions.

North Durham CCG has led the development of the Child Safe Trigger Tool which provides a systematic way of ensuring all correspondence regarding trauma in children is looked at by GP Practices from a safeguarding perspective. The information then forms part of the whole picture of the child's life and experience. The tool was launched in October 2013 locally to all practices and is being considered for inclusion in the national Royal College of GPs Safeguarding Children Toolkit. An audit is planned to assess the effectiveness of the trigger tool in terms of improving outcomes for children.

Durham Constabulary

The Police and Crime Commissioner (PCC) and Durham Constabulary work closely with a range of other agencies to improve outcomes for young people. In December 2013 the PCC launched a regional Violence Against Women and Girls Strategy. Since its launch work has been ongoing to implement the priorities, such as working more closely with schools and engaging with the wider community like employers to tackle domestic abuse.

In particular work alongside schools to educate children around risks online has ensured over 60 Police Constables and Support Officers are trained to deliver CEOP accredited online safety in schools. The Police have improved internal relationships between partnerships and

safeguarding teams ensuring the accurate education of children and their parents/carers around safeguarding issues is included in Junior Neighbourhood Watch, Jet and Ben lessons, School Carousels and by Neighbourhood Teams who engage with young people.

The Police continue, in partnership with the LSCB, to monitor and improve practice when tackling CSE. In particular, providing feedback to frontline staff to encourage the use of innovation to assist victims and tackle perpetrators which has resulted in a number of children being protected and perpetrators identified and prosecuted.

The impact that domestic abuse has on children who reside in the homes affected is profound. Durham Police secured partnership funding to employ a Diversionary Officer who contacts victims who have declined additional support from specialist workers like Harbour. Following calls from the Diversionary Officer there has been an increase in take-up of services, almost a third of victims made contact then took up the support offered by Harbour. Evidence nationally suggests a victim is more likely to live a life free from abuse when supported by services like this.

County Durham & Darlington NHS Foundation Trust

On 1 October 2012 the Safeguarding Nursing Team transferred from the Commissioning PCT to County Durham and Darlington Foundation Trust (CDDFT), Care Closer to Home Care Group, the team are managerially accountable to the Head of Child Health. The team includes:

- Named Nurses Safeguarding Children
- Safeguarding Children Training Team
- Looked After Children Nurses
- Domestic Abuse Co-ordinator
- Specialist Midwife Safeguarding Children
- Senior Nurse Safeguarding Children for Acute Services.

CDDFT have developed a Safeguarding Children Training Strategy which reflects the Intercollegiate Document and have made significant progress in training compliance. Lessons learned from Serious Case Reviews and Domestic Homicide Reviews are included in training programmes, as well as including topics relating to LSCB priorities. This will ensure our staff have the knowledge and skills to identify and address safeguarding issues and to protect children and young people from harm.

CDDFT have developed an audit for the KPI's in community children's services to determine compliance with safeguarding children policies and procedures. This will enable us to identify gaps and facilitate continuous improvement in practice.

CDDFT continue to undertake both single and multi-agency audits in relation to safeguarding children to improve practice and achieve positive outcomes for children and their families. Training audits have provided evidence to suggest where changes need to be made to ensure the training is effective, has a positive impact on practice and is fit for purpose. An audit into safeguarding supervision has identified areas to improve the effectiveness of the supervision to equip staff with the necessary skills to better manage complex cases in the future.

Work is ongoing with Contraception and Sexual Health (CASH) services and partners to develop robust information sharing to identify those children most vulnerable to Child Sexual Exploitation (CSE).

Multi-agency paediatric liaison meetings are held weekly on the paediatric wards to discuss individual cases and identify any concerns. This has improved information sharing across agencies and helped to identify children, young people and families who need support at an earlier stage.

As part of the Clinical Quality Improvement Framework (CQIF) children, young people and their families are invited to feedback on services provided. Services use the feedback to facilitate continuous improvements and display using a "You said, we did" approach.

CDDFT provides universal services to children, young people and their families and follows a healthy child pathway which enables health professionals to target those families in need, provide early help and targeted individual support.

CDDFT continues to be committed to safeguarding children and young people, providing support to those in need. However, working with limited resources due to the economic climate has had a particular impact on training figures as staffing levels make it difficult to release staff to attend training. CDDFT has developed innovative solutions to mitigate against the risk such as, the development of a workbook for level 2 training, pre-course learning to reduce session time and e-learning programmes.

Section 7: Future priorities and challenges

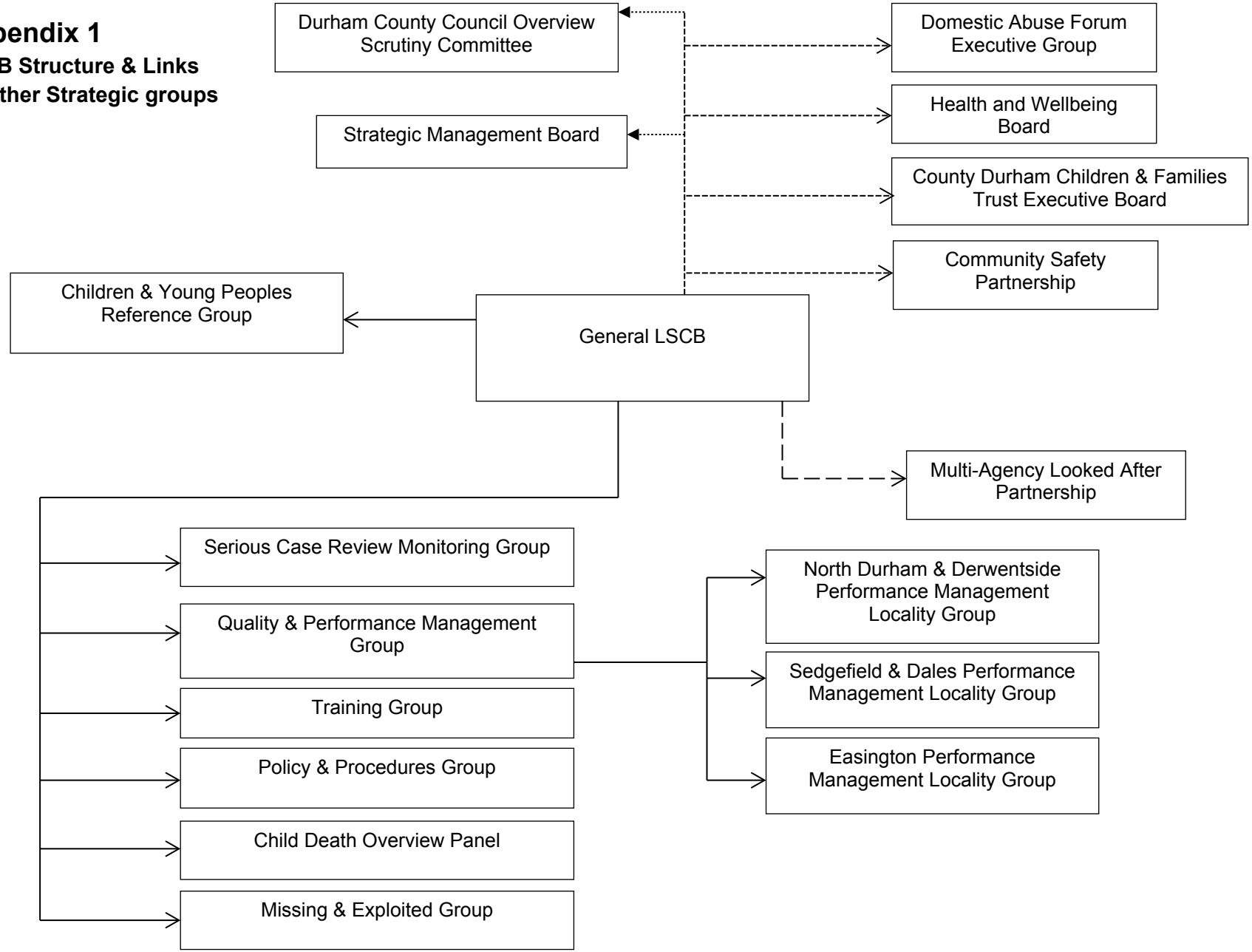
Over the next year and beyond, the LSCB and partners providing safeguarding services face a number of challenges including:

1. A continued focus on the impact of the theme of neglect on children.
2. Supporting and challenging the new arrangements for the delivery of children's services to that they deliver the benefits anticipated for safeguarding.
3. Embracing the new Single Assessment Process - ensuring that it is fully understood, embedded and effective.
4. Adopting a more coherent and robust approach to highlighting and managing risk.
5. Enriching the performance information collected so that it provides a clear line of sight to the management of risk and improvement in the Board's priorities.
6. Getting smarter about assessing the impact of what we do – for example the training programme.
7. Recruiting a new Chair of sufficient calibre who can take on the role as well as that of Chair of Safeguarding Adult Board.
8. Working with that Chair to further improve the capacity and competency of the Board.
9. Strengthening our engagement with children and young people.
10. Making sure we have more Lay Members on the Board.

Our Business Plan 2014-17 will identify clear proprieties for LSCB focus.

Appendix 1

LSCB Structure & Links
To other Strategic groups



The LSCB has direct relationships with, but is not sub ordered to and members of the LSCB are represented on the strategic group.
Multi-Agency groups which report direct to the LSCB

Appendix 2
Durham LSCB Membership

- The Board is chaired by an independent person commissioned by the Durham County Council Chief Executive
- Durham Tees Valley Probation Trust – Durham represented by a Director of Offender Services.
- NHS Commissioning Board – representation via the local Area Team
- North Durham Clinical Commissioning Group represented by
  - Board Nurse Lead
- Chair of County Durham & Darlington Child Death Overview Panel
- Durham, Dales, Easington & Sedgefield Clinical Commissioning Group
  - Board Nurse Lead
- Tees, Esk & Wear Valley NHS Foundation Trust represented by the Designated Doctor
- County Durham & Darlington NHS Foundation Trust represented by:
  - Associate Director of Nursing (Patient Experience & Safeguarding)
  - Head of Children & Families
- North Tees & Hartlepool NHS Foundation Trust will be represented by the Deputy Director of Nursing
- Cafcass (County Durham) will be represented the Service Manager – Early Intervention Team.
- Hassockfield Secure Training Centre will be represented by the Director.
- County Durham Children & Adults Service represented by:
  - Director, Children & Adults Service
  - Head of Children's Care who will also act as Vice-Chair of Durham LSCB
  - Head of Adults Care
  - Head of Education

- Strategic Manager - Youth Offending Service
- Director of Public Health

- Durham Constabulary will be represented by the Force Lead for Safeguarding.

- The Voluntary & Community Sector - represented by the Lead Officer for Communities of Interest

- Housing - represented by the Housing Solutions Manager

- Schools represented by:
  - Durham Association of Secondary Heads
  - Durham Association of Primary Heads

- Further Education will be represented by the Principal and Chief Executive of New College Durham

- Lay Members – will be represented by two members of the community whose role is to support stronger public engagement in local child safety issues and to challenge the LSCB on the accessibility by the public and children and young people of its plans and procedures

- The Lead Member will receive the papers and minutes of the Board meetings.

- Faith Communities - represented by the Child Protection Advisor, Durham Diocese and will be co-opted on to the Board when required.

LSCB Advisors

The Board is advised by:

- A member of Durham County Council Corporate & Legal Services nominated as the Board's legal advisor.
- The Designated Nurse
- The Designated Paediatrician
- Local Authority Designated Officer

Appendix 3 - LSCB Staffing and Budget 2013/15

Staffing - The LSCB is supported by the following officers:

- LSCB Business Manager
- LSCB Admin Co-ordinator
- LSCB Training Co-ordinator - this is a temporary post funded by a time limited grant to July 2014
- LSCB Development Officer
- LSCB Quality & Performance Manager, incorporating LADO duties (deputises for Business Manager) - Vacant since October 2012, filled January 2014
- LSCB Administrator (does not attend Board meetings).

LSCB Budget

The level of investment from partner organisations determined by August of each calendar year for the forthcoming financial year on the basis of the responsibilities and tasks identified in the business plan. The financial year runs from 1 April to 31 March in each year. Budget management are direct responsibility of the Manager of the LSCB and a current financial report will be presented to Board meetings at 6 monthly intervals. The majority of the budget is used to fund staffing costs including the independent chair costs, training. Part of the budget is always set aside for any Serious Case Reviews that might be needed.

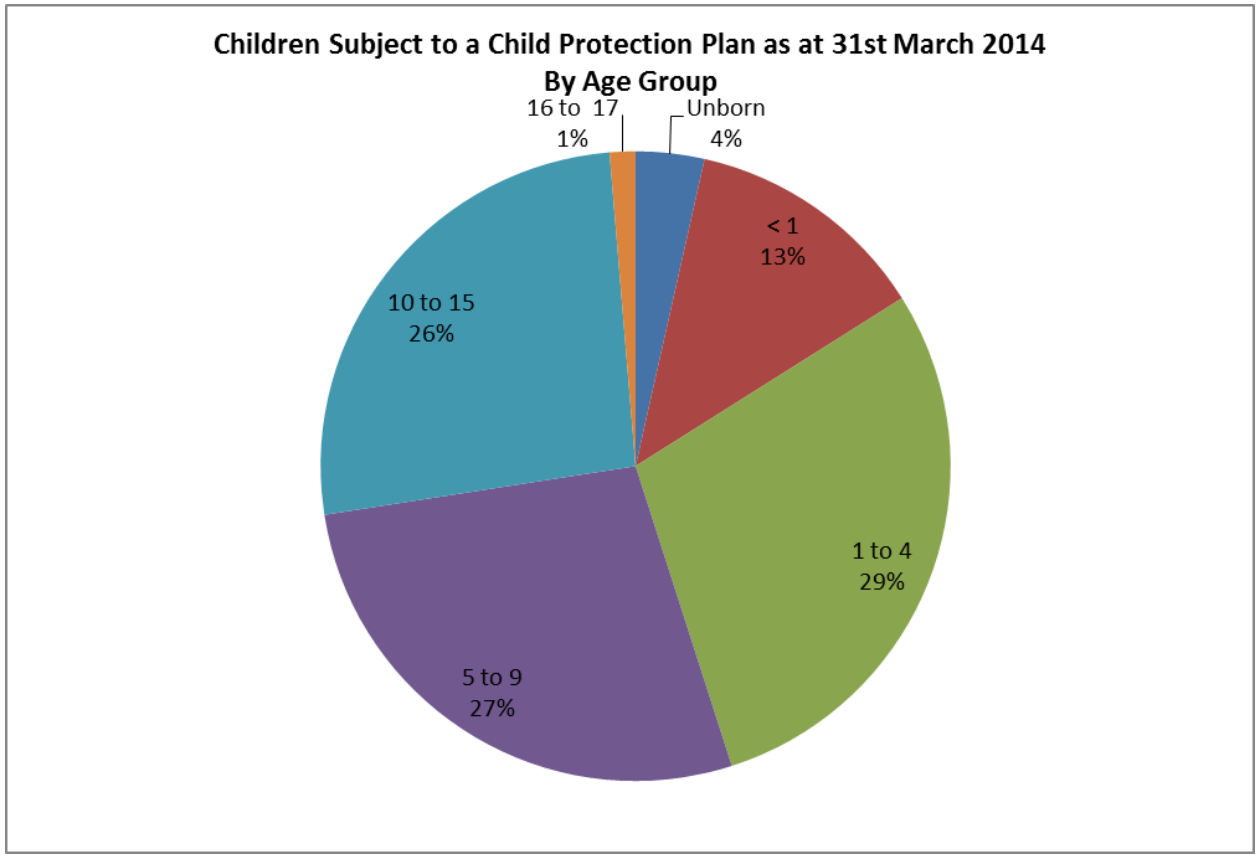
After an in year 5% reduction, the contributions from agencies during the year were as follows:

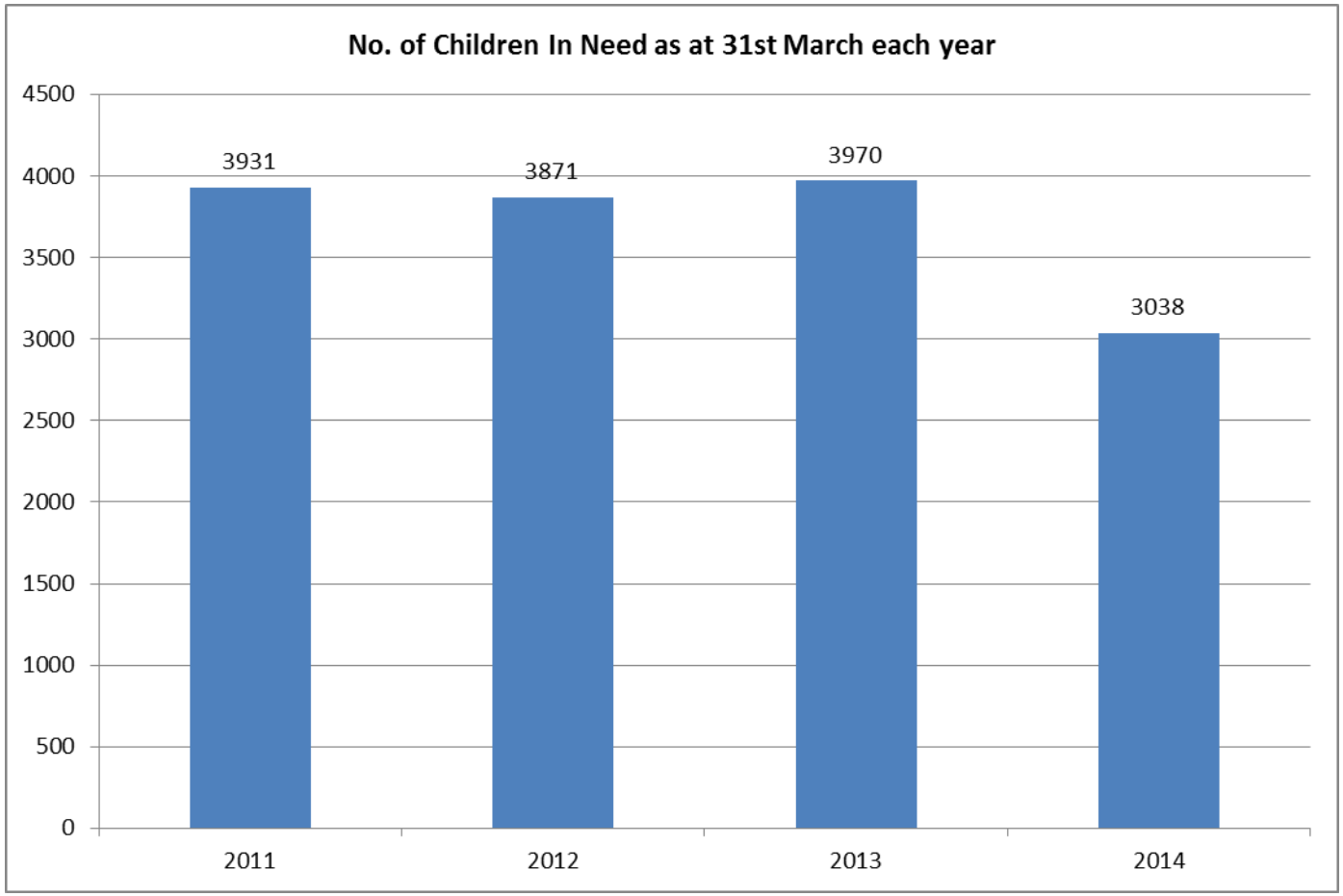
Partner agency	Financial contribution
Durham County Council	171,604
Clinical Commissioning Groups &	95,095
Tees, Esk NHS Foundation Trust	2.680
Durham Constabulary	29,285
Further Education Colleges	2,800
Hassockfield STC	2,680
Durham Tees Valley Probation Trust	2,680
County Durham & Darlington NHS Foundation Trust	2,680

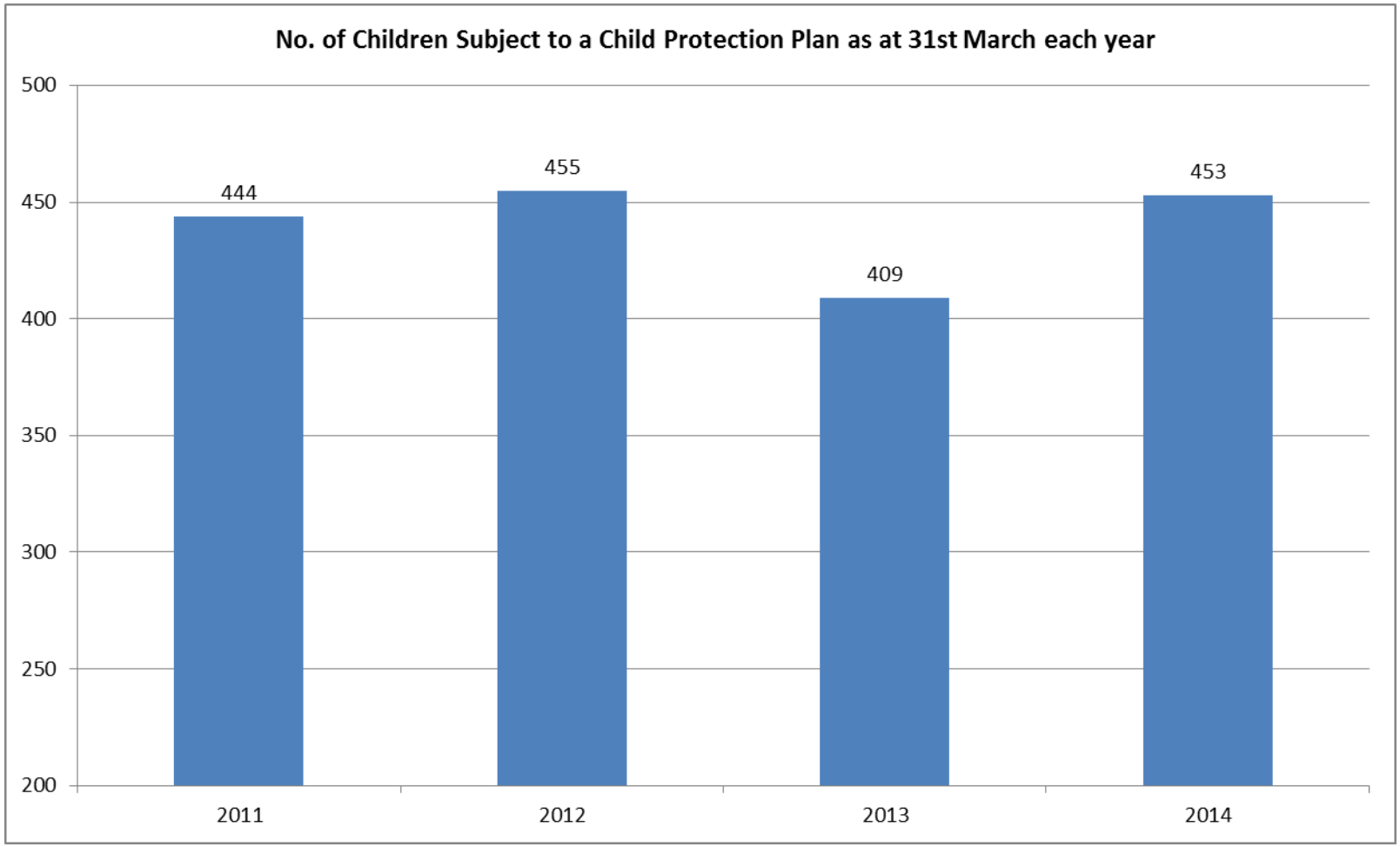
Partner agency	Financial contribution
North Tees & Hartlepool NHS Foundation Trust	2,680
Cafcass	550
Total	**£ 310,000**

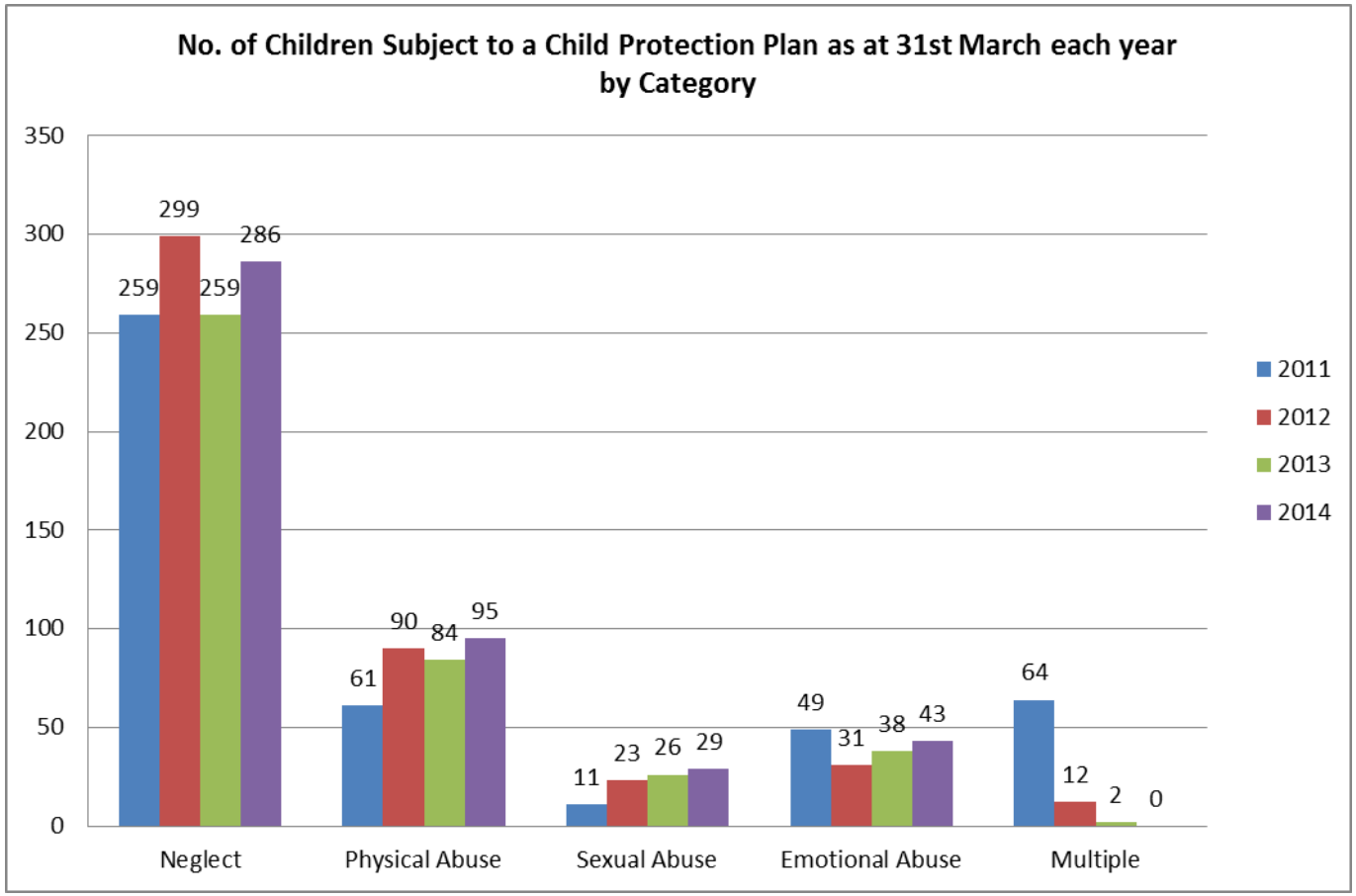
Going forward these contributions will remain the same for 2014-15

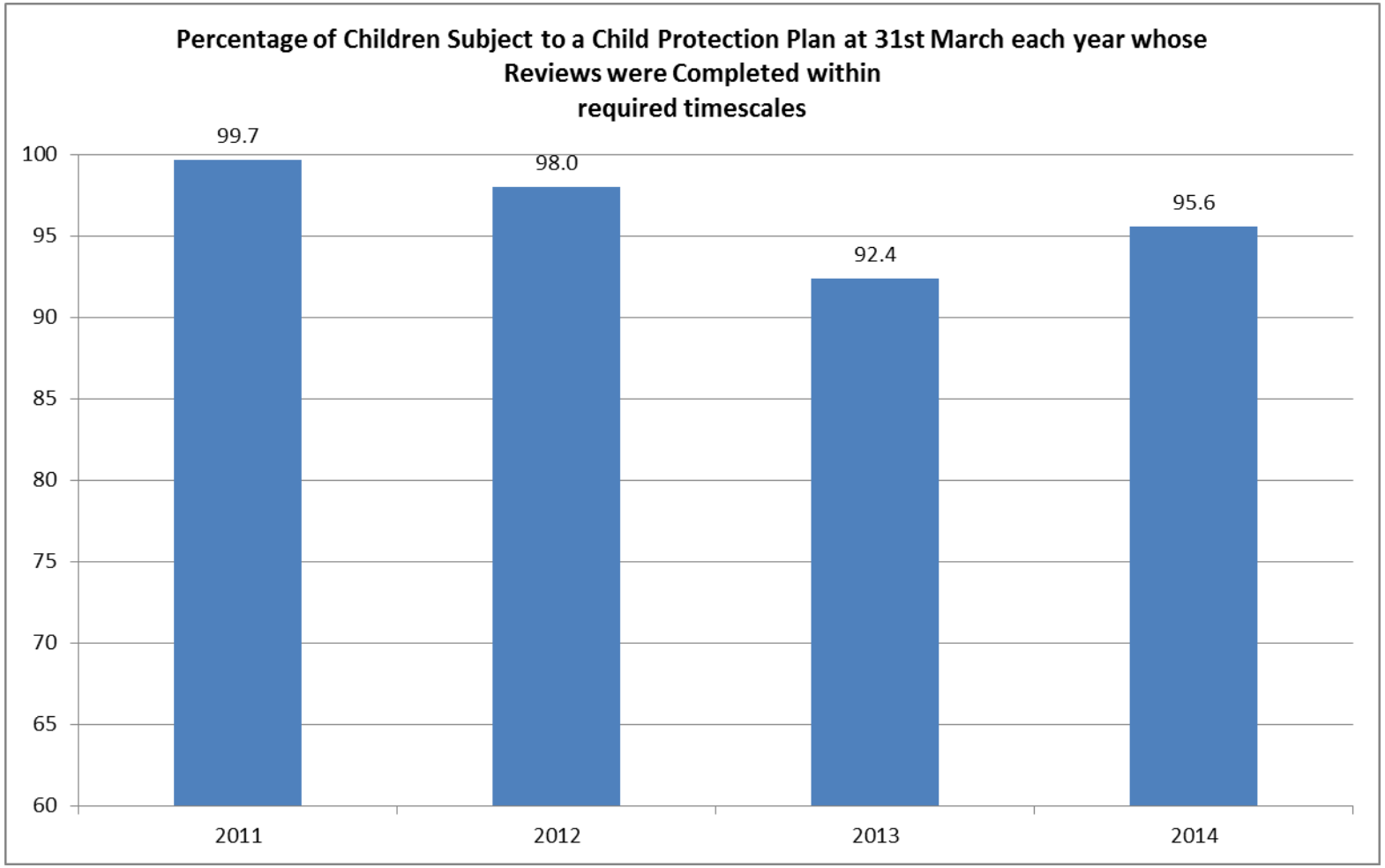
Appendix 4 Local Performance Data 2013-14

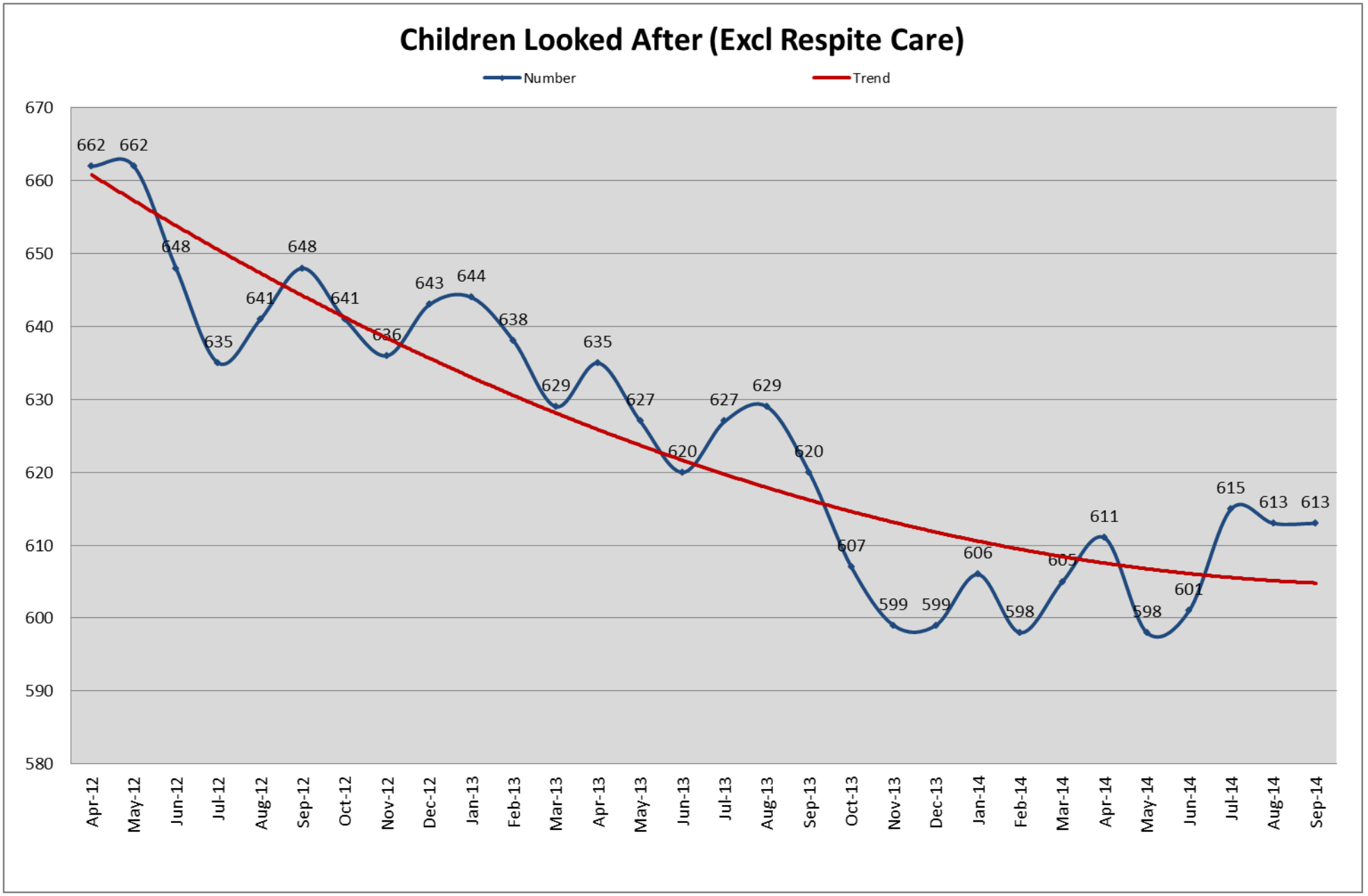



No. of Children In Need as at 31st March each year
4500
4000
3500
3000
2500
2000
1500
1000
500
0
3931
3871
3970
3038
2011
2012
2013
2014


No. of Children Subject to a Child Protection Plan as at 31st March each year
500
450
400
350
300
250
200
444
455
409
453
2011
2012
2013
2014


No. of Children Subject to a Child Protection Plan as at 31st March each year by Category
350
300
250
200
150
100
50
0
259
299
259
286
61
90
84
95
11
23
26
29
49
31
38
43
64
12
2
0
Neglect
Physical Abuse
Sexual Abuse
Emotional Abuse
Multiple
2011
2012
2013
2014


Percentage of Children Subject to a Child Protection Plan at 31st March each year whose Reviews were Completed within required timescales
99.7
98.0
92.4
95.6
100
95
90
85
80
75
70
65
60
2011
2012
2013
2014


Children Looked After (Excl Respite Care)
Number
Trend
670
660
650
640
630
620
610
600
590
580
662 662 648 635 641 648 641 636 643 644 638 629 635 627 620 627 629 620 607 599 599 606 598 605 611 598 601 615 613 613
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
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Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14

The LSCB annual report for 2013/14 has been co-ordinated by the LSCB Business Unit

If you have any queries about the report please contact the LSCB Business Manager pixley.clarke@durham.gov.uk

A copy of this report is available on www.durham-lscb.org.uk

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