Reporting to:	**Suffolk Local Safeguarding Children Board**			
Meeting Date:	17 July 2018			
Report Status: ***Please indicate as appropriate***	This report is confidential and for the attention of LSCB Members only	☐	This report can be shared without further reference following approval by the LSCB	X☐

LSCB Sub-Group Please indicate which group	**Learning and Improvement Group (LIG)**		
Sub-Group Chair/Author:	Chair: Sue Hadley Author: Tracy Murphy	**Has the Sub-Group endorsed this report?**	Yes
How does this report contribute to protecting/safeguarding children	Ensures that the relevant level of scrutiny, audit and performance reporting by the L+I group influences and improves front line practice.		
Impact/Evidence 'What will the impact of safeguarding arrangements be and how will this be evidenced'?	Improved understanding across the group of partners Safeguarding issues following presentation of the half year performance report and thematic audits.		
Where does this report link into the LSCB Forward Delivery Plan/work of the LSCB? If not, why has the work been undertaken?	Core Business - Performance Management		

Governance Arrangements	Policies and Procedures	Information Sharing	Influence and Impact	Performance & Effectiveness

'Ofsted will consider how effectively the LSCB evaluates and monitors the quality and effectiveness of the local authority and statutory partners in protecting and caring for children, including the provision of improvement advice'

What are the key issues arising from the work of the sub-group for consideration and/or discussion?	Board are asked to consider the summary of the annual performance reports reviewed by the Learning and Improvement group in June.
What are the recommended actions arising from this report for Board partners?	Approval of the LSCB annual performance report and to note the points rasied for consideration.
What are the timescales associated with this report?	**April 2017 to March 2018.**

The following annual performance reports were received at the Learning and Improvement Group in June 2018.

The Resolution Team

What's Working Well

- The majority of maintained, academy and free schools completed the self-assessment within the timeframe. The self-assessment was launched on a different platform to last year which meant schools were able to save their assessment once complete, rather than having to contact the Resolution Team to obtain a copy. This resulted in more effective use of professional's time during the assessment process.
- The more comprehensive self-assessment has resulted in the Local Authority collating data from school's which was previously not captured. This enables a more complete picture of the safeguarding provision within schools to be develop and in turn aids Local Authority officers in undertaking appropriate challenge to educational settings to continually work to improve safeguarding provision within all schools in Suffolk.
- The introduction of qualitative feedback through the self-assessment allows the Local Authority and the LSCB to understand how service provision, such as the MASH, is perceived by service users in the form of school leaders. Sharing this information with teams allows improvements to be considered if required and provides feedback to those working within the service area, of which positive feedback can have an encouraging impact on team moral and output.

What are we Worried About

- There are significant concerns over the validity of the data received. Initial analysis undertaken by The Resolution Team has confirmed that many of the statements selected by settings do not match either the information on their website and/or information held by the Local Authority. At present analysis has not concluded if there is a theme with maintained or academy status schools.

What Needs to Happen

- The Resolution Team will undertake a full, in depth analysis and share the findings with the LSCB.
- The Resolution Team will be meeting with the LSCB headteacher reps to share the findings of the 175/157 Safeguarding Self-Assessment and seek their views on assessment.
- The Resolution Team will facilitate three engagement groups in the autumn term with headteachers to share the findings of the 2018 175/157 Safeguarding SelfAssessment and consult on the assessment for 2019.
- The Resolution Team will work with colleagues to action the findings of the full report. This will include continued working with the LADO and Social Care colleagues.

Schools Choice Governor Safeguarding Training

What's Working Well

- A total of 670 Governors attended the Introduction to Safeguarding training sessions. This represents an increase of 119 from the numbers attending last year.This is due in part to a restructure of the training to one which entitles subscribing schools to more in house training opportunities.
- Evaluations from the main programme sessions show that 97% rated the course they attended as 'good' or 'outstanding'.

What are we Worried About

- In some schools the DSLs are delivering safeguarding training to Governors at the same time as their workforce. There is no way of tracking the number of Governors who have undertaken training in this way.

What Needs to Happen

- Training materials will continue to be reviewed and updated with SLQA colleagues and will be updated in line with the new Keeping Children Safe and Working Together 2018.
- Schools Choice will continue to include twelve county wide courses for Introduction to Safeguarding for Governors but will also be adding further safeguarding training opportunities.
- Schools Choice will continue to encourage governing bodies to open up their in house training sessions to other local schools.

Workforce Development Multi-Agency Training

What's Workng Well

- There is good and steady attendance on the Introduction to Safeguarding course, Working Togerther to Safeguard, CE and DA courses.
- There has been good multi-agency attendance at the safeguarding trainers forums, sessions have received good feedback from delegates and have benefitted from the involvement of practitioners and Service Managers from CYP and ACS.
- A minimum standard for the delivery of CE training by all partners and CE trainers has been agreed by the CE Strategic group and this is being monitored via the LSCB PPE/TQS subgroup and the CE strategic group.
- Online ThinkUKnow e safety courses have been delivered to some Foster Carers and Special Guardians.
- The GCP2 has been delivered to nearly 400 practitioners. The majority from SC, EH and Health.
- YOS and MAC Team expertise has been used to develop and deliver training to MASH staff on gangs and County Lines.
- An excellent piece of work on promoting e safety for children and young people has been created involving the Therapeutic Fostering Team, the Engagement Hub, the MAC team and Workforce Development.

What are We Worried About

- The number of school staff attending training on CE topics is low.
- There has been poor takeup of Private Fostering e learning training.
- More specialist training on DA is needed.
- The training promotion strategy to Foster Carers, Special Guardians and adopters needs to be improved; particularly training on CE topics and Missing Children.
- Not enough school staff are attending training on CE topics. This needs to be aligned with School Choice training.
- The Safeguarding training needs of staff in Children Homes and Boarding Schools needs to be explored with them.

What Needs to Happen

- There is a need to work with NSFT and ACS mental health services to develop a training/learning approach which builds knowledge and skills around working with people in crisis and with specific mental health conditions.
- The WFD team, the MAC team, the YOS team and the Exploited Children Co-ordintor will work together to improve the CE training offer and to better engage with schools.
- Children's Home staff have been invited to a meeting to look at their training needs.
- The WFD team will work with the QAPD team, Public Health, the Suffolk DA Forum and the LSCB to plan what needs to be in place to complement and add value to the DA Champions model and existing training.
- Reps from the WFD team, PDQA and the LSCB are working to develop a standalone face to face neglect training package. It is hoped that this might go some way to build confidence and encourage staff to complete the GCP2.

Schools Choice Designated Leads Safeguarding Training

What's Working Well

- During the financial year 2017/2018 the number of safeguarding courses accessed through Schools Choice increased from the previous financial year. 34 Designated safeguarding lead (DSL) training courses were delivered, 636 Introduction to Safeguarding courses were delivered (the majority of these courses were delivered in-house by Designated Safeguarding Leads who are T4T Training for Trainers) trained. 418 T4T forum/workshops were delivered and 88 online safety courses.
- Feedback recently from DSLs attending the DSL training has highlighted the positive involvement of the MASH team (Multi Agency Safeguarding Hub) in the DSL training. Members of the MASH team join the DSL training for a session covering the role and composition of the MASH. How to make a good referral and what happens to the referral when it is received by the MASH team.
- Feedback also indicates that the Safeguarding courses are relevant and have increased delegates knowledge and confidence in their ability to complete Safeguarding roles. The resources received by delegates were also rated highly in feedback comments.
- Relationships between Schools Choice, the LSCB and the MASH team are very positive with a common approach to current and future working.

What are We Worried About

- There were some staff changes at Schools Choice during the year which led to an unsettled period with associate trainers taking the DSL courses and some Introduction to Safeguarding courses. This was addressed with the appointment of a new Safeguarding Training Manager.
- There is a concern regarding the lack of monitoring of Safeguarding training completed by schools that is not through Schools Choice. This was raised as a concern recently and a suggestion of asking schools for their Safeguarding trainer, if not Schools Choice, was suggested to keep a check on Safeguarding in schools.

What Needs to Happen

- Schools Choice are looking to continue to provide effective, relevant and up to date Safeguarding Training. Course materials will be updated for September 2018 in line with the new Keeping Children Safe in Education and Working Together to Safeguard Children documents and any other new statutory guidance. Schools Choice will look to the LSCB to quality assure their courses as they have done previously.

- The new Safeguarding Training and Development Manager will look to forge positive relationships with all agencies and educational establishments in Suffolk to make sure that the training is covering local issues as well as national. They will also pass concerns raised at the courses to relevant agencies to allow for positive dialogues between all parties involved in the Safeguarding of children and young people in Suffolk.
- Schools Choice is looking to move the resources for DSL courses into a page tiger format which will make them accessible on line and allow for resources to be downloaded and printed if and when required.

LADO Report

What's Working Well

- Enhanced relationships with colleagues internally and improved links with external organisations.
- The effectiveness of the LADO process in stopping unsuitable adults from continuing to work in positions of trust.
- Increased knowledge of and confidence in the service is demonstrated by a steady rise in the number of referrals to the service and other feedback.
- This year has seen improved recording and tracking.

What are We Worried About

- We still have an incomplete picture of the organisations that do not refer sufficiently. We are furthering our knowledge of this and this will be further explored.
- The time taken to complete Police investigations and the impact on organisations and individuals on being suspended for a long period of time prior to resolution.
- Lack of training and knowledge in transport providers.
- The number of placement breakdowns following allegations
- There is likely to be an increase in the number of Subject Access Requests.

What Needs to Happen

- To target organisations under represented in terms of LADO referrals to ensure that they are aware of LADO thresholds and processes.
- Create training specifically for targeted organisations to ensure that they are aware of LADO thresholds and processes and the need to share information and follow LADO advice.
- Quarterly meetings with Police, Education, Adoption and Fostering, Health, Early Years, Independent Fostering providers, transport providers and key Voluntary organisations will be held with a view to improving communication and understanding and ensuring delays are minimised.
- Continue to review the style and content of LADO minutes and recording, particularly in the light of the new recording system, Liquid Logic.
- Lack of training and knowledge for transport providers is being addressed in liaison with Passenger Transport and a further meeting was held in May to progress the matter.
- To work with Practice Development and Quality Assurance Team to look at reducing placement breakdowns

Missing Children Report

What's Working Well

- A recent Ofsted Inspection recognised that Suffolk's response to missing children has '*Significantly Strengthened'.*
- Presentations continue to be delivered internally and externally about missing children and child exploitation
- There are clear procedures in place for responding to missing children and the procedures encompass a multi-agency approach including Education, Police and Health.
- There are good secure information sharing strategies between police and CYPS to safeguard and ensure no child slips through the net.
- There has been a reduction in repeat missing children this year.
- The majority of missing children are located or return within 24 hours.
- 79% of missing children were already open to CYPS.
- 90% of the CiC reported missing between 10-20 times were presented at TTCG.
- Providers are reporting that children are going missing on a more consistent basis.
- 85% of all children in care reported missing between 10-20 times had MAC intervention through direct work or consultation.
- Return interview compliance is continuing to increase across social care and early help services. Overall compliance currently at 83%, Early Help at 99%, Social Care at 74%.
- Quarterly return interview auditing is evidencing improvements in the quality of return interviews.
- Indicators of CE are beginning to be better evidenced and considered when responding to missing children, based on return interviews.

What are We Worried About

- The number of missing children continues to increase overall.
- More children are remaining missing for longer periods of time (over 1 month).
- Some of these children are known to have links with gangs and county lines.
- More boys are being reported missing. Analysis reflects many are linked with gangs and county lines.
- The average age of children missing is reducing.
- The school holidays continue to receive an increase in missing reports compared to other times of the year.
- Ethnicity of missing children and young people is not being consistently identified and recorded.
- Children in Care continue to receive high levels of missing episodes.
- Concerns linking to placement type including supported lodgings and children's homes.
- The average age for CiC reported missing is 16-17 years.
- Inconsistent processes remain in place for Suffolk becoming notified when children placed in another LA area are reported missing (and vice versa).
- Links with missing episodes and child exploitation continue to be seen within this report.
- Certain areas of Suffolk receive higher numbers of missing episodes.

- There is further room for improvement in return interview compliance. Busier teams are experiencing lower compliance potentially due to the increased demand in reports.
- Safety plans require strengthening in response to missing children.
- The majority of reasons for missing children episodes are linked to potentially inappropriate pull factors.
- Where young people refuse to disclose their whereabouts following a missing episode, there appears to be a link with concerns and indicators of CE (76%).
- More qualitative exploration into the links between missing and CE is required.

What Needs to Happen

- Tighter and more robust planning are required for children who continue to be missing over one month. Whilst there are case by case processes in place, formal procedures are required to ensure these cases have a consistent response and authorisation of closure if required.
- Closer liaison between the Missing Co-ordinator and the Gang, Violence and County Lines team is needed to explore how worries can be better monitored.
- Liaison with schools to explore if further intervention is required to support diversion and risk assessing of missing episodes alongside CYPS.
- Exploration into school holiday activities and community activity opportunities for young people to be put in place.
- Police reports to ensure the consistent identification of ethnicity and this information to be uploaded onto CF6 child's record.
- Research project to be undertaken starting with Suffolk children's homes to gather young people's views around missing and what they would like to be implemented to aim to reduce episodes.
- Missing coordinator to visit supported lodging accommodation providers to explore missing protocols.
- More exploration required around this older age group to identify any potential patterns or trends which may better inform our understanding and responses to older children in care.
- Missing coordinator to establish relationships with neighbouring Local Authority Missing Co-ordinators.
- Exploration required to see if Foster Carers would be able to notify missing children in a child placed in their care by Suffolk was reported missing to police.
- Quarterly reports for missing to explore themes further alongside the CE coordinator. More detailed analysis required to explore areas of the county and map concerns of CE.
- Gang violence and County Lines team has been created to explore the increase in gang activity, tackle and create diversions.
- Return interviews to focus on exploration of gangs where indicated this is a concern. Resources to be developed to work more creatively with these young people e.g. rag rating mapping of areas of safety for the young person, different safety plans to reflect this *(contextual safeguarding network).*
- Monthly data information to be shared with Heads of Service, CYP Service and Practice Managers.
- Work to be conducted between the Missing Co-ordinator and Leaving Care teams to explore outstanding return interviews and suggest alternative strategies to better manage this.

- Reporting of missing children to be managed on a case by case basis with young people having individual missing protocols to be followed when reported missing.
- Auditing of Return Interviews to continue and findings to be shared with relevant practitioners.
- Practitioner workshops to take place exploring successful return interviews.
- Examples of good safety plans to be added to the CYP Good Practice Guide.
- Auditing to explore links between lack of disclosure and CE.
- A small audit to take place to explore the outstanding return interviews to clarify whether they hav been completed directly with the young person but not recorded on the system.

Private Fostering

What's Working Well

- Responsibility and delivery of the service to Privately Fostered children and their carers remains with the Fostering Changes for Children Team (FCFCT) in the Adoptiom and Fostering Service bringing consistency and continuity. There is significant expertise located within the team.
- The Private Fostering Panel met five times during the year and benefited from the considerable expertise provided by Health and Early Help colleagues as well as the FCFCT manager. The Panel considered 27 arrangements, a significant increase over the number brought to Panel in the previous year.
- The Manager of the FCFCT has returned to sit on the Panel. This has provided an overview of the Private Fostering Arrangement Assessment Reports (PFAARs) and Regulation 8 welfare visit reports as a whole, to the service and has enabled feed back on timeliness in completing reports to Panel and the usefulness of the new reporting paperwork introduced the previous year.
- The new readable version of the reports designed for sharing with children, their parents and carers is much more accessible and focusses on what we would want to know about the arrangement rather than on our processes and data quality needs. However, the reports do not contain the manager's supervision summary, and this will now be provided separately to the Panel.
- An E-Learning Module on Private Fostering has been developed and is available for all staff. A set of slides has been developed to ensure a consistent message to all single and multi-agency settings.
- The team have been able to respond to opportunities to offer and provide be-spoke training sessions and provide support for CYPS colleagues in all areas of family and friends care. They have provided training for MASH colleagues and social work students, updated the private fostering section of the multi-agency safeguarding training and completed an e-module on private fostering for Suffolk County Council's social staff. They continue to offer a duty service during office hours to offer support and advice for any private fostering questions and queries.

What are We Worried About

- The number of notifications had been reducing over the previous three years but stabilized and slightly increased this year to 43 from 39 in 2016/17.
- Whilst the reduction in the number of foreign language students coming to the UK has been maintained this year, and fewer have stayed for a full year, some of the arrangements are of concern and they have highlighted the problems of regulating Educational Guardianship companies. Advice has been sought from SCC's legal service, AEGIS (The Association for

the Education and Guardianship of International Students), DfE and Coram BAAF as to how these arrangements could be managed differently but there is a consensus that the regulations are limited. In addition, in accordance with the Private Fostering Regulations 2005 the Local Authority has no choice but to bear the responsibility and costs of the private fostering assessment, statutory visits and social work intervention, despite the Educational Guardianship Companies bringing children to the UK for profit.

- Families are still not making many private fostering arrangements in child in need or child protection situations which had been expected as a result of family network meetings under Signs of Safety and Well-Being. This continues to result in more children coming into care under Connected Person arrangements than might otherwise be necessary.
- A recent audit of Connected Persons arrangements (usually placements with extended family members or friends) identified several situations where families had made private fostering arrangements but had not been identified as such by the social work teams working with the child and family. This highlights the need to continue raising awareness among professionals of promoting private fostering as a positive alternative to care.
- A new Experienced Social Worker post was created in Autumn 2016. The post has a lead role in Private Fostering with responsibility for overseeing and coordinating all raising awareness activities. Unfortunately, the new appointee has been off work due to health concerns since the summer of 2017 and the practice manager has also unfortunately been unwell for an extended period. These factors have contributed to the lack of progress with meeting the proposed raising awareness plan during 2017/2018.

What Needs to Happen

- A Private Fostering Task and Finish Group should remain the aim of the FCFCT in order to create a forum for service improvement, to review and update all existing documents related to PF and explore ways of increasing notifications and improving practice. A new and relevant audit tool, more closely aligned to the CYP learning tool already in use for other child care cases, will be implemented this financial year.
- The new Liquid Logic system is developing a Private Fostering process which should similarly align PF to other casework systems. It will also provide a systematic trigger for recognizing a PF arrangement.

CDOP Report

Whats Working Well

- Expert panel representing multi-agency professionals from different background and responsibilities chaired by Public Health Consultant so dissemination of learnings are chaired by Public Health Consultant so dissemination of learnings are wide reaching. Panel has a strong dialogue with Suffolk Public Health work streams and utilise specialist expertise to 'drill down' on areas of concern and seek assurance.
- Quarterly Newsletters proactively disseminating local learnings and national level child safety evidence/news. Sharing key preventative messages from local and national child death reviews directly to the public increases parent's knowledge and understanding to take positive steps to safeguard their children and potentially prevent further child deaths.
- Successful implementation of Safer Sleeping Strategy has had a positive impact on reduction of cot death (there has been only one case of SIDS in the last two years). Unfortunately, two of these reviewed cases were due to co-sleeping/accidental overlaying and use of soft surface. Parents of these babies had consumed alcohol and reported to smoking. This shows that focused and targeted campaign work can bring positive outcomes but needs more efforts from all partners to reinforce safer sleeping messages.
- The 'Asthma kills' campaign was led by Public Health to raise awareness of potential seriousness of asthma and improve its management and care at home, in primary and secondary care. A multi-agency action plan has been developed and implementation is monitored to see if it has an impact. The campaign and action plan address issues flagged up from asthma death reviews.

What are We Worried About

- Form B has been re introduced. This form needs to be completed by all professionals involved in child's life prior to death. Timely data collection and quality of information collated through Forms B and C is still an issue and more work needs to be done to inform and educate our professionals in this regard.
- When death occurs outside Suffolk it can be increasingly difficult to find out information from the respective Coroner's office and hospitals which can delay the review process for considerably longer period of time. We are working closely with East CDOP group to look at developing a network of regional professionals to unpick similar challenges.
- Recruitment to the Designated Doctor role is proving difficult but hoping this can be resolved soon.

What Needs to Happen

- The need to work together to provide more support to agencies to collect and submit good quality information in timely manner (refine the process for collection and collation of good quality data via Form B and C).
- The need to refine the current process of obtaining information on delayed cases from Coroner's office.
- Develop a process of communication with parents/carers. Development of a poster to be displayed at pertinent sites to introduce CDOP and promote the bereavement support pages available on the LSCB web pages.
- The need to share the learning from each reviewed case with professionals/agencies who have been involved in the life of a child prior to death.
- Continue dissemination of 'learning from cases' and proactive dialogue with public and professionals through CDOP newsletters. This will include wider safety and preventative issues but with more focus on modifiable factors identified by reviews (car seat safety for

children, emotional and mental wellbeing, e safety parental guidance/control, importance of asthma management at home, promotion of 'Common Illness and Wellbeing Booklet' through its App to reduce hospital attendance and admission and many more).

- Review and update the current SUDIC protocol/process in line with forthcoming CDR review process and exploration of Rapid Response Team
- Agree work plan for how partners will be compliant with the new Child Death Review Statutory Guidance which will be coming out in June 2018. The need We will need to publish the plan by September 2018 (within 3 months of the guidance coming out) with specific actions on what we will do during the transition period between June and September 2019 (15 months from publication).