
# Wirral Local Safeguarding Children Board

## Annual Report and Business Plan 2011-12

*Draft*

**To be tabled at LSCB on 15th March 2011**

**To be tabled at Children's Trust on 18th March 2011**

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# 1. Chair's Welcome

The last year has seen significant challenges for Wirral Safeguarding Children Board. Nationally there have been serious concerns, evidenced through a number of high profile cases, about safeguarding arrangements for some children.
This has led, in turn, to many agencies reconsidering the focus and effectiveness of their child protection practice.
There has also been, on a national basis, a significant rise in the numbers of children in the care of local authority whilst at the same time financial constraints, experienced by all organisations, because of the global economic position.

There are, however, some positive indicators for the future as Wirral Safeguarding Children Board responds to these pressures.
The restructuring of Wirral Safeguarding Board will allow the Board to manage the business more effectively and to ensure that there is a significant focus on front line performance and practice.
Similarly the restructuring of the Board should assist in stimulating even wider multi agency involvement.

There are likely to be additional challenges for 2011-2012. The Government intention to introduce new national guidance for the safeguarding and protection of children by April 201,may well mean that we have to reconsider priorities and approaches for the future.

In my first year as Independent Chair of Wirral Safeguarding Children Board, despite all of the changes and uncertainties, I have been heartened by the contribution and energy of Board members. There is a real and very tangible commitment by all agencies to protect and safeguard children in Wirral. Agencies clearly wish to find effective ways of working together and that is seen through many of the initiatives outlined in this Annual Report.

This Annual Report sets out the progress and achievements of Wirral Safeguarding Children Board over the last year. It also prioritises actions and initiatives for 2011-2012. The Annual Report is very much a working document and I hope that both professionals and members of the public will find the Report interesting and informative in outlining the progress, aspirations and arrangements for safeguarding children in Wirral

Dennis Charlton
Independent Chair
Wirral Safeguarding Children Board

# 2. Local and National Context

## Wirral Borough

Wirral's population has declined from over 355,000 during the 1970s to 308,500 in mid-2009. The population is skewed towards older age groups, with a lower proportion of younger adults (approximately 67,000) and a higher proportion of older people than the averages for the rest of England and the North West. The fastest falling population categories are the 24 years and under age groups.

Wirral covers an area of approximately 60 square miles and its major urban centres are to the east on the Mersey coast, with a high proportion of the population living in Birkenhead and Wallasey areas. It is well served by a motorway network and is connected to mainline rail routes.

Wirral is a borough of enormous opportunity but it is also a place of sharp contrasts, with the overall picture masking stark inequalities for local people. Many of our citizens enjoy an excellent quality of life, with good housing, schools and a high quality living environment. In certain parts of the borough, however, there are significant levels of deprivation. Some of the 3% most deprived areas in the country fall within the urban areas of Birkenhead and parts of Wallasey. Within Wirral, localities range from the 26$^{th}$ most deprived in the country (around St James Church in Birkenhead) to one of the most affluent, or least deprived - in South West Heswall less than 6 miles away.

## The Local and National Context in Safeguarding Children

Protecting Wirral's children and young people is a key priority, not only for the LSCB, but for all the agencies which provide services for children and for the dedicated professionals who work directly with them and their families.

Safeguarding children includes protecting them from maltreatment, preventing their health and development from being impaired and ensuring that they are growing up in safe circumstances with adults who care for them. Child protection is the aspect of safeguarding which focuses on making safe those children who are, or who are likely to be, suffering significant harm.

Safeguarding children requires that agencies and professionals work effectively together. This has been the standard for many years when children and young people are the subjects of child protection plans, and this model has been extended locally to ensure that agencies and professionals also work together in a co-ordinated way when working with children and families who are experiencing difficulties that they can't manage alone.

Agencies and professionals working in this way make use of the Common Assessment Framework to determine how they can support children and families and work in a 'Team around the Child' to provide the right kind of services to tackle problems and to prevent them getting worse. Detailed information about how local agencies and professionals worked to safeguard children and young people in the borough is contained in the body of this report.

In May 2010, the general election led to a change of administration both nationally and locally. In June 2010, the Secretary of State for Education, the Right Honourable Michael Gove, MP, asked Professor Eileen Munro of the London School of Economics and Political Science to conduct an independent review of children protection in England.

The premise for this review is that, although protecting children from abuse and neglect has been high on the political agenda for many decades, reforms have not led to the expected improvements in frontline practice. Indeed, there is evidence that previous reforms have created new, unforeseen complications in terms of professionals' ability to exercise their professional judgement and to act in the best interests of the child. Professor Munro's final report will be published in April 2011, and its recommendations for change will be considered and implemented by the LSCB.

In addition, it is important to recognise that the context, both nationally and locally, is one of financial constraint across public services, increasing demand for children's social care and radical plans for the way in which the government is approaching public services, including a major restructuring of the National Health Service.

# 3. LSCB Purpose and Structure

## Purpose

The LSCB is the key statutory mechanism for co-ordinating the work of each person and agency represented on the Board to safeguard and promote the welfare of children, and for ensuring their effectiveness in doing so. *Working Together to Safeguard Children* (2010) outlines the scope of the LSCB, covering three main areas:

- Activity that affects all children and aims to identify and prevent maltreatment or impairment of health or development, and ensure that children are growing up in circumstances consistent with safe and effective care
- Proactive work that aims to target particular groups
- Responsive work to protect children who are suffering, or are likely to suffer, significant harm

## Structure

Wirral LSCB is served by an Executive Group and nine committees, each with a specific area of responsibility. The primary function of each committee is to assist the LSCB to achieve its priorities and fulfil its statutory duties.

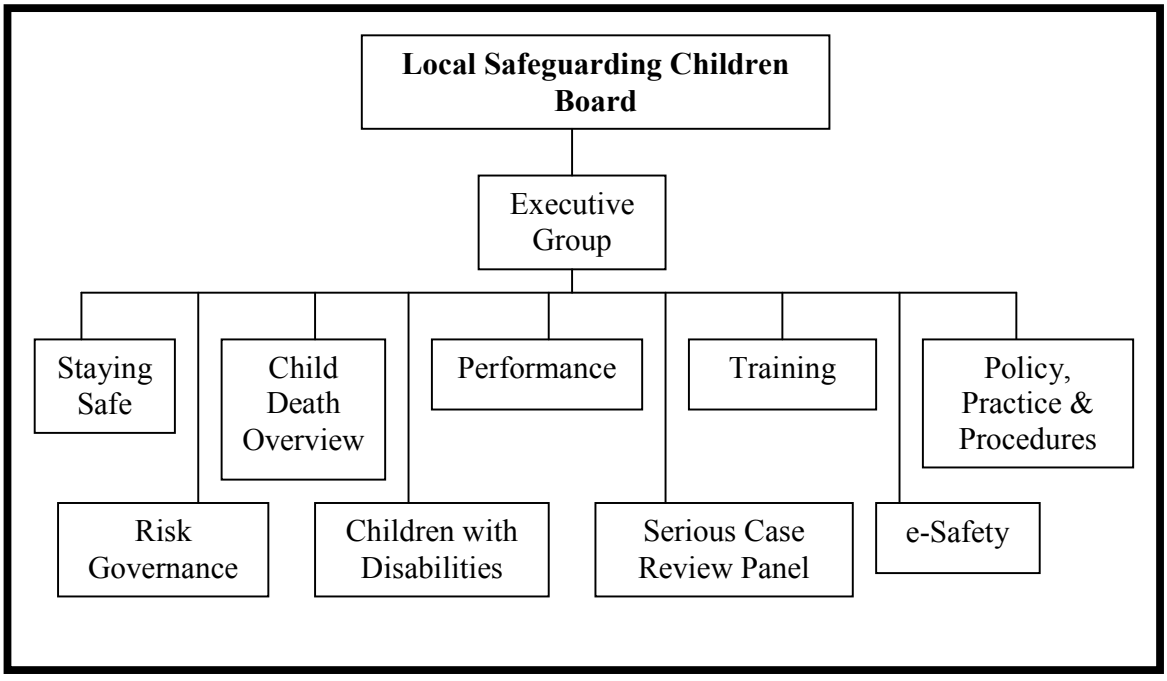



**Figure 1.1: Wirral LSCB and its Committees**

**The Executive Group** comprises the Director of Children's Services, the Chair of each committee and senior representatives from agencies belonging to the LSCB. Its function is to co-ordinate and support the work of the committees in order to drive forward the business of the LSCB.

**The Staying Safe Strategy Group** serves both the LSCB and the Children's Trust. Its function is to promote the availability of safeguarding services in Wirral and to ensure that all agencies understand their accountability in relation to safeguarding practice.

**The Child Death Overview Panel** collects, collates and evaluates information about the deaths of children in Wirral, seeking to identify learning through preventable or modifiable factors.

**The Performance Committee** monitors and evaluates the effectiveness of multi-agency safeguarding practice and has a responsibility for undertaking Critical Incident Reviews.

**The Training Committee** plan, designs, delivers and evaluated multi-agency LSCB training as well as monitoring the effectiveness of single-agency training across the borough.

**The e-Safety Committee** monitors child safety issues related to Information Communication Technology, advising in respect of education, training and expectations of agencies and employees.

**The Serious Case Review Panel** makes recommendations to the LSCB Chair on the need for SCRs. They are responsible for overseeing the production, publication and quality assurance of SCRs. If a SCR is agreed by the Independent Chair, the SCR committee is formed which is made up of core members of the Panel as well as Quality Assurance senior officers from the agencies involved.

**The Risk Governance Group** utilises multi-agency partnerships to monitor and support cases where children and young people are identified as posing a high risk to others.

**The Children with Disabilities Committee** ensures that the needs of those with complex needs are considered and accommodated in all aspects of safeguarding.

**The Policy, Practice and Procedures Committee** has responsibility for providing staff with guidance in line with national and local requirements.

# 4. Governance and Accountability

Whilst Wirral LSCB has a role in co-ordinating and ensuring the effectiveness of local agencies in safeguarding children, it is not accountable for their operational work. Each member agency retains its own existing lines of accountability within its service. This means that each organisation is responsible for ensuring that its work is informed by Wirral LSCB and that safeguarding activity in undertaken in line with its guidance. The LSCB monitors the quality and effectiveness of safeguarding in individual organisations and in the way that organisations work together.

## Relationship between the LSCB and the Children's Trust

The Children's Trust aims to meet the needs of children in relation to the five outcomes of *Every Child Matters*. The work of the LSCB to safeguard children contributes to the wider goals of the Children's Trust, with particular focus on the *Staying Safe* outcome. The Children's Trust has a role in the planning and development of services for children and young people, whereas the function of the LSCB is to co-ordinate and ensure the effectiveness of these services.

The LSCB is not subordinate to or subsumed by the Children's Trust, it has a separate identity and an independent voice which allows it to challenge and scrutinise the effectiveness of the work of the Children's Trust and its partners. During 2009 a *Memorandum of Understanding* was agreed to clarify and strengthen the relationship between the two bodies.

## Roles and Responsibilities of Members

The Director of Children's Services and the Lead Elected Member for Children's Services have crucial roles in improving outcomes for children and young people in Wirral: the Director of Children's Services has lead organisational responsibility and the Lead Member is politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding children. The Director of Children's Services is a member both of Wirral Children's Trust and of the LSCB. The Lead Member is Chair of Wirral Children's Trust and is a 'participant observer' of the LSCB, a role which is defined by *Working Together to Safeguard Children* (2010).

All members of the LSCB are accountable to its Independent Chair for their contribution to the work of the Board, whether they are local authority officers, professionals or lay members. Professional members of the Board both represent and 'hold to account' their own organisations.

## Reporting Mechanisms

The LSCB Committees report to the Executive Group on a quarterly basis. Each chair provides details of progress against targets, activity undertaken in priority areas and

identifies issues for resolution. Recommendations presented by the committee chairs are considered by the Executive Group in light of the over-arching priorities of the LSCB. The Executive Group reports to the LSCB on the work undertaken by the committees to safeguard local children.

## Accountable Body

Wirral Council acts as the Accountable Body for the LSCB providing an administrative and financial role, which involves:

- Human Resource management and administration of financial dealings
- Ensuring that funds are spent in accordance with the plan agreed by the LSCB
- Systems for monitoring performance and audit are in place and effectively maintained

As the Accountable Body, Wirral Council does not have decision making power in terms of the work of the LSCB, other than by means of its representation on the Board.

# 5. LSCB Progress and Achievements

## Report of the Outgoing LSCB Chair

Howard Cooper was the Director of Children's Services in Wirral from 2006, he was also the Chair of the LSCB from its inception in 2006 until the appointment of an Independent Chair in 2010. Mr Cooper reflects on the progress made and the achievements of the Board:

"*The LSCB, at its inception, replaced the Area Child Protection Committee and dramatically broadened what had been its role in relation to child protection to a focus on children's safety in all its respects. At that point, I could see that collaboration and communication between agencies was reasonably effective already but I felt that we were still some way from having a really integrated approach.*

*My early ambitions for the LSCB fell into three main areas.*

*My first ambition was to make genuine progress from cooperation and collaboration to achieving an integrated understanding of how we can make children safer and what kind of impact we could make. As a Board we were enabled to do this, by the prominence given to integrated work in the statutory guidance. This emphasis struck a chord with me to the extent that I would say that it is the best thing that has happened in my working life with children.*

*My second ambition was to consolidate the shift of focus from child protection to safeguarding, leading to a better understanding of how a broad impact on the safety of all children would improve their lives both during their childhood and as adults, in addition to ensuring that children were protected from direct harm from abuse and violence. For me, avoiding neglect is an under-addressed and absolutely key issue, locally and nationally. What stands in the way for many of our most vulnerable children is how their families deal with the problems they face in their lives and the way in which this impacts on their capacity to provide care for their children.*

*Thirdly, I wanted us to focus on more than 'fire-fighting', after a child has suffered abuse and to look more at what we could do improve underlying systems, processes and workforce knowledge and skills to ensure that children are safe. I wanted to see change being driven by making improvements to how we all work with children today and not only to be a response when things have gone wrong. So, although the LSCB's responsibility for children who live with abuse and violence was still key, I wanted the Board, and the Children's Trust, to change the context in which children live and to try to reduce the likelihood of them being abused or hurt at all.*

*I think that we have made considerable progress in Wirral since the Children Act 2004, the Act which fundamentally changed how agencies work together. This is evident both in the Children's Trust and at the LSCB, but it is not just at that level that changes have taken place.*

*When I am talking to different professionals and organisations, the quality of the discussion has profoundly altered. For example, schools are more involved, both in CAF (Common Assessment Framework) and 'Team Around the Child'; health visitors and community midwives see partners' input as being absolutely central to how they work in teams like Children's Centres; and CAMHS (Child and Adolescent Mental Health Services) are now working with children's social care and in education to provide mental health support to children in families, where previously these children might have become looked after by the local authority. Police officers are more engaged in dealing with the impact on children of adult crime and we have also been able to develop a better understanding between children's justice and social care, so that criminal justice agencies are more alert and know better what to do to safeguard children, even when children are not themselves the subjects of violence. An example of how this better understanding has resulted in better actions would be through the use of Multi-Agency Risk Assessment Conferences, which are part of the community response to domestic abuse.*

*I am pleased that there now seems to be a greater coherence in the approach to meeting children's needs, and CAF has played a central but not exclusive part in this. This has meant that there is more protection in place for those children who are often most vulnerable as they fall just below one of the various 'thresholds'.*
*I think we have become more open with one another about our work with children. For example, as part of the wider Merseyside response to the death of Baby Peter Connolly, we took part in an audit and review of sixty-six cases across the region to see how the children in those families had been served by local professionals and organisations. AS a result, we now have a common 'escalation procedure' and have improved how we manage those cases where children move between local authority areas.*

*Although there is much yet to do, I am most proud of the extent to which the LSCB has contributed to bringing safeguarding children to the top of everyone's agenda and that we are now in the position that all agencies are unlikely to retreat from their commitment to integrated working and to the essential importance of safeguarding children.*

## Improvements to the Infra-structure of the LSCB 2008-2010

The membership of the LSCB by partner agency accords with statutory requirements and has increased to include representation from Housing, Further Education and Adult Social Services. The LSCB has also appointed two Lay Members to the Board and is confident that they perspective they offer will further enhance its work.

In 2010 the Board appointed an Independent Chair. The Independent Chair has a crucial role in making certain that the LSCB operates independently and is able to hold organisations to account. Also in 2010 the Lead Elected Member joined the LSCB as a participating observer in line with the revised guidance of *Working Together to Safeguard Children (2010).* Another step taken to ensure that the Board makes progress against its priority areas is the introduction of an Executive Group. The purpose of the Executive Group is to monitor and support the work of the committees. It offers a link between the Board and the committees and encourages the committees to work in a more co-ordinated fashion.

In addition to the changes to the structure of the Board and its Committees already described, the LSCB has this year appointed a Business Manager to co-ordinate the many varied strands of the work of the LSCB and to ensure that the Chair and Board members are enabled to fulfil their responsibilities. The Board has also benefitted from the services of a CAF manager to assure the quality of the safeguarding work of agencies in this crucial area of the Board's responsibilities and from the work of the Local Authority Designated Officer (LADO) who deals with allegations against professionals, foster carers and other adults working with children. These latter two posts have been funded on a temporary basis by the LSCB.

The establishment of the Child Death Overview Panel was supported by funds from central government which provided for the appointment of a dedicated administrator to ensure that the required information is collected and collated, exercising strict confidentiality in the process.

## Assuring the Quality of Multi-Agency Safeguarding Work

Wirral LSCB has given priority to its role in monitoring the effectiveness of the way in which professionals and partner agencies work together to promote the welfare of local children and to keep them safe. The Board has employed a number of strategies to assist in this function. These include:

- Regular scrutiny of key child protection data each quarter
- Establishing a monthly quality assurance process for CAF
- Implementing the Quality Assurance task group and monthly reports to improve the quality of CAFs
- Case file audits
- Reports on the functioning of child protection processes, specifically the thresholds for Initial Assessment and Core Assessment
- Undertaking a Domestic Violence review in 2009/10 with revised threshold procedures
- Reviewed the effectiveness of multi-agency training
- Reviewing the purpose and functioning of the Board's committees through a review of each committee's effectiveness

- Conducting an audit of the Board's effectiveness through 'Challenge and Improvement'
- Introducing an escalation procedure across the partnership on thresholds for services
- Undertaking a review with Senior Police colleagues of 66 case files across 5 Merseyside LSCB's on the compliance with *Working Together* standards and practice in these cases
- Board members agreed to conduct another cycle of Section 11 audits on agency's compliance with the duty to co-operate
- Improving lessons learned from SCR's by participating in the SCIE pilot project work and submitting the findings to the Munro Review 'call for evidence'
- The Ofsted unannounced inspection from July 2010 found much strong practice and no areas requiring urgent action. 'Good' grades with several 'outstanding' features were awarded to both Safeguarding and Looked After Children services in January 2011. Our partnership working was seen by Ofsted to be 'outstanding' with highly effective strategic leadership.
- The Ofsted inspection considered that the LSCB was robust in auditing the work of agencies and their compliance in SCR action plans

# 6. Agency Reports 2008-10

## Children's Social Care

### *Working in partnership with the LSCB*

Julia Hassall, Head of Branch Children's Social Care is the lead officer responsible for Children's Social Care in the Council and represents Social Care on the Local Safeguarding Children's Board (LSCB). Julia also Chairs the Staying Safe Strategy Group, is a member of the Risk Governance Committee, and the Serious Case Overview Committee, as the Quality Assurance Officer to consider Individual Serious Case Reviews. The Strategic Service Manager, Safeguarding serves on the LSCB, chairs the SCR criteria Panel in addition to the Policy, Practice and Procedure Committee.

Each of the LSCB Committees has Children's Social Care membership, with a designated District Manager taking lead responsibility for the Social Care Branch on the Policy, Practice and Procedure Committee: Child Death Overview Panel: and the Training Committee. The Social Care Branch is represented at the Performance Committee by the Quality Assurance Manager, and the Branch is represented at the newly established Disability Committee by the Children with a Disability Service Manager. The Strategic Service Manager, Children and Families, is a member of the Serious Case Review Panel and the Staying Safe Group.

During 2010 the new elected member Safeguarding Reference Group has been established, which has had its inaugural meeting in November 2010. The Head of Branch, Children's Social Care and the Strategic Service Manager, Safeguarding represent the Department at this Committee, and also attends the recently formed LSCB Executive.

Children's Social Care has contributed £70,000 annually to the LSCB during the past two financial years.

### *Safeguarding Training*

The last year has been notable in that more focused training and development has taken place in respect of child protection work for Children's Social Care staff members. This has included:

A structured training programme for all newly qualified social workers, with mandatory training which has included essential children protection training; bespoke training on

undertaking assessments and working with families where chronic neglect is a feature. This has been supported by an additional dedicated training officer, recruited in 2009.

Refresher training for all Children's Social Care Fieldwork Managers in Child Protection work, informed by the findings of a current Serious Case Review, was delivered by the two Strategic Service Managers, Safeguarding and Children and Families, with the LSCB Training Officer. 186 social workers and Managers have received this training, delivered through six full day sessions between September and December 2010.

In February 2010 the Children's Social Care Conference, held at the Floral Pavilion, for all Children's Social Care employees received input and focused workshop training on Neglect, delivered by Researchers / Trainers from Salford University.

**Learning from case file audits**

There has been an ongoing process of learning through case file auditing for example, through Themed Audits held three times last year in respect of Children subject to repeat child protection registrations, Children in need and Children in care; monthly trigger reporting by Independent Reviewing Officers, with required follow up by individual Teams, and multiagency auditing through the Staying Safe Group, in the early part of 2010 on threshold application between children in the Team Around the Child process and the interface with Children's Social Care. An independent Audit has also been undertaken in the two Assessment Teams involved in the most recent Serious Case Reviews, randomly sampling a percentage of all cases opened and closed during a specified period and all cases during the same period of children currently aged 5 years or under.

## *Key Achievements*

- The Council invested over £750,000 into the core Children's Social Care budget to improve safeguarding activity in 2009. This included investment in Area Teams; more social workers; a new field work front line management structure; increased investment to support the infrastructure and Council investment to support more robust LSCB systems and processes.

- In line with the investment above, 7.5 permanent Area Team Leaders were recruited and in post from February 2010, and the equivalent number of Information Sharing Co-ordinators were recruited to Area Teams. Plans are being implemented to co-locate all Area Teams by August 2011, supported by the inward Council investment from the Co-location Fund.

- A permanent Practice Manager for the Central Advice and Duty Team has been recruited and eight of the eleven locality Practice Managers are permanently in post, with the other three posts covered by experienced agency Managers.

- Five of the seven new Principal Team Managers have been recruited, with a focus on driving up the standard of children's plans, improving performance through supervision, and specifically reducing drift and delay.

- There has been Increased investment in IRO posts to create additional capacity to implement the new regulations (April 2011) for looked after children.

- There is improved compliance in using the Integrated Children's System (ICS), supported by the ICS Project Manager and temporary Data Officers.

- All social worker vacancies have been covered by agency social workers during the past year, and an additional Care Management Team has been established in Birkenhead to improve managerial oversight and spans of control. The rolling monthly social work recruitment process has continued, overseen by a responsible District Manager and vacancies are kept to a minimum.

- The first Unannounced Inspection of Contact, Referral and Assessment services, on 21/22 July 2010 was positive, with many strengths identified, including the systems in place at the Central Advice and Duty Team, and weekly monitoring arrangements. There were four areas for development and no priority actions. Preparation for the inspection was used as a lever to drive up improvements in practice.

- Systems for monitoring and recording Common Assessment Framework (CAF) and Team Around the Child activity have continued to be strengthened under the leadership of a new officer recruited by the LSCB. The Integrated Working Guide has been refreshed and the monthly Quality Assurance audit continues to drive up practice standards and has informed the refreshed training plan.

## *Key Developments for 2011/12*

- Complete the review of the Child in Need systems and process;
- Implement improved electronic child protection and Children's Social Care procedures (Tri x)
- Continue to learn from SCR's and Critical Incidents and fully implement the findings from the SCIE pilot project
- Deliver improved consistency in practice across Care Management Teams, through consistent implementation of Team Plans;
- Roll out the learning from the CWDC Remodelling Social Work Delivery Pilot to inform best practice across all co-located Area Teams;
- 
- Implement a training plan for 2011/12 which specifies mandatory training for job roles;

- Promote reflective supervision through revision of the Supervision Policy; peer development opportunities and training of all Managers in expectations, with external input, and audit consistent application;
- Increase the pace and urgency in delivering children and young people's plans, to improve their opportunity to grow up securely attached to permanent carers for their childhood.

## Merseyside Police

### *Working in partnership with the LSCB*

Superintendent Michael Cloherty, is responsible for operational activity in the Wirral Basic Command Unit (BCU), and represents Wirral Area Command Unit on the LSCB. Detective Inspector David Grisenthwaite is responsible for the Family Crime Investigation Unit (FCIU) based at Bebington. He represents Wirral BCU on three LSCB committees: Policy, Practice and Procedure; Training, and Performance. DI Grisenthwaite also sits on the Serious Case Review Panel. Both officers regularly attend the Wirral Child Death Overview Panel. Police attendance at the Board and at committee meetings has been regular. These officers have similar responsibilities in respect of Wirral's Safeguarding Adults Board.

Merseyside Police are routinely involved in Serious Case Reviews and Critical Incident Reviews. In order to ensure the objectivity and transparency of the Police involvement in these processes, the agency's Individual Management Review reports (IMRs) are undertaken by FCIUs from command areas other than Wirral. This process is co-ordinated across Merseyside by the Force Crime Operations Unit (FCOU). This also means that the Detective Inspector at the FCIU Wirral completes Individual Management Reports relating to SCRs in the Sefton Command Area.

The response to SCR recommendations is co-ordinated through the Protecting Vulnerable Persons function of the FCOU. The Wirral FCIU reports on Wirral Critical Incident Reviews to the wider force.

The Wirral Area Command Unit has contributed £10,000 annually to the LSCB respectively for the past two financial years.

### *Safeguarding Training*

The FCIU is responsible for the recording and investigating allegations of child abuse, domestic abuse and offences against vulnerable adults. More recently the Unit has been expanded to include the Sigma Unit, which is responsible for investigating hate crime. The FCIU consists of a detective inspector, three detective sergeants and fourteen investigators. There is an office manager for the Child Protection Team and the Domestic Violence Team respectively, supported by four police staff. All child abuse investigators are Home Office accredited investigators and receive further training through the Specialist Child Abuse Investigator Development Programme, a nationally accredited qualification provided by the National Police Improvement Agency (NPIA). Domestic Abuse Investigators, if not already accredited investigators, are following the Trainee Investigator Programme towards the qualifications required of child abuse

investigators mentioned above. The objective is to develop staff so they are able to investigate all the categories of crime dealt with under the FCIU remit. Five FCIU staff members are trained as Family Liaison Officers.

Officers and police staff colleagues are nominated to attend courses provided by Wirral LSCB, which are relevant to their role.

## *Key Achievements*

A continuous achievement for the Wirral FCIU has been consistency in convicting a large number of child abusers and securing significant terms of imprisonment for those offenders. This has been achieved through the integration of professional investigation, allied to an ethos of total victim care and support during, and often beyond, the criminal justice process. The FCIU works effectively with the Public Protection Unit, Sex Offender Unit and the Family Safety Unit.

During the past 12 months FCIU staff have:

- dealt with 3640 incidents of domestic abuse,
- responded to 618 child protection referrals, and,
- attended 208 Wirral child protection conferences.

Wirral patrol inspectors have initiated 18 Police Protection Orders during the same period, to ensure that children can be removed quickly from dangerous situations to a safe place.

The role of the FCIU domestic violence team has been fully integrated in to the Multi-Agency Risk Assessment Committee (MARAC), chaired *inter alia* by DI Grisenthwaite. Effective partnership working has been maintained with the Wirral Domestic Violence Co-ordinator, and the Family Safety Unit (FSU), working as part of the Crime and Disorder Reduction Partnership. All victims of domestic violence are assessed by the FCIU and those assessed as 'high risk' are referred automatically to the FSU who then initiate a bespoke 'wrap round' safety package for victims and their children. 40% of the referrals to the FSU are from the FCIU. A pilot scheme is currently evaluating the attachment of an Independent Domestic Violence Advisor from the Family Safety Unit to the Family Crime Investigation Unit.

## Wirral Schools and Further Education Providers

### *Working in partnership with the LSCB*

Schools are represented on the LSCB by three head-teachers: Su Lowy, Jill Billinge and Gordon Fair. Ms Lowy is Head-teacher of Hayfield School and she represents special schools. She attends Special School Heads (WISPHA) consultation group and her local Primary Heads' Cluster group. Ms Lowy is a champion of children with disabilities and has helped to establish the Children with Disabilities Committee. Ms Lowy helped provide the safeguarding audit for use in primary schools, and continues to advise colleagues on safeguarding procedures.

Jill Billinge is Head-teacher at Devonshire Park and she represents primary schools. Ms Billinge is Chair of the Primary Head-teachers' Consultation Group, which has identified their specific concern in terms of additional capacity required to participate fully in the formal safeguarding processes, such as *Team Around the Child*, *Child in Need* meetings and child protection conferences and core groups.

Gordon Fair is a former secondary Head-teacher who has been working, in recent years, as a Consultant Leader in Wirral. His post is part-funded by secondary schools. He is a member of the Wirral Association of Secondary Head-teachers (WASH) whose membership has been expanded to include the further education college, the sixth form college and the Academies in Wirral. Mr Fair has contributed to the development the safeguarding 'audit tool' for use in secondary schools and regularly reports back to schools on issues related to safeguarding.

Mr Fair also sits on the Serious Case Review committee and has been part of two serious case reviews in 2009/2010.

### *Safeguarding Training*

Between September 2009 and November 2010, 172 senior staff from schools completed the *Designated Person Child Protection Training*.

*Whole School Training* in safeguarding children has continued and all requests have been met or agreed including a number of bookings for 2011. In addition, to ensure consistency for those schools which prefer to deliver their training internally, the LSCB Safeguarding Training Officer provides appropriate training materials. This training pack is updated regularly and accessed by schools.

School staff took advantage of 225 training places offered by the LSCB from September 2009-October 2010, to promote best safeguarding practice. Two further safeguarding sessions have recently been arranged for Teaching Assistants and staff who are appointed between whole school training sessions are encourage to order and make use of the *Safeguarding* DVD available from the LSCB Safeguarding Training Officer.

*Safer Recruitment* training will be provided by the LSCB in 2011/12, and has been previously been available as an on-line package through the LSCB website.

## *Key Achievements*

In 2010 representation on the LSCB was gained for Further Education, Training Providers and Sixth Form Colleges. The representative is Wirral Metropolitan College Deputy Principal Barry Leatham-Jones who is also the Senior Designated Person for Safeguarding matters at the College. This is an exciting progression for the LSCB as safeguarding issues for older young people are becoming more prevalent. The college have taken many steps to improve safeguarding for their students.

In February 2010 the College appointed a full-time Safeguarding Manager, Lorraine Gardner who in addition to taking forward the College's strategy for safeguarding internally and building stronger 'multi-agency' links externally will also join the LSCB e-Safety Committee.

The College's business is predominantly vocational, post-compulsory, education and training for young people, adults and employers. It works closely with many school partnerships and with an annual 16-18 client population of around 2,000 learners (as well as some 11,000 adult learners) is well placed to bring a unique insight to the work of the LSCB.

The College's safeguarding strategy, based on "Working Together to Safeguard Children" and "Safeguarding Children and Safer Recruitment in Education", encompasses Child Protection, Child Concern and Safe Recruitment.

The College has 600+ staff, 98% of whom (including Governors) have undergone safeguarding awareness training during the last 12 months.

As part of its emphasis on Every Child Matters the College regularly involves its students in activities which contributes to their own awareness raising and provides valuable intelligence about what concerns them and how they feel. For example, most recently in the planning, co-ordination and delivery of dramatic performances and giving more personal views through the MiPod Diary room, as part of Anti-bullying week.

## Merseyside Probation Service

### *Working in partnership with the LSCB*

Merseyside Probation Trust (MPT) is responsible for the supervision of adult offenders who are subject either to a Community or Suspended Sentence Order or have received a custodial sentence of 12 months or more. Some of these offenders may pose a direct risk of serious harm to children, whilst other offenders may live in households where the children are subject to a child protection plan; have been assessed as being in need, or may be suffering from neglect. Offender managers are aware that it is their responsibility to work alongside their colleagues in other agencies to promote children's well being and safeguard their welfare.

MPT is one of the three responsible authorities for Multi-Agency Public Protection Arrangements (MAPPA) for those offenders who are considered to pose the greatest risk of harm to others. The agency works with a wide range of partners who are identified as having a 'duty to cooperate' to ensure the process of risk assessment and management in these difficult cases is as robust as possible. In Wirral, the Local Authority Designated Officer (LADO) attends most Multi Agency Public Protection Panels to help ensure that safeguarding needs are identified and appropriate steps taken by the necessary agencies to reduce or manage any known risk.

The Assistant Chief Officer is a member of the LSCB and Executive Group. The Risk Governance Management Group, Training Committee and Policy, Practice and Procedures Committees are attended by representatives from Merseyside Probation Service.

Merseyside Probation Service has made a contribution of £5,000 annually to the LSCB for the last two years.

### *Safeguarding Training*

In 2011/12, as well as attending internal safeguarding training, there will be renewed attention paid to involvement in LSCB training initiatives for staff and managers of all grades. The management team of MPT in Wirral is giving consideration to a number of initiatives linked to improving safeguarding responsibilities, including improved awareness of the role of the Community Alcohol and Drugs Team; ensuring that the escalation process is embedded; and, reviewing how the key lessons from SCRs are disseminated to the wider staff group.

## *Key Achievements*

During 2009/10, Merseyside Probation Trust has restructured the way in which it delivers its services to ensure greater local focus and improved continuity of offender management. Practice advice has been issued to staff with respect to the need to monitor who lives in a household where there are children present, paying particular attention to identifying the presence of men who either reside in the household or who are regular visitors: this follows from a findings of a significant number of serious case reviews nationally where 'hidden males' have posed an unrecognised risk to children. The Trust's safeguarding policy and practice requirements are currently being re-written to reflect the changes to Working Together 2010. The LSCB Manager has had opportunity to critically review the proposed changes.

Merseyside Probation Trust were one of the key agencies that participated in the SCIE pilot, a project which aimed to improve the lessons learned from SCRs through better multi agency collaboration.

## Greater Merseyside Connexions Partnership

### *Working in partnership with the LSCB*

Connexions is represented on the LSCB in Wirral by the Director of Services to Education and Training. Nominated staff also link with appropriate committees and Connexions is a member organisation of the Children and Young People's Executive, the Staying Safe Strategy Group, Training Committee, Performance Committee and participates in Serious Case Reviews as required.

Safeguarding is a priority for the Greater Merseyside Connexions Partnership (GMCP) and is a key feature in the role of every member of staff. The Connexions Leadership Team is responsible for overseeing all policies. The Audit and Risk Sub-Committee of the Connexions Trust Board oversees all aspects of the Safeguarding Policy and Strategy.

The **Chief Executive** is responsible for ensuring that GMCP fulfils its responsibility to protect adult clients and its duty under Section 11 of the Children Act 2004 to safeguard and promote the welfare of children, in accordance with government guidance. The Chief Executive is also responsible for ensuring that GMCP is represented on, and works in accordance with the policies and objectives of, the LSCBs and works in accordance with local interagency adult protection policies and procedures.

**The Director for Services to Education or Training** in Wirral and the Services to Adults Manager are responsible for:

- The quality of safeguarding and protection work in their area;
- The effective management of safeguarding and protection work in their area;
- Developing effective working relationships with local social care services; and,
- Referral criteria and arrangements.

**Operational Managers** are accountable to the Director for Services to Education and Training or the Services to Adults Manager for the work of their teams in safeguarding and protecting both children and adults. They are responsible for:

- Ensuring that everyone in the team has attended training concerning the Safeguarding and Protection Policy and Procedures and understands, and works according to, their defined role and responsibilities;
- Organising their availability so that they are accessible at all times during normal working hours if there is a need for advice or for support to be provided in relation to a child protection concern. This includes ensuring that appropriate on-call cover is in place, in line with Connexions policy and procedures concerning on-call arrangements;
- Deciding what action is required, having considered the information presented about the case;
- Making any referral to Adult or Children's Social Care Services; and,

- Liaising with the Social Care Services with regard to any consequent actions and for attending meetings or assisting with further information as appropriate.

**Personal Advisors** work directly with children, young people and adults and are accountable to their Operational Manager. Personal Advisors are responsible for:

- Being aware of, and alert to, the risk factors and signs and indicators of abuse and neglect;
- Ensuring that when a disclosure is made that they support and assist the person making the disclosure appropriately;
- When a concern of abuse or neglect arises as an allegation, or as the result of an observation or disclosure, recording the information and bringing the matter to the attention of the Operational Manager; and,
- Assisting any consequent actions by children's or adult social care or other agencies, by attending meetings or contributing information, as required.

GMCP in Wirral has made a contribution of £5,000 per annum to the LSCB; a sum which is reviewed annually.

## *Safeguarding Training*

GMCP ensures representation at the development days for the LSCB and Connexions staff have participated in multi-agency training, as appropriate.

It is Connexions policy to ensure that all employees receive appropriate training and support to ensure that they safeguard and promote the welfare of children and young people and protect adult clients from abuse and neglect. Single agency training delivered includes the following:

- Induction training, delivered by means of a bespoke e-learning package, which provides a basic awareness of safeguarding issues, policy and procedures. This is undertaken by all levels of staff and monitored through Staff Supervision;
- Frontline staff, including Personal Advisors, complete a more in depth e-learning programme and attend a one day in house training day on safeguarding. This is delivered by members of the Wirral Management Team, who have attended a Training Workshop and Refresher Training to support their delivery of this training.
- Refresher training in safeguarding is then scheduled to ensure currency of knowledge. Refresher training took place for Wirral staff during May 2010.

## *Key Achievements*

Connexions records all safeguarding actions in the Connexions Centre Safeguarding logs and these are forwarded to the Director of Services to Education and Training and reviewed monthly at Performance Management Team meetings.

Wirral also operates as a 'safeguarding hub' with Sefton Connexions in order to review and share good practice.

## Link Forum

### *Working in partnership with the LSCB*

The Link Forum is an independent body that plays an active role in influencing the shape and delivery of services on the Wirral for children and young people. The one area they have in common is the provision of care, support and activities to children and young people from 0 to 19. Many organisations are represented on the Link Forum including, uniformed organisations, family support groups, drug and alcohol services, play provision, youth clubs, information, advice and guidance groups.

A Link Forum member contributes to:

- Quarterly LSCB meetings
- LSCB Development Days
- LSCB Training Committee
- LSCB e-Safety Committee
- LSCB Children with Disabilities Committee
- Representation and contribution to Serious Case Reviews is also provided as necessary

Link Forum makes contributions 'in-kind' to LSCB. Time is provided by host organisations to attend meetings and development days; for reading; report writing; and, feedback to the Link Forum. Link Forum also encourages Voluntary, Community and Faith Sector (VCF) organisations to complete the Safeguarding Audits, co-ordinates their responses, promotes multi-agency training in safeguarding and provides other information required by the Board.

### *Safeguarding Training*

VCF organisation have benefitted from attending LSCB multi agency training, such as:

- Train the Trainer in Child Protection
- Chairing a Team Around the Child Meeting
- Information Sharing
- CAF training
- Role of the Lead Professional
- Safeguarding Children Module on the Common Induction Programme
- The Effects of Neglect and Use of the Assessment Tool
- *Working Together to Safeguard Children* Levels 1 & 2
- The Effects of Domestic Abuse on Children
- Train the Trainer in Safeguarding Children-Policy into Practice

The Link Forum has also been involved in the delivery of multi agency safeguarding training via the Safeguarding Children module on the *Common Induction Programme*.

## NHS Wirral Provider Services Report

### *Working in partnership with the LSCB*

NHS Wirral Provider Services Safeguarding Service sits within the Primary Care & Provider Services Directorate of NHS Wirral and is part of the portfolio of the Clinical Director of Provider Services. The service links to Commissioning and with Wirral University Teaching Hospital NHS Foundation Trust

The role of NHS Wirral Provider Services Safeguarding Service is to support all staff irrespective of background/role in the organisation regarding all aspects of safeguarding. This includes safeguarding training, identification of potential abuse or neglect and taking appropriate action. This service is operationally managed by the Head of Safeguarding Service and accountable to the Clinical Director of Provider Services. The Clinical Director of Provider Services is the LSCB representative.

Within the Provider Services arm of NHS Wirral there are a number of staff with specific roles and responsibilities, summarised as follows:

| | |
|---|---|
| Head of Safeguarding | Provides operational and strategic leadership to staff within the service |
| Named Nurse-Safeguarding Children | Provides advice, training, support and child protection supervision to all NHS Wirral Provider Service staff |
| Named GP- Safeguarding Children | Provides extensive input into raising awareness amongst GP's of child protection issues and requirements and is the point of contact for GP's with queries and concerns |
| Named Nurse-Looked After Children (LAC) | Responsible for ensuring that the minimum statutory requirements for children in care are met, as laid out in the *Children Act* (2002) and *Promoting the Health of Looked After Children* (2002/2009) |
| Support Nurse- Looked After Children (LAC) | Works with the Named Nurse-LAC to ensure that best practice is achieved |
| Safeguarding Practitioner- Lead for Safeguarding Adults/Domestic Abuse | Provides an advisory and support function to the multi-disciplinary team/clients/carers/external agencies |
| Safeguarding Practitioner-Lead for Mental Capacity Act (MCA) /Deprivation of Liberty Safeguards (DOLS) | Works in partnership across the health economy to establish strategic priorities, agree and implement a programme of work which ensures the implementation of MCA |
| Administration Team | Supports and facilitates all aspects of safeguarding work |

There are regular safeguarding meetings at various levels in order to ensure effective communication across the organisation. In addition this supports the embedding of safeguarding into all services delivered by NHS Wirral Provider Services and facilitates a co-ordinated approach which meets local and national safeguarding guidance/requirements.

In addition, NHS Wirral Provider Services is represented at the following meetings:

- The LSBC, the Executive Group and each of the 9 committees
- Safeguarding Adults Partnership Board (SAPB) and sub groups
- LAC Network meetings
- Named Nurse, Safeguarding Children regional network meetings
- Multi Agency Risk Assessment Committee (MARAC)
- Multi Agency Public Protection Arrangements (MAPPA)

## *Safeguarding Training*

The Safeguarding Training strategy was reviewed during 2009 to ensure that it met the requirements of national/regional guidance along with NICE guidance, Statutory Guidance on Promoting the Health and Well-being of Looked After Children *(2009)*.

The Safeguarding Training strategy is currently under further review to reflect the requirements of

- *Working Together to Safeguard Children* (*2010)*
- *Safeguarding Children and Young People: roles and competencies for health care staff ( 2010)*
- Safeguarding Children – "A review of arrangements in the NHS for safeguarding children" *(Care Quality Commission, July 2009)*

NHS Wirral Provider Services staff attendance at safeguarding training 2009/10 is as follows:

| **Training Session** | **Number** |
|---|---|
| Domestic Abuse training | 310 |
| MARAC process training | 73 |
| Safeguarding Adults training | 40 |
| Safeguarding Adults & Domestic Abuse combined training sessions | 410 |
| Safeguarding Children training | 8 |
| Essential Learning (programme included Safeguarding Children & Domestic Abuse) | 310 |

The Essential Learning programme, which is mandatory training for all practitioners with direct patient contact, has a whole day dedicated to safeguarding so that staff are clear in their responsibility relating to safeguarding patients of all ages.

## *Key Achievements*

All Named Nurses within NHS Wirral Provider Services Safeguarding Service are competent to meet the supervision requirements identified within NHS Wirral's Safeguarding Supervision policy. These practitioners have received certificated Child Protection Supervision training and accreditation via NSPCC. Staff undertaking child protection supervision sessions attend NSCPCC training on a 3 yearly basis The NHS Wirral Supervision Policy has been reviewed and updated to incorporate all elements of safeguarding supervision for both children and adults.

Part of the child protection supervision process involves completion of an audit tool relating to all children subject to a child protection plan. The audit tool was originally created in order to respond to a piece of work requested via the Local Safeguarding Children Board (LSCB) as a result of the Haringey enquiry. The audit is now ongoing and data is analysed weekly in order to report any trends to the Local Authority and also to escalate individual cases if required.

Following a Serious Case Review, NHS Wirral allocated funding specifically to update the training package delivered to GP practices. The training programme was updated to ensure that it reflects the most recent national and local best practice guidelines, incorporates case studies to encourage discussion regarding subtle signs of child abuse and meets the recommendations of the latest local serious case review along with requirements of the Care Quality Commission (CQC) report published July 2009 entitled "A Review of arrangements in the NHS for safeguarding children" in July 2009. A central register of GP attendance at the training is being compiled and GPs will receive a certificate of attendance at the first stage of the training and a certificate of competency after completion of a cd-rom package. Safeguarding training attendance/certification has formed part of the GP Appraisal process and QAF visits.

Learning from Serious Case Reviews and organisational incidents is shared and action taken to reduce the likelihood of incidents reoccurring. Examples of key changes made as a result of Serious Case Reviews are listed below:

- Paediatric competency's introduced in Unplanned Care
- All Under 1s seen by a medical professional in Unplanned Care
- HV record keeping has been reviewed and training delivered to ensure compliance with record keeping standards
- GP safeguarding training package was reviewed and mechanism put in place to evidence GP attendance and competency

NHS Wirral Provider Services have introduced a root cause analysis (RCA) approach to investigating all incidents which have a safeguarding element (relating to children or adults). Safeguarding Practitioners have received RCA training to enable them to undertake this approach which also assists when compiling chronology information part of a Serious Case Review.

## NHS Wirral Commissioning Directorate Report

### *Working in Partnership with the LSCB*

The role of the Commissioning Directorate (including Strategic Partnerships) within NHS Wirral is to work with the Local Authority to improve the health and wellbeing of their local population including children and young people. The PCT has to ensure that all providers, from whom they commission services, are aware of their Safeguarding responsibilities and have policies and procedures in place to safeguard and promote the welfare of children. These should be in line with and informed by LSCB procedures.

The role of the Designated Nurse within the Commissioning Directorate of NHS Wirral is to ensure that commissioners and providers are fully aware of their Safeguarding Children responsibilities to promote and safeguard the welfare of children and that these responsibilities are included within contracts and form part of the monitoring process.

The Designated Nurse also works closely with the Designated Doctor to provide advice and support to Health staff across Wirral's Health Economy. This includes involvement in all Serious Case Review work as well as involvement in reviews of Critical Incidents. In 2010, the Designated Nurse and Doctor have been involved with two Serious Case Reviews and two Critical Incident reviews. The Designated Nurse will monitor the recommendations from the Serious Case Reviews and the Critical Incident reviews to ensure that the Health elements of the reviews are completed within the appropriate timescales.

The Designated Nurse and Doctor continue to participate in Wirral's LSCB and on several of the LSCB sub-groups. This gives the designated professionals the opportunity to provide skilled advice to the LSCB on health issues.

### *Safeguarding Training*

A key feature of training has been the development of supervision in relation to safeguarding. The Designated Nurse meets with the Named Nurses from NHS Wirral Provider Services, Wirral University Teaching Hospital and Cheshire and Wirral Partnership Trust and provides Safeguarding supervision at 8-12 week intervals. The Designated Nurse is currently undertaking a 5 day Supervision course with staff from Wirral University Teaching Hospital. This is an accredited course run by the NSPCC which will update the skills of the Designated Nurse. The course will also ensure that Wirral University Teaching Hospital is able to meet its responsibilities for delivering effective Safeguarding supervision to its staff.

## *Key Achievements*

In 2010, the Strategic Health Authority worked with the Designated Nurses across the North West to produce a Safeguarding Policy which now forms part of all new contracts. This policy is to be audited on an annual basis to ensure that providers are meeting their responsibilities as per the *Children Act* of 2004 and the current guidance in *Working Together to Safeguard Children* (DCSF March 2010).

The Designated Nurse has undertaken significant developments in networking, both locally and nationally and this will continue throughout 2011 to ensure that Safeguarding Children issues are not "lost" within the changes that will take place in Wirral over the course of the next twelve months. This will be particularly important as Wirral's GP consortia will commence work in January 2011 and they need to be fully aware of their Safeguarding Children responsibilities in all future commissioning work.

## Cheshire and Wirral Partnership- NHS Foundation Trust

### *Working in partnership with the LSCB*

Cheshire & Wirral Partnership NHS Foundation Trust (CWP) continues support the work of Wirral LSCB. Representation at Board level is made by the Director of Nursing, Therapies and Patient Partnership. CWP is appropriately monitored for Safeguarding by LSCBs, Care Quality Commission, National Health Service Litigation Authority (NHSLA) and Monitor (Foundation trust Monitoring Body), in relation to their responsibility to ensure that the needs of children are considered in delivering care to families under Sec 11 Children Act (2004).

Trust-wide work for safeguarding children continues to be undertaken by a safeguarding team, which include three Named Doctors (one for each constituent LSCB), one Lead Nurse (incorporates the role of Named Nurse) and two Safeguarding Practitioners one for Children and one for Adults. The Safeguarding Children Practitioner's role is very much centred on the day-to-day advice on safeguarding children. The team continues to provide information, supervision and advice on the effects of abuse and neglect of children. The team also delivers Level 1 and 2 safeguarding training. The package has been ratified by constituent LSCBs. The Team represents CWP on several of the LSCB committees.

The assurance of CWP's integration of Safeguarding into Clinical Practice is overseen by a Trustwide Safeguarding Strategic Group for children and adults. This group is chaired by the Director of Nursing, Therapies and Patient Partnership or the Deputy Director of Nursing. Each Service Line is represented by its General Manager to ensure that safeguarding is central to each service. It is here that the work with partner agencies such as LSCBs and Multi Agency Risk Assessment Conferences (MARACs) is reported back as well as policy or procedure issues that affect all services. External or internal audits including action plans are monitored and ratified by this group.

### *Safeguarding Training*

As well as an utilising an e-learning package, the team continues to deliver face-to-face basic awareness (Level 1) on all induction sessions and Level 2 mandatory training. The package has been ratified by constituent LSCBs as "Excellent and very informative". The Safeguarding Lead and Safeguarding Children Practitioner have attended additional 'training for trainers' to enhance delivery. Children and Adolescent Mental Health Service (CAMHS) clinical staff are also are required to attend Level 3 training annually.

Present Training figures

| | Staff in Post | Total number of Staff | % attended | |
|---|---|---|---|---|

| | | Trained | | |
|---|---|---|---|---|
| Level 1 | 2652 | 2652 | 100% | Includes all staff who received handbook up to April 2009 and from May 2009 new starters who have received induction including CD of presentations which includes Safeguarding level 1 |
| Level 2 | 1904 | 1110 | 58% | This is likely to be understated as the Trust has difficulty validating training that staff completes external to CWP and the 3 yearly compliance requirement of level 2. We have recently significantly increased the training investment to meet our targets and project a 100% compliance by 2012. |
| Level 3 | 257 | 190 | 75% | This is specific to CAMHS. Remaining staff are booked on future sessions - both internal and external - which will bring the figure to 100% by 2011. |

## *Key Achievements*

**The Safeguarding team has:**

- Continued to provide advice and support to healthcare professionals in an ever increasing market place;
- Responded to changes Government legislation, reports and guidance such as review of Baby Peter, the Independent Safeguarding Authority Vetting and Barring scheme ;
- Reviewed the role of the Trust safeguarding Children Group;
- Led and reviewed the Clinical Service Units Safeguarding Groups;
- Continued membership of Cheshire East and West Domestic Abuse Strategic Group;
- Continued membership of NHS North West 'Mental Health Safeguarding Children Group';
- Continued membership of Multi Agency Risk Assessment Conferences for Domestic Violence (MARAC) for Cheshire and Wirral.

# 7. Child Death Overview Panel Report

Child death review processes became mandatory in April 2008, thus arrangements have been in place for just 24+ months. The panel is responsible for over-viewing the processes to respond to unexpected deaths and for reviewing information on all child deaths that occur within the Wirral LSCB area. The purpose is to:

- Assess preventability of all child deaths
- Collect information which enables local patterns/trends to be identified
- Compare statistical data with other neighbouring areas, and the North West
- Make recommendations and monitor actions and where possible to prevent future child deaths.

Child death is a very sensitive issue and of crucial importance. The panel is committed to learning from any such death in order to identify preventable factors at both local and national level, and to inform action that can be taken to reduce the number of child deaths in the future. Four principles underpin the CDOP work:

- Every child death is a tragedy.
- Learning lessons to prevent future child deaths.
- A multi-agency approach.
- Possible action to safeguard and promote the welfare of children.

## Cases reviewed by Wirral CDOP

- 16 deaths were reported to the Wirral CDOP during 09-10. However, as the review of neonatal deaths did not commence until November 2009, a full year's report on all child deaths is not possible.
- Of these 16 deaths – 11 child death reviews were completed in the reporting period, 4 cases were still open (and as yet uncategorised) and one case was not reviewed as it did not fulfil the CDOP criteria.
- Of these 16 children, 9 were male, and 7 were female.
- 14 of these 16 children were under the age of 5 years.

Categorisations for the cause of death are as follows:

| Category | Number of children |
|---|---|
| Malignancy | 1 |
| Chronic Medical Condition | 2 |
| Chromosomal, genetic and congenital anomalies | 3 |
| Perinatal/neonatal event<br>Infection | 2 |

| | |
|---|---|
| Infection | 2 |
| Sudden Unexpected Unexplained death | 1 |
| As yet uncategorised | 4 |
| *Not for CDOP review.* | *1* |
| *TOTAL* | *16* |

- In terms of categorising the preventability of deaths, the CDOP forms in 09/10 used the terminology – *preventable*, *potentially preventable* and *not preventable*. During the reporting period, 3 deaths were classified as *potentially preventable*, and 8 were categorised as *not preventable*.
- The potentially preventable child deaths were categorised as follows:
  - 1 due to infection,
  - 2 due to perinatal/ neonatal events.

  These three deaths were all in children under 1 year of age.

## Key Developments 2009/10

• The revision of *Working Together to Safeguard Children* in 2010 included new guidance on the processes to be followed by the CDOP when a child dies. Key changes include:

  - revised definitions of *preventable deaths* and *unexpected deaths*;
  - clarity on the roles of coroners and registrars;
  - guidance on responding appropriately to the death of a child with a life limiting illness;
  - clarification on the level of involvement parents and family members should have in the process and the type of support they will need;
  - clarification that CDOP processes do not apply to still births or legal planned terminations;
  - revised and more substantial guidance on the requirements for rapid response arrangements for all stages of the process

Wirral CDOP has incorporated these changes into its processes and functions.

- Data collection accords with the reporting information required from the Department for Education.

- Since November 2009, Wirral CDOP reviews all neonatal deaths in addition to child deaths.

- Contact with bereaved parents has increased and benefitted from the introduction of a letter and leaflet for parents which ensures they are aware of the CDOP process and helped to understand its purpose. It has been agreed that it is not appropriate to send this letter to the parents of a neonate.

- A database for recording child death information has been established and is maintained by a dedicated CDOP Administrator. The database is updated as necessary to meet CDOP and reporting requirements.

- Wirral CDOP continues to meet regularly and attendance is good from all agencies: it also benefits from its links with the Merseyside CDOP group and the Regional (North West) CDOP Steering Group. Given the relatively low numbers of child deaths on the Wirral, the LSCB is informed by the work of colleagues in other boroughs, the data in the North West Child Death report, and national data.

- 2009/10 has provided the opportunity to build on the firm foundations of the first year, so as to strengthen the links between Serious Case Reviews, the CDOP process, and other Board activities, to ensure that all learning and appropriate actions are taken in a timely manner. This is work which is strengthened through the introduction of the Executive Group.

## Key issues for development 2011/12

- The CDOP Nurse post should be resourced and implemented. Contact with bereaved parents has increased, and at present the main contact point for parents is the CDOP Chair.
- Utilising the new national leaflet on child deaths needs to be considered to further improve communication with parents.
- Work has been undertaken since the introduction of CDOPs to raise awareness of its existence and function; however this continues to provide challenge and will remain a priority for 2011/12.
- With the change in preventability categorisation to *modifiable factors/non modifiable factors*, consideration should be given to the categorisation of neonatal deaths. Given that this is a relatively new development for Wirral CDOP, and the complex nature of many of these deaths, this will be a difficult but necessary task.
- Opportunities for benchmarking the categorisation of cases should be taken at a local and regional level.
- 2010/11 will be the third year of reporting and it will be appropriate to look at Wirral trends. However, this will need to be undertaken with great caution given the small numbers involved, and should be done within the context of North West data.
- Improving the collection of information continues to feature as an issue both for Wirral CDOP and at a regional level. The panel will continue to evaluate its effectiveness and liaise with neighbouring CDOPs to work together to establish a more robust process which complies with statutory guidance.

# 8. Serious Case Reviews

## Guidance for Serious Case Reviews (SCR)

*Working Together* (2010) sets out the criteria for undertaking a Serious Case Review (SCR); the procedural requirements and timescales which should be adhered to when a case is being considered. SCRs are conducted when a child dies, and abuse or neglect is known or suspected to be a factor in the death. Additionally the LSCB will always consider whether a SCR should be conducted in other significant circumstances. Those cases which do not meet the criteria for a SCR may become subject to a Critical Incident Review, a non-statutory process to gain understanding and learning from 'near misses'. Wirral LSCB agreed that the SCIE framework for conducting a Critical Incident should be used with a case that was subject to adult and children's services involvement. The learning from this case was presented to the LSCB in December 2010 and the Adults Safeguarding Partnership Board in January 2011.

The purpose of serious case reviews is to establish whether lessons can be learned from the case about the way local professionals and organisations work together to safeguard and promote the welfare of children, to act upon these lessons and as a consequence improve inter-agency working. To ensure that the review is conducted in a non-biased way, an Independent Chair and Independent Overview Author are appointed to each case.

It is the responsibility of the LSCB Chair to decide whether a case warrants initial discussion at the Serious Case Review Panel. The panel, Chaired by the Strategic Service Manager for Safeguarding is made up of representatives from partner agencies, and additional members can be added if required in a particular case. Once the LSCB Chair has instructed the panel to meet, the case files are secured in order to help inform the panel's decision making process.

The Serious Case Review Panel meet within 7 days of the request by the LSCB Chair and make a recommendation within 4 weeks as to what action is necessary and if a SCR is to take place. If a SCR is to take place the Terms of Reference are drawn up and the LSCB Chair will inform Ofsted that the case is to become the subject of a SCR.

## The Process

The process of SCRs involves gathering Individual Management Reviews from each agency involved, producing a case chronology which covers the agreed review period, producing an Overview Report with recommendations for service improvements and an Executive Summary for publication. The Overview Report should be completed within 4 months and presented to the LSCB for approval before being forwarded to Ofsted, in the required format, for grading.

The publication of SCRs is a serious and complex issue. Published SCRs are appropriately redacted and anonymised to protect the privacy and welfare of vulnerable children and their families. In future it will be a requirement to publish the Overview Report in its entirety rather than just the Executive Summary. It is believed that this will encourage further transparency of services and processes.

## Lessons Learned

SCRs are of little value unless lessons are learned from them. In order to maximise the opportunity to improve the effectiveness of safeguarding arrangements, an action plan, which contains the recommendations specific to each case, is produced and monitored by the Executive Group.

Three SCRs have been completed between 2008 and 2010. Contributions have been made by Children's Social Care, Merseyside Police, housing associations, Greater Merseyside Connexions Partnership, education, Wirral NHS and PCT, and many other partners. An action plan has been produced for each SCR. The action plans are monitored by the Executive Group of the LSCB and are intended to ensure the implementation of recommendations made through the SCR process. Examples of positive changes which have arisen through SCRs are:

- Wirral NHS has reviewed its 'Paediatric Competency' framework;
- Merseyside Police has reviewed its Child Protection Policy in relation to Public Protection Orders, to ensure that health professionals are provided with the necessary information;
- A single point of access to Child and Adolescent Mental Health Service from Children's Social Care has been established;
- The LSCB has revised existing training on parental mental health and its impact on children, ensuring that all relevant practitioners are able to recognise and respond appropriately;
- All Health Visiting teams are informed by telephone of attendance at walk-in centres for children under the age of 12 months
- The LSCB has adopted a formal risk management approach across all agencies, identifying young people with highest risk of harm or serious offending, quantifying risk by considering the history of each young person and developing specific plans to mitigate this risk and establish cross-agency monitoring mechanisms.

Significant efforts have been made by LSCB partners to ensure that SCRs are effective in bringing about positive change from lessons learned. Members of the Serious Case Review Panel and Independent Authors have received bespoke training in 2009-10, from the Social Care Institute of Excellence (SCIE).

**SCIE Pilot**

Wirral LSCB has recently participated in a pilot project led by the Social Care Institute for Excellence (SCIE) into a 'systems approach' to SCRs. One of three LSCBs in the North West of England invited to participate; the project was commissioned by the Government to explore a more effective review method. This has been a valuable learning opportunity for the Serious Case Review Panel and has already influenced the approach taken in Critical Incident Reviews as well as making a contribution to the 'call for evidence' for the Munro Review.

# 9. Multi-Agency Safeguarding Training Report

Steve Withington joined the Children and Young People's Department as Safeguarding Training Officer for the Wirral LSCB following the retirement of Shelagh Hozack. This post is responsible for the co-ordination and organisation of the multi-agency training programme.

### Review of Training 2009-10

A number of courses were cancelled as there was no trainer in post and due to the commissioned trainer for two courses withdrawing. The courses that have run were well received with good attendance. Issues raised in evaluation have been considered and changes have been made to reflect Working Together 2010, Lessons from Serious Case Reviews and other research.

Multi agency attendance at LSCB training courses was as follows:

| AGENCY | NUMBER OF ATTENDANCES |
|---|---|
| Children's Social Care | 276 |
| Schools | 225 |
| Education Welfare Service | 51 |
| Children's Centres Staff | 56 |
| NHS Wirral | 44 |
| Foster Carers | 36 |
| Third Sector Partners | 25 |
| Emergency Duty Team | 17 |
| Youth Offending Service | 13 |
| Police | 12 |
| Wirral Drugs Service | 12 |
| CAMHS | 7 |
| Family Intervention Project | 3 |
| Probation | 1 |

Attendance at multi agency training is now an agenda item for the Executive Group. This allows it to be monitored and provides evidence of which agencies need to be targeted to widen participation in safeguarding training.

## Overview of training for 2011-12

The multi-agency training courses offered through the LSCB for 2011/12 are as follows:

· Working Together – Refresher
· Working Together to Safeguard Children Level 1
· Working Together to Safeguard Children Level 2
· Child Protection Case Conferences and Core Groups
· Effects of Domestic Abuse
· Safeguarding Children with Disabilities
· Missing/Young Runaways
· Effects of Parental Substance Misuse
· Safeguarding Children in Whom Illness is Fabricated or Induced
· Children Abused through Sexual Exploitation
· Working with Young People who Display Sexually Harmful Behaviour
· Sudden Unexplained Death in Infants/Children
· Multi Agency Public Protection Arrangements
· Seeing and Interviewing the Child as part of Initial Assessment and S47 Enquiries
· Achieving Best Evidence in Criminal Proceedings
· Lessons from Serious Case Reviews
· School Designated Person Training
· 'Think-U-Know' Internet Safety
· Managing Allegations against Staff
· Safer Recruitment
· Neglect and the Graded Care Profile
· Child Death Overview
· Effects of Parental Mental Health on Children
· Risk Assessment and Critical Analysis in Safeguarding
· Critical/ Analytical Thinking
· Reflective Supervision in relation to Safeguarding
· Working Effectively with Resistant Families
· Working with Sexually Active Young People
· Sexual Abuse

Full details of the training programme and training applications can be accessed through the LSCB website.

The plan, approved by the Training Committee, promotes a variety of courses reflecting the issues raised in Serious Case Reviews including sexual abuse, domestic abuse, alcohol and substance misuse, neglect and parental mental health. Within the constraints of the budget the training will be delivered drawing more upon local expertise than previously and a challenge is to increase the size of the training pool. This requires a commitment from agencies to release staff.

There has been an increase recently in attendance from agencies such as Adult Social Care, Police Housing and Health. There are limited places on training and a multi-agency mix is vital. This will be pursued by widely promoting the training programme and encouraging "champions" in services who can attend and cascade information.

The Training Committee have developed a work plan for 2011/12 which focuses on mapping current single agency safeguarding training and quality assuring both single agency and multi agency training. The LSCB are committed to supporting partners to provide staff with regular and up-to-date training and will be running a number of key events throughout 2011/12 including a launch of and case study exercise of the Graded Care Profile.

# 10.Local Authority Designated Officer (LADO) Report

## The Role of the LADO

The role of the LADO is set out in *Working Together to Safeguard Children (2010)*. Appendix 5 outlines the procedures for managing allegations against people who work with children in a position of trust.

The LADO should be alerted to all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.

This applies to paid/unpaid employees, volunteers, casual/agency staff, and those self-employed. The LADO is responsible for considering concerns, allegations or offences emanating from within or outside of work.

LADO responsibilities include:

- Management and oversight of individual cases
- Monitoring the progress of cases to ensure they are dealt with within agreed timescales
- Ensuring a consistent and thorough process for all adults working with children and young people against whom allegations are made
- Providing advice and guidance to Senior Managers within partner agencies
- Liaising with Police in relation to allegations where it is suggested a criminal offence may have been committed
- Supporting Senior Managers to make a referral to the Independent Safeguarding Authority (ISA) or appropriate regulatory body
- Delivering training to agencies representatives in relation to the management of allegations and also safer recruitment procedures
- Representing the LSCB in MAPPAs (Multi Agency Public Protection Agreement meetings) for offenders who are to be released into the community, and who pose a risk to children and young people

## Data Collection

Data with regard to allegations against professionals has been collated by the LSCB since August 2008. During this period the following statistics have been recorded:

| Period | Number of Allegations Recorded |
|---|---|
| August – December 2006 | 3 |
| January – December 2007 | 16 |
| January – December 2008 | 53 |
| January – December 2009 | 50 |
| January 2010 to the present date | 84 |

As can be seen from the figures above, there is a steady increase in the number of allegations reported to the LADO. It is suggested that this does not reflect an increase in instances of inappropriate behaviour, rather that awareness of the procedures and role of the LADO has significantly improved. This reflects the commitment of local agencies to work together to safeguard Wirral's children and young people.

During 2010, allegations managed by the LADO have been categorised as follows:

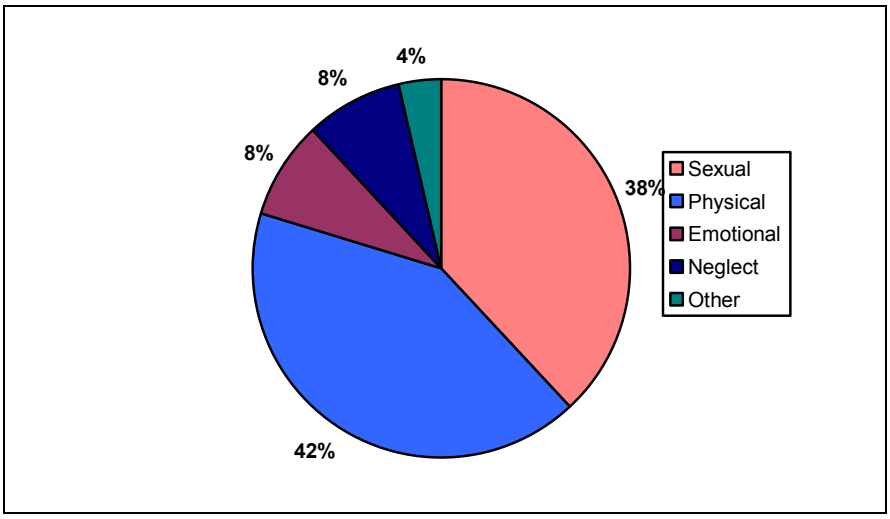



**Figure 9.1: Categories of alleged abuse**

Allegations that are recorded as *other* include those where the allegation reported included either multiple concerns, or concerns relating to incidents that did not relate directly to children and young people, but were perceived as being such that it would suggest that the individual was not suitable to work with minors.

Allegations recorded in 2010 have resulted in the following outcomes:

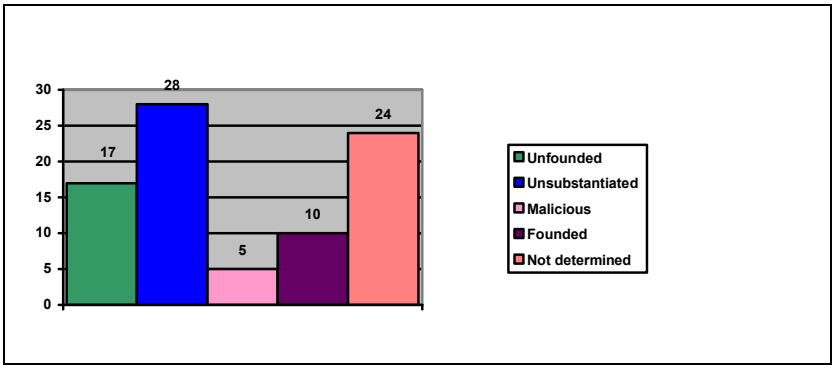



**Figure 9.2: Outcomes of investigations of allegations**

Those recorded as *not determined* relate to current allegations which continue to be investigated. Allegations, where police investigations are also taking place and cases are being considered by the Crown Prosecution Service can result in allegations taking a number of months to conclude.

## Key Developments 2009-10

Significant improvements to the functioning of the LADO role include:

- Reviewing the Allegations Referral form to improve the management of allegations
- Establishing and maintaining a database to track all allegations
- Developing a MAPPA database to manage the caseload of offenders who are subject to Multi-Agency Public Protection Plans
- Updating and delivering *Managing Allegations* multi agency training
- Raising the profile of the role with across the partner agencies
- Delivered seminars and talks to referring agencies and foster carers

## Planned developments 2011/12

- Establish a *Consultation/Initial Consideration* database which will allow the LSCB to monitor the training and support needs for partner agencies
- Develop a LADO section within LSCB website allowing partners to access relevant documentation, FAQs and flowcharts
- Devise a format to collect statements from witnesses and those whom allegations are made against
- Support partner agencies in the development of relevant procedures to support the safeguarding of children and young people, including *Safer Recruitment* and *Safer Working Practices*

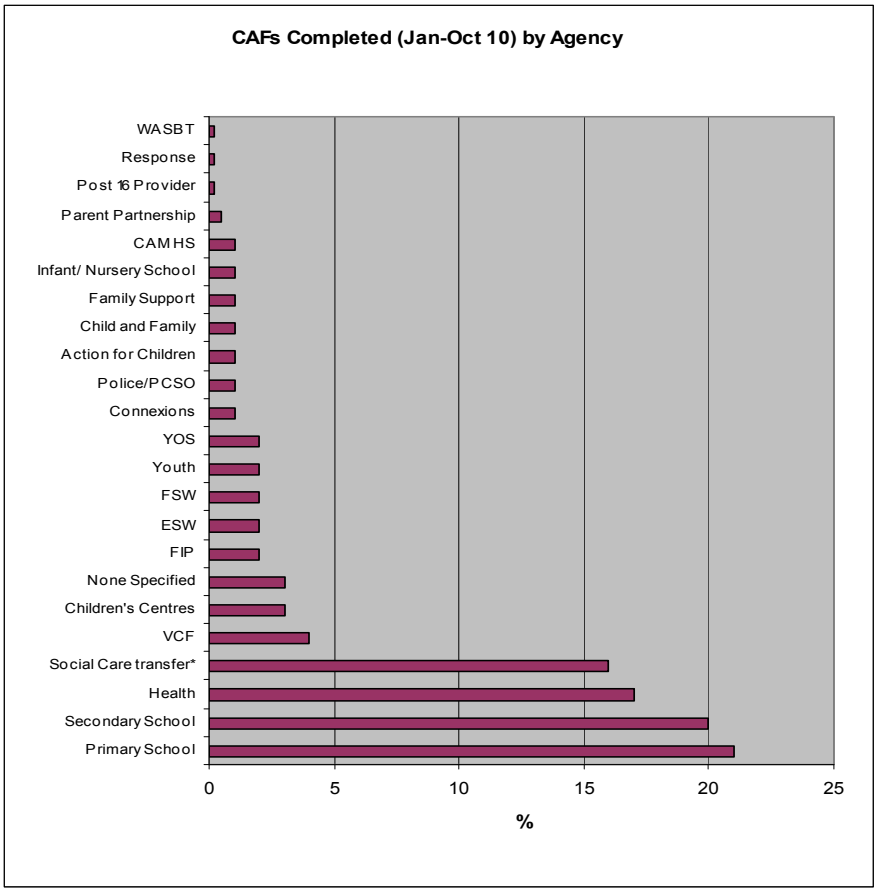
# 11.Common Assessment Framework Activity Report

CAF Activity Reports are produced monthly and detail the CAF activity across Wirral for the preceding four weeks. The purpose of each report is to monitor all CAF and TAC, as well as 'consultation' activity across the 11 area teams. The report provides a wide range of data which can identify areas of need, examples of good practice and inform the future development of the CAF/TAC process across Wirral to maximise the positive outcomes for local children and young people.

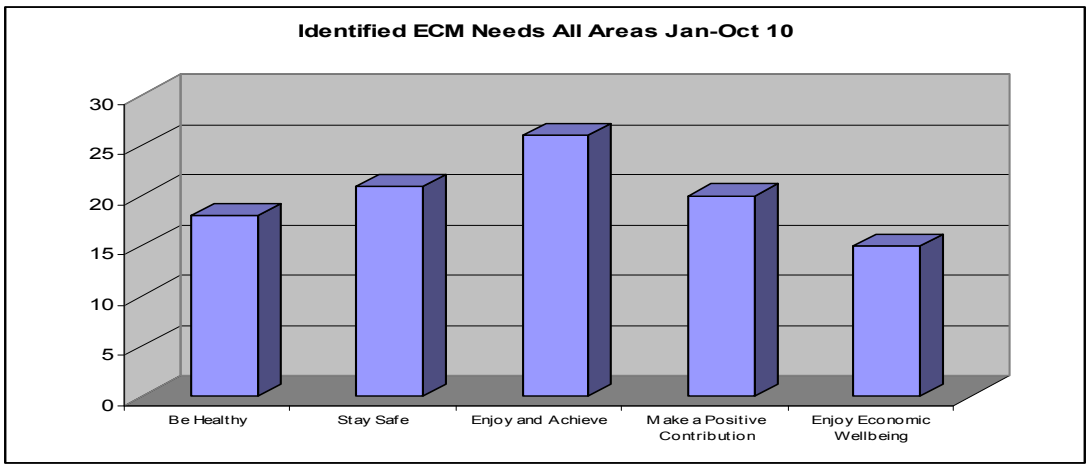
Data collected for 2010 shows:

- 941 CAFs were undertaken across Wirral
- Primary (21%) and Secondary (20%) schools author the most CAFs
- Most CAFs are completed in respect of children in the 5-10 age group (34%)
- 59% of CAFs have boys as the subject; 41% are girls
- Where ethnicity is stated, 97% of children and young people described themselves as white British
- 16% of CAFs have a child with disabilities as its subject
- Agencies from across the Children's Workforce are engaged with the CAF/TAC process including statutory, voluntary, community and faith organisations

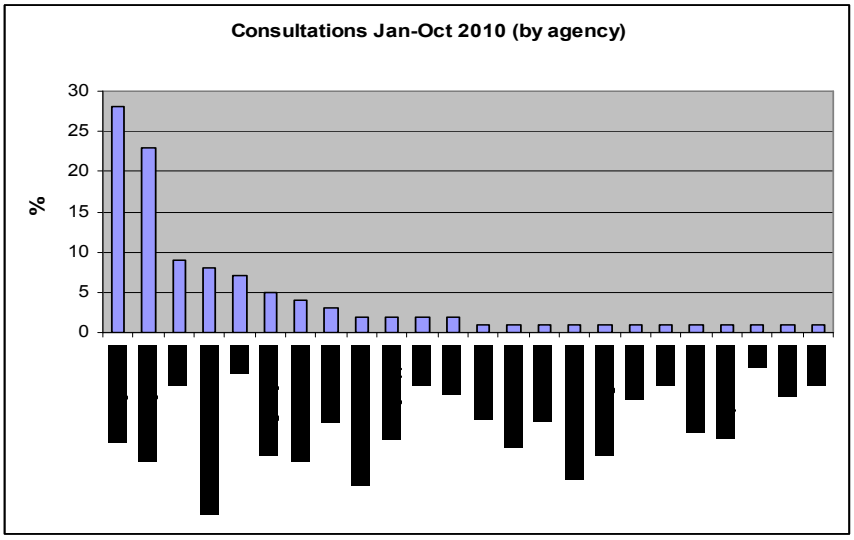
The CAF/TAC process is widely embedded across agencies in Wirral. The graph below shows the number of CAFs completed by agency across all the areas. Social Care transfer, which accounts for 16% of CAF/TAC activity refers to those children and young people who move into TAC from being Children in Need. Well-developed processes ensure that children move to the most appropriate level of need swiftly and smoothly.




Agencies are asked to indicate which of the 5 Every Child Matters outcomes apply to each completed CAF form. This data can then be analysed to inform what provision should be made available to each child or young person.



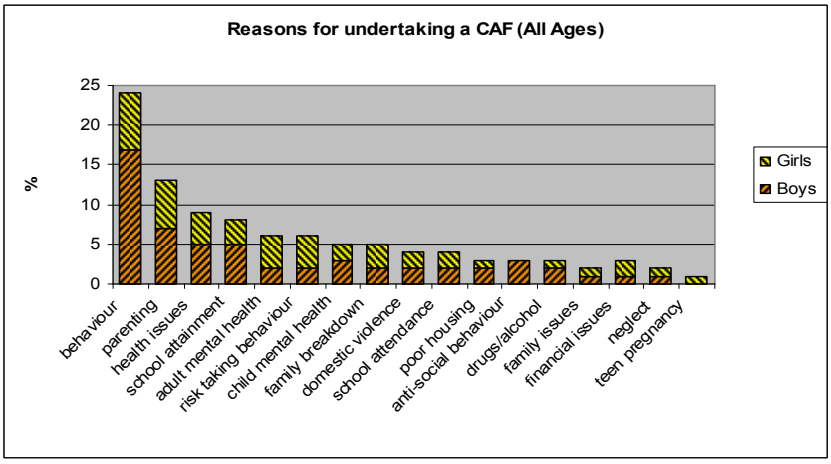
The consultation process performs an important function by offering guidance to agencies with queries about appropriate courses of action for children. All Area Teams support their local agencies with Professional Consultations and it is an important tool for identifying appropriate needs early. Between January and October 2010 2,494 consultations took place across the Area Teams.




Schools (53%) are involved in the majority of consultations, with primary schools (28%) being the biggest agency. Over 30 agencies took part in consultations.

From all the consultations which took place between January and October 2010, 19% were about a child already in TAC, 20% were advised to complete a CAF and 6% were advised to refer to Children's Social Care.

An audit of CAF activity was undertaken in 2010 to enhance provision for support and understand local needs. The information presented below is based on the small sample currently available.



The audit tells us that CAFs are taken for a variety (and combination) of reasons, and these reasons vary between age and gender. The graph above shows that while behaviour (23%) is the most common single reason why a CAF is completed; it is a far more common reason in boys than in girls. For boys, behaviour, parenting, health and attainment at school appear more often than other reasons on CAFs. For girls the most common reasons are behaviour, parenting, health, adult mental health and risk taking behaviour. Boys are 3 times more likely to have behaviour cited as a reason for CAF and girls are 3 times more likely to have risk taking behaviour cited.

## *Key Achievements*

Improving the quality of CAFs and monitoring the activity undertaken across the borough has been a key priority for the LSCB in 2010. Key achievements are as follows:

- Reviewing and updating the Guide to Integrated Learning
- Producing a new Summary Guide to Integrated Learning
- Producing a Wirral CAF with accompanying guidance material
- Providing regular updated CAF and TAC training sessions across the borough
- Establishing a CAF webpage on the Wirral Council website including the new guidance material
- Developing a new Wirral quality assurance tool to support the audit of CAFs
- Producing new monthly CAF Activity and CAF Quality Assurance reports
- Developing a consultation pathway with Wirral Partnership homes
- Presenting information and training to post 16 training providers

In addition, Wirral was invited to take part in the Pathways to Support project led by Outcomes UK and Government Office North West. The processes and literature we have developed to improve the quality of assessment were presented at the North West conference in September.

## *Future Developments*

Planned future developments for CAF/TAC in 2011/12 include:

- Reporting on the monthly CAF Audit investigating why CAFs are undertaken
- Review and promotion of the CAF/TAC training
- Highlighting the role of the Lead Professional for agencies
- Developing and publishing a quality assurance toolkit to facilitate practitioners becoming part of the CAF QA process
- Trialling and roll out of a CAF/TAC distance travelled tool to measure the progress made by children, young people and their families in the process
- Continuing work with post 16 agencies and young people to improve the accessibility of CAF to this age group
- Further development of the CAF webpage to include a page specifically for children and young people

# 12.Child Protection Performance Data

## Referrals

A referral is taken by children's social care when a parent, professional or a member of the public either expresses concern about a specific child's welfare or makes what appears to be an appropriate request for a service on behalf of a child. Not all contacts with children's social care become referrals. Professionals or members of the public might also be given information about different services or advice about other ways to deal with the problem: the giving of this information or advice would not necessarily be recorded as a referral, but could be registered as a 'contact' relating to that child.

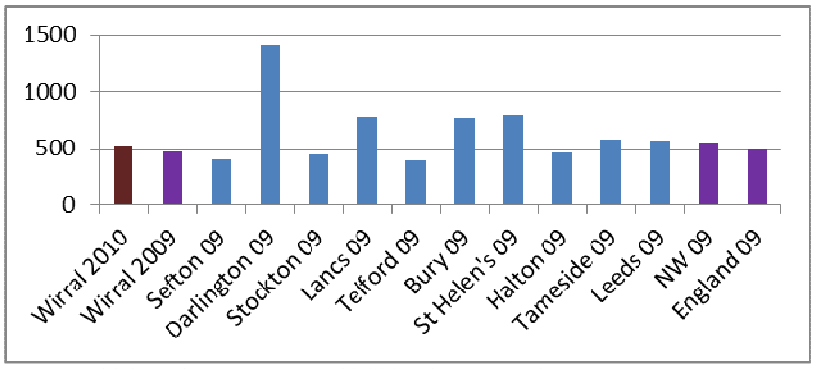



Table 11.1: Referral rates per 10,000 child population

During the year ending March 2010, Wirral children's social care recorded 3,503 referrals. This approximates to a rate of 517 referrals for every 10,000 children in the borough and is an increase of 10% when compared to the year before. Table 1 demonstrates how the rate of referral in 2009-2010 compares with the data from 2009-2009 for Wirral, for the authorities which the government considers to be most like Wirral, with all of the authorities in the North West and with England as a whole.

It can be seen that the rate of referral in Wirral is similar to the rate for the North West and for England generally. However, there is some considerable variation in the data provided by Wirral's comparator authorities. It is likely that some of the extreme variation in statistics provided by particular authorities is due to there being different interpretations of what constitutes a referral and what should be recorded as a contact.

The effect of this can be seen in Table 2. For example, Darlington had a referral rate of 1400 in the year 2008-2009. However, just over 20% of those recorded referrals progressed to initial assessment, whereas in Wirral, the North West and in England in 2008-2009, over 60% of referrals led to initial assessments.

In Wirral, in 2009-2010, 75% of referrals were followed by an initial assessment.

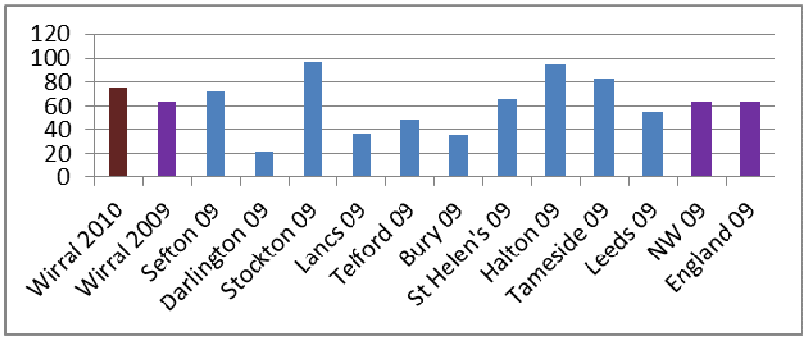



Table 11.2: Percentage of referrals going to initial assessments (national indicator)

## Initial Assessments

The purpose of an initial assessment is to determine, quickly and accurately, whether a child is 'in need' and the nature of the services he or she requires. Table 3 indicates the percentage of initial assessments which were completed within 7 days of a referral being initiated. From April 2010, the timescale nationally for completion of initial assessments was extended from 7 working days to 10. It is anticipated that these extra three days will allow local authorities to assure the quality of initial assessments, without sacrificing timeliness.

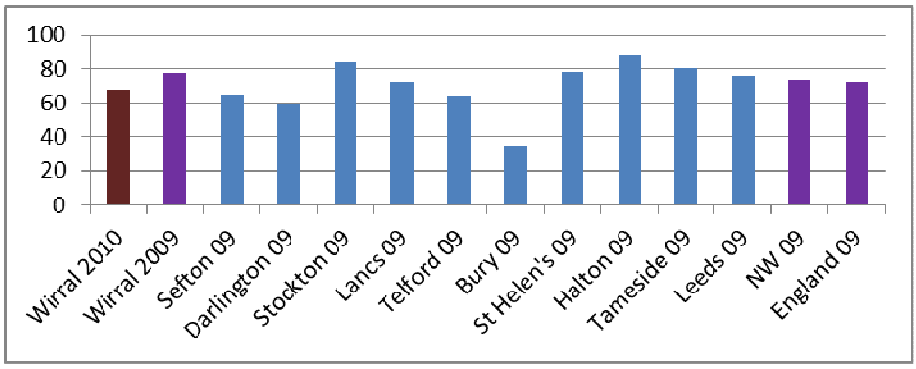



Table11.3: Percentage Initial Assessments completed within 7 days (national indicator)

An initial assessment might conclude that the child's needs are too complex to be understood quickly or that the child appears to be suffering, or to be at risk of suffering, abuse or neglect. In these circumstances, the local authority is required to make a more in-depth assessment of the child and his or her family: this is known as a core assessment.

## Core assessments

Core assessments can provide a sound evidence base for professional judgements as to what types of services are most likely to bring about good outcomes for children with complex needs or complicated family circumstances.

However, core assessments are also the means by which child protection enquiries are carried out: these are often known as section 47 enquiries. In these cases, the objective of the assessment is to determine whether action is required to safeguard the child as well as

to ascertain whether services are required to promote his or her welfare. The number of core assessments conducted in Wirral in 2009-2010 rose by 40% in the last year.

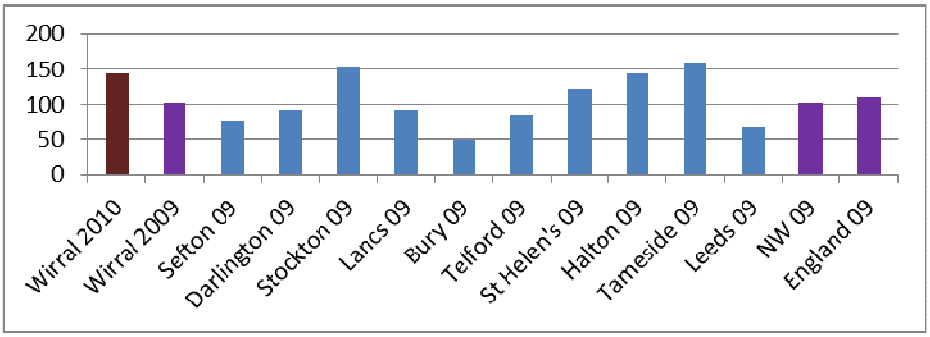



Table 11.4: Rates of core assessments by 10,000 child population

It is expected that core assessments will be completed within 35 working days of the referral which began the process. Table 5 compares the performance of Wirral 2009-2010, with last year's performance by comparator authorities and with regional and national averages. 76% of core assessments were completed within 35 days during the year, which is a slight drop from 2008-2009. However, the actual number of core assessments completed within timescales rose from 540 to 744.

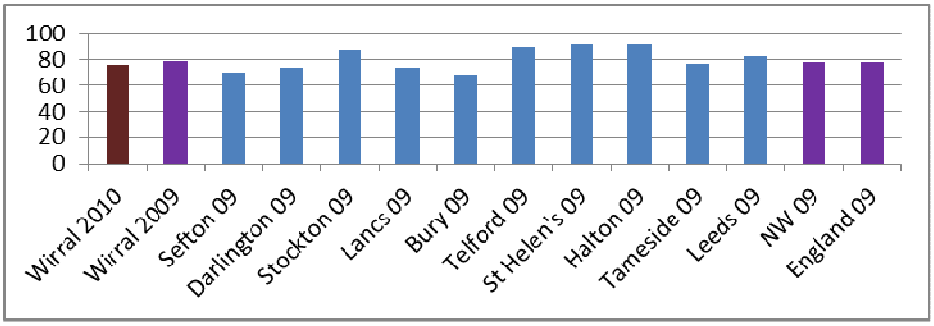



Table 11.5: Percentage of core assessments completed within 35 days (national indicator)

## Initial child protection conferences and reviews

Child protection conferences and reviews bring together the child (where this is appropriate), family members and those professionals most involved with child and family, following child protection enquiries.

In some cases, child protection enquiries will indicate that there is no need to hold a child protection conference. This is usually because the concerns that the child was being abused or neglected were not substantiated or, less frequently, because agencies most involved with the child and family agree that, despite the harm the child has suffered, a plan to ensure the child's future safety and welfare can be developed and implemented without the need for a conference or child protection plan.

When concerns have been substantiated and the child is judged to be at continuing risk of significant harm, an initial child protection conference must be convened. The aim of the conference is to allow those professionals most involved with the child and family,

and the family themselves, to evaluate the relevant information and to plan how best to safeguard the child and to promote his or her welfare.
The timing of an initial child protection conference must balance the need for adequate preparation and assessment of the child's needs and circumstances with the necessity of avoiding delay where a child is suffering, or is at risk of suffering, significant harm. Consequently, there is an expectation that all initial child protection conferences will take place within 15 days of the decision to start s47 child protection enquiries.

Table 6 demonstrates the relationship between the numbers of S47 enquiries started, the number of initial child protection conferences held and the numbers of conferences held within the 15 working days timescale.

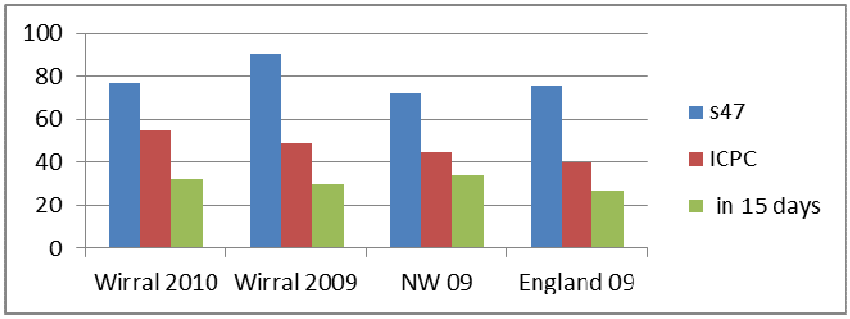



**Table 11.6: Rates per 10,000 child population of s47 enquiries, initial child protection conferences and of initial child protection conferences held within 15 days of the relevant strategy discussion**

The initial child protection conference decides whether there is evidence that the child needs a child protection plan and, where this is the case, will make recommendations on how professionals and the family can work together to safeguard the child. These recommendations are developed by the professionals working most closely with the family into a comprehensive plan.

The extent to which the plan has been successful in safeguarding the child is reviewed in accordance with a nationally determined time frame. Each review considers whether the plan should remain in place or should be changed. It is important that these reviews take place as anticipated to help keep professionals and the family focussed on achieving the necessary changes and to prevent drift.

Table 7 provides information about Wirral's success in meeting this target.

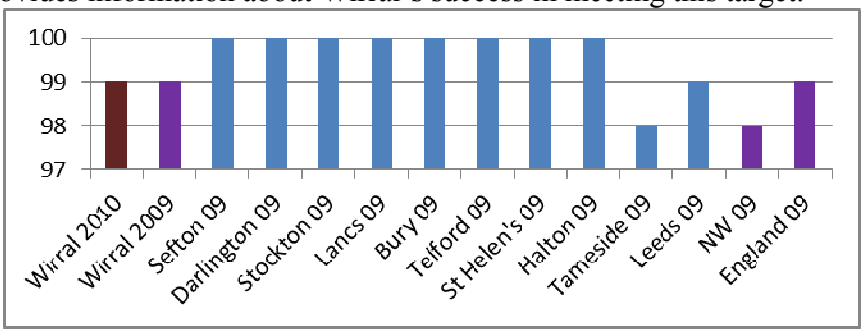



**Table 11.7: Percentage of child protection reviews conducted within required timescales (national indicator)**

## Children with child protection plans

The number of children in Wirral with a child protection plan at the end of March 2010 was 237, a slight increase on the numbers of children with a child protection plan a year earlier of 226. This means that there were 35 children with a child protection plan for every 10,000 children in Wirral. Table 8 demonstrates that this rate accords exactly with the regional and national averages at the end of March 2009, and with the average of Wirral's comparator authorities.

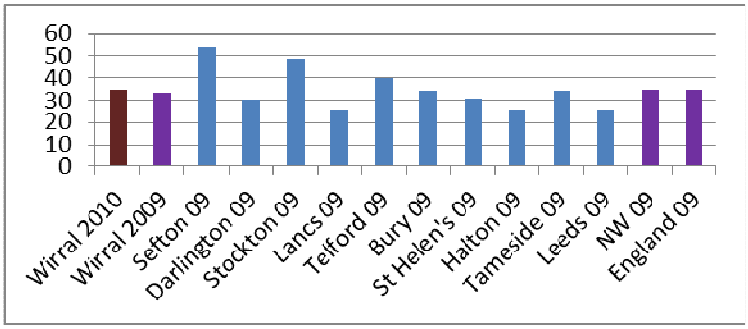



**Table 11.8: Rate per 10,000 child population of children with a child protection plan at March 31 2010 compared with March 2009**

However, the numbers of children with a child protection plan on a particular date does not provide the full picture of the extent to which child protection plans are initiated and ended. As can be seen in Table 9, the number of children with active child protection plans at any one time is a result of the underlying rate at which the number of plans being started is balanced by the rate of those coming to an end.

For example, 43% fewer plans were started in October 2009 than in April. However, this resulted in only a 13% drop in the number of active child protection plans as the rate at which plans had ended from April to July had been generally lower than the rate at which they begun. During the school summer holiday period and into the autumn, the rate at which plans were ending exceeded the rate at which new plans were beginning.

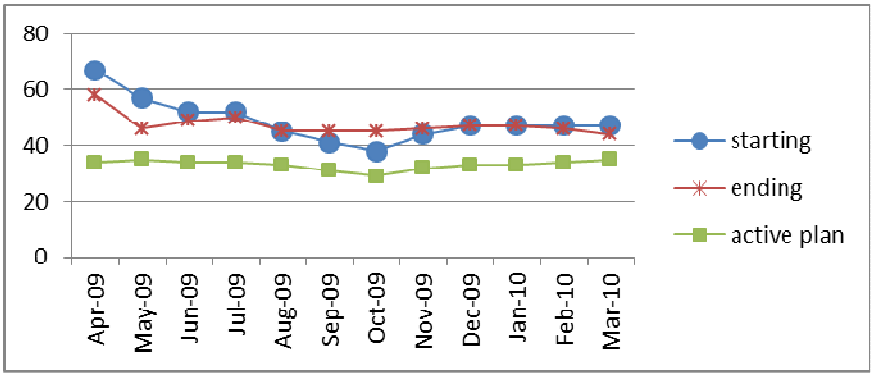



**Table 11.9: Rate per 10,000 child population by month of children becoming the subject of child protection plans, of child protection plans ending and of active child protection plans**

Child protection plans end when the likelihood of harm has been reduced and professionals agree that the child can live safely without a child protection plan. Table 10 provides a summary of length of time that child protection plans were in place before they were ended during 2009/10 and the preceding 3 years.

The proportion of child protection plans which ended within the first three months rose significantly between 2007/08 and 2008/9. Some of these children will have moved to foster placements during this time. The relative duration of child protection plans remained almost identical between 2008/09 and 2009/10.

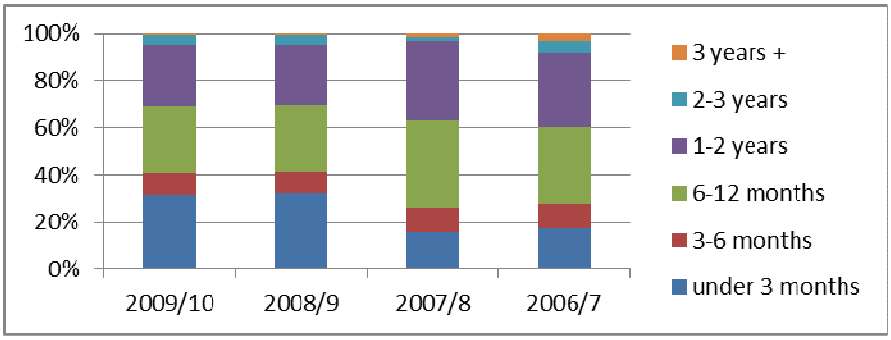



Table 11.10: The length of child protection plans

The purpose of child protection plans is to ensure that children do not suffer abuse or neglect. Although some children will come into care while they have a child protection plan, most children will continue to live with their parents. The rate at which parents can affect the changes that need to be made, and to demonstrate that these can be maintained, will vary from family to family. However, sustained change should be evident in less than two years: where this cannot be achieved, the viability of the child remaining with his or her parents or carers must be questioned.

The local authority provides information annually to the government about the numbers of children whose plans lasted more than two years. From the number of child protection plans which ended during the year, Table 10 compares the percentage of those plans which lasted 2 years or more. In Wirral in 2009/10, only 9 of the 314 plans which ended had been in place for 2 years or more. This compares favourably with performance in this area nationally, regionally and against the average of comparator authorities.

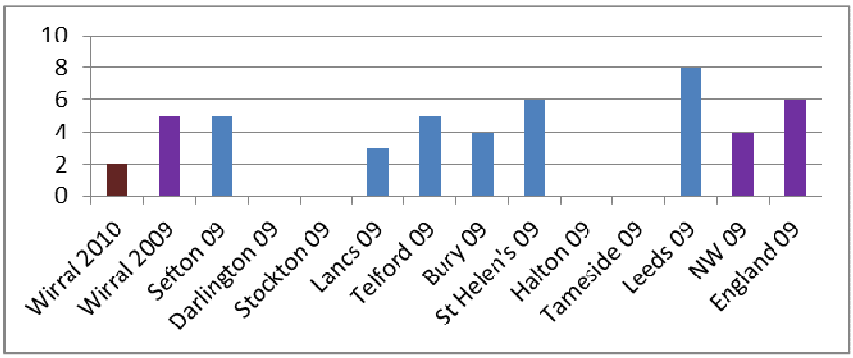



Table 11.10: Percentage of child protection plans lasting 2 years or more (national indicator)

Child protection plans should only be ended when the child is no longer suffering abuse or neglect and the risk of further abuse or neglect has been reduced. This change can be as a result of action taken as a result of the child protection plan, or the child and family's circumstances may have changed so that the child protection plan is no longer necessary. However, a child who is no longer the subject of a child protection plan may still require additional support and services and discontinuing the child protection plan should never lead to the automatic withdrawal of help. One of the ways in which the government measures the success of child protection work with families is by taking account of the numbers of children who have a second or subsequent plan. Unfortunately, during 2009/10, 55 of the 325 children who became the subject of child protection plans had previously had a plan.

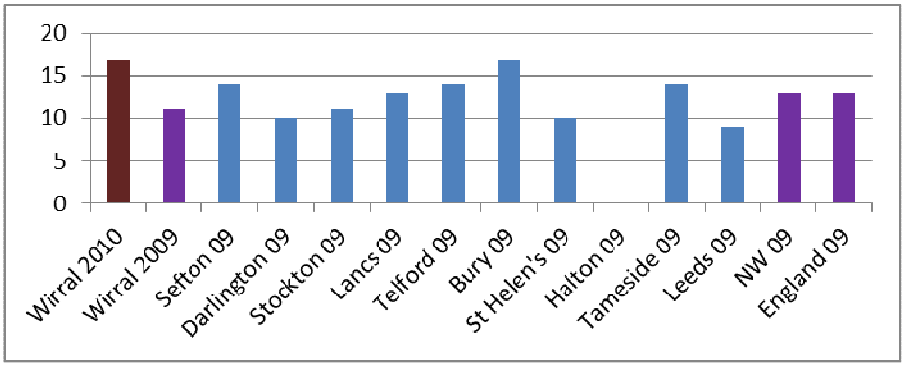



**Table 11.11: Percentage of child protection plans started in the year for children who have previously had such a plan (national indicator)**

Table 12 provides information about the ages of children who had a child protection plan at the end of March for the last four years. Consistently, around 40% of children with a child protection plan are 4 years old or under, around 30% are between the ages of 5 and 9 years old; the largest proportion of the remaining children are between 10 years old and 15, with 5% or fewer 16 years or older. In the latest summary of information about children in England who have died or have been seriously injured by their parents or carers, physical assault accounted for around 57% of cases, primarily inflicted on babies aged under 1 year old, within a family context.

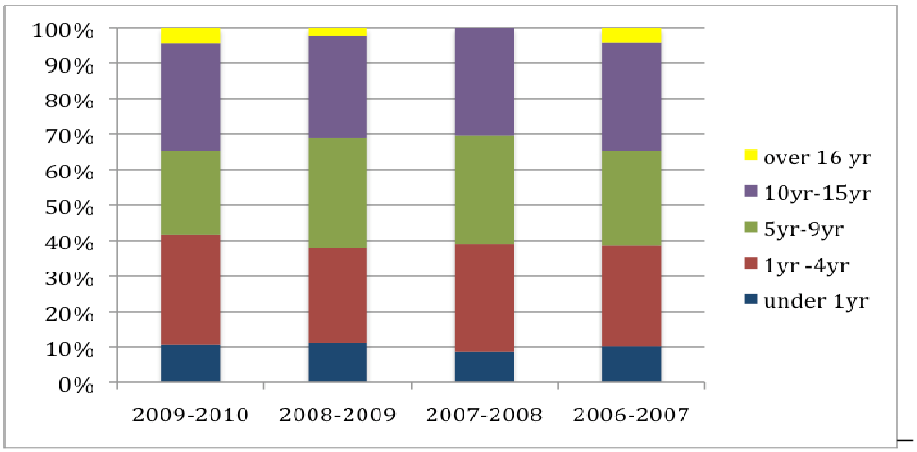



**Table 11.12: Numbers of children with child protection plans by age**

## Notifications of children missing from home or care

*This section needs something about Barnardo's right track project*

During the year ending March 31 2010, there were 357 notifications of Wirral young people missing from home or from care: the notifications were equally divided between children who were missing from care and those who had gone missing from home.

Children and young people cite a variety of reasons for going missing or running away. Table 13 illustrates the most commonly given reasons.

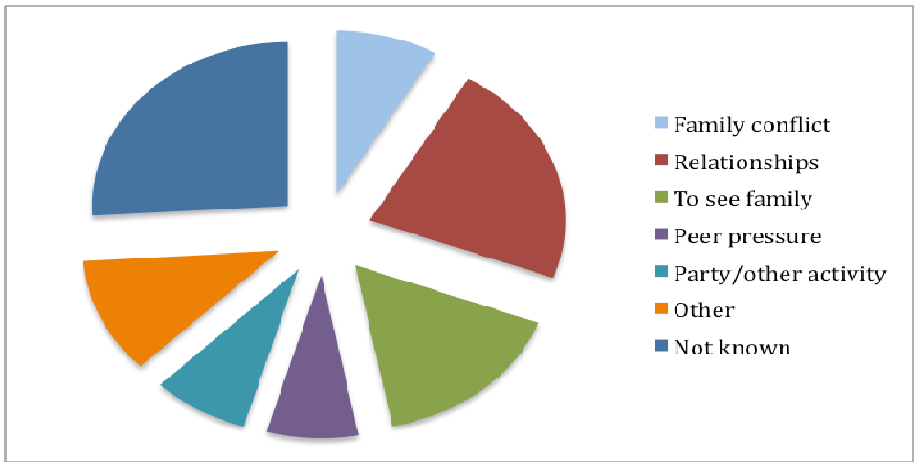



Table 11.13: Reasons given for each notification of missing

Table 14 indicates the numbers of young people who were interviewed by Barnardo's on their return, as part of the Right Track Project.

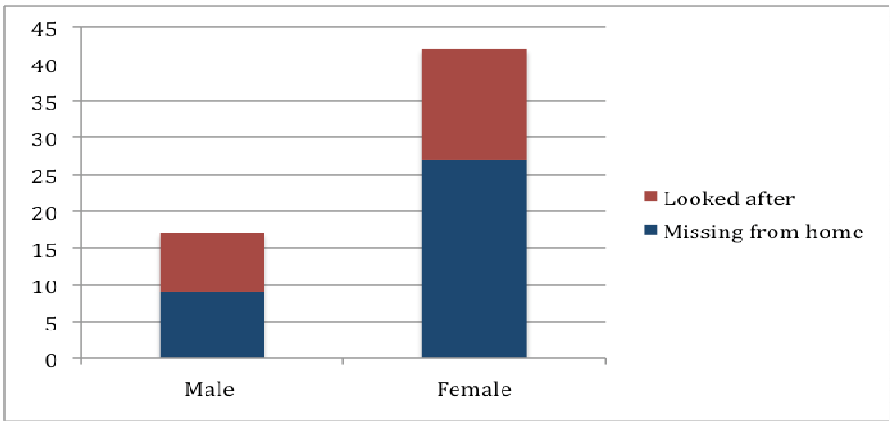



Table 14: Numbers of young people interviewed by Barnardo's following their return going missing

# 13.Financial Report

| **Expenditure** | **2009-10** | **2010-11** |
|---|---|---|
| Staffing | 145 092 | 178 155 |
| Training | 17 147 | 12 000 |
| Serious Case Reviews | 12 718 | 15 000 |
| Advertising/marketing | 12 616 | 0 |
| Room Hire | 17 915 | 11 400 |
| Printing/Copying | 5 895 | 5 500 |
| General expenses | 3 988 | 4 000 |
| Total | 215 371 | 226 055 |
| **Income** | **2009-10** | **2010-11** |
| Children's Social Care | 70 000 | 70 000 |
| CAFCASS | 500 | 550 |
| Merseyside Police | 10 000 | 10 000 |
| Wirral PCT | 30 000 | 30 000 |
| Connexions | 5 000 | 5 000 |
| Probation Service | 3 500 | 5 000 |
| Schools | 0 | 20 000 |
| Schools Budget | 0 | 20 000 |
| Child Death Grant | 0 | 56 100 |
| Total | 119 000 | 216 650 |

The LSCB is supported financially by its member organisations and, when available, by government grants. Managing the finances of the LSCB is a difficult process as although *Working Together to Safeguard Children* (2010) states that contributions should be made by partners, it does not specify a formula to do so. Rather, it is through negotiation and the commitment of the individual members that the contributions made remain consistent.

The LSCB consider the budget on a quarterly basis. Planning spending is challenging as the fees incurred by Serious Case Reviews can be variable and the requirement to undertake a Serious Case Review is essentially unpredictable. The Regional Group for LSCB Business Managers plan to devise a standard fee for the services needed for such reviews in order allow better budget planning.

Balancing the finances is a delicate task as there are areas of expenditure which should not be compromised. The training budget, for example, is used to facilitate the multi agency training which is paramount to effective safeguarding. The room hire detailed above refers to the cost of renting accommodation for Child Protection Conferences in locations which are easily accessible to the parents/carers and families who need to attend them.

# 14.LSCB Priorities 2011/12

1. To continue to improve the functioning and accountability of the Board by:

- publishing an annual report and business plan in line with requirements of Working Together
- implementing the recommendations from the review of the LSCB committees
- ensuring membership of the LSCB accords with Working Together guidance, including the appointment of Lay Members
- implementing induction processes for new Board Members
- undertaking annual audit of member agencies in fulfilling their responsibilities to co-operate (Section 11 Children Act 2004) in relation to safeguarding children
- conducting accountability meetings with partner agencies

2. To improve learning from Serious Case Reviews and Critical Incidents by making use of and developing SCIE model as a review framework.

3. To evaluate the extent to which lessons identified in previous or current reviews have been learnt in practice, specifically relating to issues of parental mental ill-health, child sexual abuse, domestic abuse and neglect.

4. To continue to monitor thresholds across the partnership for Common Assessment Framework, Child in Need, Team Around the Child and Child Protection.

5. To monitor closely the effects of budgetary pressures and potential organisational restructuring of services, acting as necessary to continue to effectively safeguard and promote the welfare of children.

6. To improve communication processes between the LSCB, its committees, the wider workforce and general public.

7. To strengthen joint working arrangements between the LSCB and the Safeguarding Adults Board.

8. To maintain representation and contribution to Multi Agency Public Protection Panels.

# 15.LSCB Business Plan 2011-12

## 1. Continue to improve the functioning and accountability of the LSCB

| ACTION | LEAD | TIMESCALE |
|---|---|---|
| Publish an annual report and business plan in line with requirements of Working Together | Strategic Service Manager, Safeguarding | March 2011 |
| Implement the recommendations from the review of LSCB Committees | Executive Group Chair | March 2011 |
| Ensure membership of the LSCB accords with Working Together guidance, including the appointment of Lay Members | Chair LSCB | March 2011 |
| Implement induction processes for new Board Members | LSCB Business Manager | March 2011 |
| Undertake annual audit of member agencies in fulfilling their responsibilities to co-operate in relation to safeguarding children (Section 11) | LSCB Business Manager | June 2011 |
| Conduct accountability meetings with partner agencies | Chair LSCB | December 2011 |

**LSCB Priorities 2011/2012**

| **2. Improve learning from Serious Case Reviews and Critical Incidents by making use of and developing SCIE model as a review framework** | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Complete exemplar critical case review using modified version of the SCIE model, including recommendations and action plan | Strategic Service Manager, Safeguarding | February 2011 |
| Evaluate the process through which the critical case review was undertaken | LSCB Business Manager | March 2011 |
| Produce final report of critical case review and its evaluation for LSCB | Strategic Service Manager, Safeguarding | March 2011 |
| Devise draft procedure based on evaluation for conducting future critical case reviews taking into account lessons learnt from examplar case | Chair Performance Committee | June 2011 |
| LSCB to approve and implement revised procedures for conducting critical case reviews | LSCB Chair | July 2011 |

**LSCB Priorities 2011/2012**

| **3. Evaluate the extent to which lessons identified in previous or current reviews have been learnt in practice; specifically relating to issues of parental mental ill health, child sexual abuse, domestic abuse and neglect** | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Devise programme of thematic multi-agency audits to be conducted on behalf of the LSCB | Chair Performance Committee | March 2011 |
| Undertake audits as proposed | LSCB Business Manager | As per programme to ensure completion by March 2012 |
| Evaluate multi-agency safeguarding practice on the basis of thematic audits | Chair Performance Committee | As per programme, within 6 weeks of completion of individual audits |
| Report to the LSCB | Chair Executive Group | Quarterly |
| Undertake a study of neglect and use of the Graded Care Profile reviewing cases in practice | Policy, Practice and Procedure Committee | December 2011 |

**LSCB Priorities 2011/2012**

**4. Continue to monitor thresholds across the partnership for Common Assessment Framework, Child In Need, Team around the Child and Child Protection**

| ACTION | LEAD | TIMESCALE |
|---|---|---|
| Collect and collate data in respect of CAF, CIN, TAC | Chair CAF Quality Group | Ongoing |
| Report to LSCB in respect of performance in respect of CAF, CIN, TAC | Chair CAF Quality Group | Quarterly |
| Collect and collate data in accordance with key LSCB CP indicators | Strategic Service Manager, Safeguarding | Ongoing |
| Report to the LSCB in respect of performance against key CP indicators | Strategic Service Manager, Safeguarding | Quarterly |
| Produce annual report of performance in respect of CAF, CIN, TAC | Chair CAF Quality Group | June 2011 |
| Produce annual report of performance in respect of key CP indicators | Strategic Service Manager, Safeguarding | June 2011 |
| Revise the procedures and processes in place for CIN | CIN Officer | December 2011 |

**LSCB Priorities 2011/2012**

| **5. Monitor closely the effects of budgetary pressures and potential organisational restructuring of services, acting as necessary to continue to effectively safeguard and promote the welfare of children** | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Set out budgetary requirements for LSCB, based on current activity, to ensure that agencies and organisations have clarity about proposed contributions | Strategic Service Manager | Completed November 2010 |
| Identify any likely shortfalls and risks to Board | LSCB Chair and Executive Group Chair | February 2011 |
| Produce contingency plan | Strategic Service Manager | March 2011 |
| Record and report to Board on the effects of budgetary pressures and organisational restructuring of services to safeguard children and promote their welfare | All LSCB members | Ongoing |
| Record and report to Department of Education on the effects of budgetary pressures and organisational restructuring of services to safeguard children and promote their welfare | LSCB Chair | Ongoing |
| Implement contingency plans | LSCB Chair with Strategic Service Manager, Safeguarding | As required |

**LSCB Priorities 2011/2012**

| 6. Improve communication processes between the LSCB, its committees, the wider workforce and the general public | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Ensure implementation of agreed reporting arrangements between Committees, the Executive Group and the LSCB | LSCB Chair with LSCB Business Manager | Ongoing |
| Identify 'in-house' magazines and newsletters currently in use by member agencies, and explore potential for providing LSCB contributions | All LSCB members with LSCB Business Manager | October 2011 |
| Develop quarterly Newsletter for distribution electronically to workforce in all agencies, either via already developed 'in-house' magazines or separately which will also be linked to information about LSCB multi-agency training | LSCB Business Manager with Chair Training Committee | January 2012 |
| Identify means of developing and maintaining LSCB website | LSCB Business Manager | March 2011 |
| Establish and maintain LSCB website | LSCB Business Manager | June 2011 |

**LSCB Priorities 2011/2012**

| 7. Strengthen joint working arrangements between the LSCB and the Safeguarding Adults Board | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Working with Chair of Safeguarding Adults Board identify strategies to support the development of the Safeguarding Adults Board | Interim Head of Safeguarding- Children and Adults | With immediate effect |
| Identify activities that are common across both Boards which can be undertaken jointly | Interim Head of Safeguarding- Children and Adults | With immediate effect |
| Report on progress to LSCB | Interim Head of Safeguarding- Children and Adults | Quarterly |
| Ensure LSCB annual report and business plan 2011-2012 is provided to SAB members | LSCB Business Manager | On publication of report |
| Provide copies of LSCB newsletter to SAB | LSCB Business Manager | Quarterly from January 2012 |
| Arrange joint biennial development day for LSCB and SAB | LSCB Business Manager | November 2011 |

**LSCB Priorities 2011/2012**

| 8. Maintain representation and contribution to Multi Agency Public Protection Panels | | |
|---|---|---|
| ACTION | LEAD | TIMESCALE |
| Continue to provide, where appropriate, LSCB representation at MAPPA through services of Local Authority Designated Officer | LADO | Ongoing |
| Monitor functioning of MAPPA | Strategic Service Manager working with LSCB member for Merseyside Probation Trust | With immediate effect |
| Provide annual report on functioning of MAPPA to LSCB | LSCB Member for Merseyside Probation Trust | November 2011 and November 2012 |