DSCB Annual Report 2016-17 Annex 2

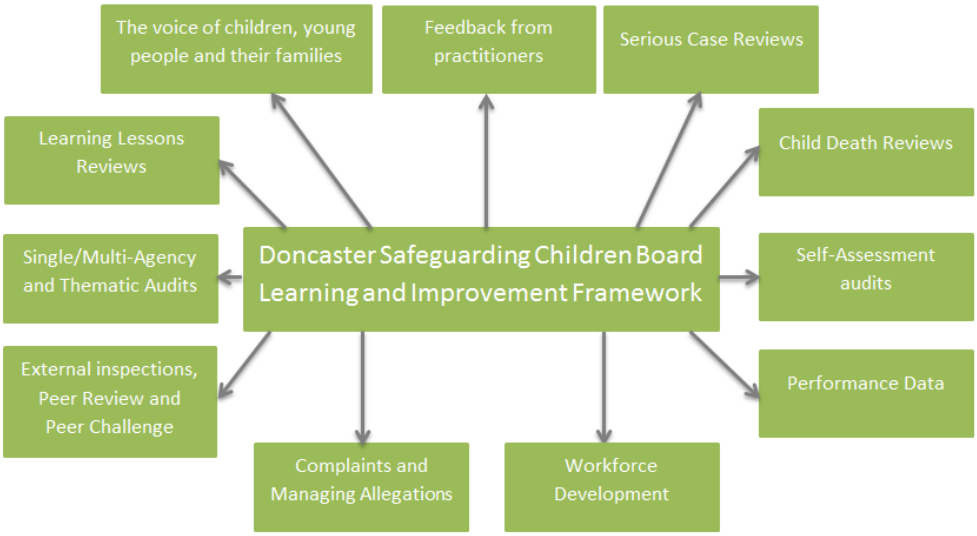
Learning and Improvement

Doncaster Safeguarding Children Board

Working to make our children's lives safer

1. Annex 2 - Learning and Improvement

A key function of the LSCB is to promote learning and improvement across the partnership. DSCB has established a learning and improvement framework that is intended to disseminate learning from a range of sources to improve practice. The Learning Improvement framework was agreed by the Board in 2015 April. The key elements are laid out in the diagram below:



The Business Coordination Group has responsibility for the implementation of the Learning and Improvement Framework, supported by the DSCB sub-groups, in particular the Case Review Group, and the Quality and Performance Group.

1.1 Performance Data

A recommendation from Ofsted's Single Inspection in 2015 was to "Ensure that high quality performance data is available and robust analysis occurs to enable the Board to have a good understanding of child protection and safeguarding activities across Doncaster " (Ofsted, 2015, P40).

Following the Ofsted Inspection, there was significant development of the DSCB Performance report throughout 2015/2016 with a full range of relevant safeguarding performance data and other information from partner agencies available from Q1 2016/2017. The new report includes an extensive range of performance indicators from all agencies involved in the safeguarding and assessment of children. This has allowed for a wide and far reaching understanding of the effectiveness of safeguarding activities and multi-agency working in Doncaster. Further development of the data and performance framework is, however, required to improve analysis and evaluation of the impact and outcomes for children and young people. A review of the data set is planned for 2017/18 with a focus on enhancing agency analysis on the impact of safeguarding activity and reducing the duplication of data reporting through an alignment with other performance reporting cycles. Revisions to the overarching DSCB Performance Framework will be made accordingly.

The key issues identified during 2016/17 and reported to DSCB Board members are detailed below;

- Q1 identified that the number of children subject to a child protection plan for the category of neglect was showing an increasing trend. The development of the Neglect Strategy and implementation was seen during the year and multi-agency training was provided on tools to identify neglect at an early stage. The DSCB has planned a re-audit of neglect for October 2017 to monitor progress.
- Q1 data showed an increase in the number of contacts made to DCST but with a reduction in the number of contacts becoming a referral. This raised a question around the application of thresholds by professionals. Data provided in Q2 further compounded the view that thresholds were not properly understood with an increasing number of Children and Family Assessments resulting in no further action being required. An increase in the pressure on the volume of work within DCST locality teams was seen as a result. Thresholds became a focus and the DSCB undertook a multi-agency audit to better understand the application of thresholds. (see section on multi-agency audits for more details, section 1.2). The DSCB also provided 22 training sessions to increase understanding amongst professionals. Q4 began to see a decrease in the disparity between the number of contacts and the referrals along with an increase in the number of open cases to Early Help.
- Q1 saw a significant increase in the number of closed cases where all needs had been met and the action plan completed. However, in Q1 only 32% of open cases had a family plan evidenced on the Early Help Assessment. A single agency audit was undertaken by DMBC and a plan for improvement identified and implemented.
- Q3 identified that the number of children presenting at A&E and those being admitted to an acute ward for substance misuse and alcohol related issues was substantially higher than the number of referrals made to Project 3 (service provider for substance misuse support) This raised an issue about the help being sought for young people by both hospital staff and agencies in general. A substance misuse challenge meeting was held in response. Agencies were invited to consider the referral pathway to Project 3 and how this could be better embedded into individual agency process to increase the number of referrals. Agencies identified that increased awareness of the need for a referral amongst staff was required. Changes to internal agency referral paperwork were also identified as being required to simplify the referral process for staff. Discussion with key agencies that were not present at the meeting has been followed up separately. Progress is monitored through the Quality and Performance Sub Group. A challenge is currently in process to improve the help provided to young people.

Areas for development:

- Review the performance reporting process and performance framework
- Monitor existing identified issues through performance reporting and re-audit

1.2 Audit Activity

A recommendation from Ofsted's Single Inspection in 2015 was to "Ensure there is a programme of audits, and re-audits; to identify the strengths in multi-agency practice and where weaknesses are identified these are addressed promptly" (Ofsted, 2015, P0).
The Quality and Performance Sub Group (formerly the Learning and Improvement Sub-Group) identified a timetable for four multi-agency audits to be completed throughout 2016/2017. An

additional two multi-agency audits were completed in response to requests from partners. Each audit has its own action plan. Updates are provided to the Quality and Performance Sub Group. Lessons learnt from audits are communicated in line with DSCB Communication Strategy.
The following audits were completed during this period:

An audit of children in secure accommodation and custody

The purpose of the audit was to provide DSCB with assurance that Doncaster children who are detained either in custody or secure accommodation are safe and that children/young people are only detained when absolutely necessary and for the absolute minimum amount of time. The audit highlighted areas of improvement in terms of both more effective exit planning upon discharge and the availability of specialist CAMHs resources in custodial settings. It also provided assurance that young people are only detained when absolutely necessary. It provided further evidence of the already known concerns regarding the shortage of PACE beds, both locally and nationally. An action plan is being implemented to address the issues. The demand for PACE beds is, however, currently being reviewed in the light of recent changes to the Bail Act where it is anticipated that there will be less need for the service. Regular update reports to the Quality and Performance Sub Group are provided. Updates are provided to the Quality and Performance Sub Group.

Mental health of children and young people

This audit was undertaken after information within the performance report identified an increase in the number of children and young people who had been admitted to acute wards via A&E due to attempted suicide. In addition the data highlighted an increasing number of children and young people being admitted to acute wards via A&E due to deliberate self-harm. Issues in relation to the timeliness and completion of assessments by CAMHs, a lack of joint working and a high number of appointments not attended at CAMHs were identified. This resulted in a change being made to the Health and Wellbeing Plan to include the development of a self-harm pathway and updates on the progress of the plan continue to be provided. A challenge was also made to CAMHs regarding the timeliness of LAC assessments. An Assurance Report was provided to the Quality and Performance sub-group that increased staffing levels have improved this practice. The trend for the number of children admitted to acute wards via A&E or mental health services due to attempted suicide has shown a downward trend throughout 2016/17.

LGA Peer Review audit

This audit was undertaken to support the DCST Peer review where the DSCB undertook an additional multi-agency audit of children known to DCST. Evidence was seen of improvements in the quality of multi-agency safeguarding practice. Specific issues that were identified were the attendance of some agencies at Child Protection Conferences, understanding of the CIN process, supervision of staff and information sharing. A multi-agency action plan was developed and progressed through the Quality and Performance Sub Group. Ongoing audit by DCST has shown improvement throughout the year. For Children In Need, the percentage of Good and Outstanding cases have improved to over 35% in Q4 16/17 from 18% in Q1 16/17.The percentage of Good and Outstanding child protection cases have improved to 26% in Q1 to 59% in Q4 16/17.

Multi Agency Child Sexual Exploitation Re-audit

An audit of multi-agency practice in relation to CSE was first undertaken in 2015. A number of practice issues were identified and an audit action plan was devised. This was progressed through the Quality and Performance Sub Group. This re-audit was undertaken to review the progress made. The audit identified 10 areas where practice had improved; in particular the audit demonstrated that practitioners knew the signs and risk indicators of child sexual

exploitation and this was articulated in referrals, assessments, case file recording and supervision within all agencies involved. The response demonstrated by agencies was appropriate, timely and children had been kept safe. Tenacious practice was evidenced to disrupt activity of perpetrators.

Multi Agency re-audit of Thresholds and the Effectiveness of Early Help

This thematic audit focussed on a re-audit of Thresholds and the Effectiveness of Early Help Services and was first undertaken in June 2015. The purpose of the audit was to assure DSCB that thresholds are clearly understood across the partnerships and that Early Help services were effectively responding to the needs of children and families. The audit of thresholds and the DCST front-door raised a number of queries about the quality of assessments and the early help pathway. As a result DCST commissioned an independent review of the DCST front door.

Domestic Abuse

The Ofsted Single Inspection in November 2015 highlighted that whilst Multi-Agency Risk Assessments Conferences (MARAC) are well attended re-referral rate for MARAC cases was 40%, which was over twice the regional average. The purpose of this audit was to assure DSCB that agencies in Doncaster were delivering effective preventative and safeguarding services for children and families who are experiencing domestic abuse. The audit identified a number of strengths in practice but also identified areas to develop around domestic abuse awareness, the review of 'lower risk' cases and the implementation of dynamic risk assessments. An action plan has been devised and will be progressed through the Safer Stronger Doncaster Partnership. The Growing Futures Project has been developed by DCST to break the cycle of domestic abuse within families and a reduction in the number of repeat cases to MARAC has been seen throughout 2016/2017.

There has been a focus on developing the audit methodology and improving the quantity and quality of multi-agency audits. Further improvements have been identified: for each audit there will be a designated 'expert' in the audit theme who can inform the scope, audit tool and action plan; the audit process itself will be streamlined to ensure that learning is disseminated in a timely way. These changes are being implemented for the Board's audit programme in 2017-18

Areas for development:

- Utilise the knowledge of an 'expert' in the audit theme to inform process and actions Strategy.
- Streamline the audit process and Improve the timeliness of the dissemination of learning from audits

1.3 Learning from Serious Case Reviews and Learning Lessons Reviews

The DSCB Case Review Group has responsibility for reviewing cases which may provide learning for the partnership, and developing appropriate actions as result. If a case appears to meet the criteria for a serious case review (as defined in Working Together 2015), then a separate panel of Board representatives is convened to make recommendations to the

Independent Chair, to inform his decision on whether a serious case review should be undertaken.

The last serious case review that the Board undertook was in 2014-15 in relation to a child known as Child A, who died after being shaken. Due to the length of the criminal proceedings this report could not be published until October 2016. Nevertheless the DSCB had already developed and implemented an action plan to improve practice. All these actions are now complete with the exception of one which required an audit to be undertaken to evaluate the extent to which required changes in practice are now evident in casework. This relates to whether information from GPs is being shared effectively in early help and child in need cases.

The DSCB has participated in two external serious case reviews relating to children who had previously resided in Doncaster. These reviews are also now complete and awaiting publication of the reports. It is understood that one of these reports will not be published in order to the preserve the privacy of the young person. The DSCB again has developed its own action plans which have been implemented apart from those requiring audit to evidence the changes have been put into practice. One of these reviews involved a serious sexual assault on a young person; the other involved a baby being seriously injured due to being shaken whilst resident in the other local authority area. The key lessons from the reviews were in relation to transferring information between Local Authorities and Schools, the role of females in sexual abuse and the importance of listening to the voice of the child. New guidance has been shared regarding best practice in sexual abuse and assurances have been received from partners about how they ensure the voice of the child is heard.

The Case Review Group has sought to find a way to access learning more quickly enabling it to consider a larger number of cases. This enables it to consider the learning from cases which do not meet the criteria for a *serious case review,* but where there is still learning from how partners have worked together. It was agreed that a more proportionate response was to use the multi-agency guidance for Child Practice Reviews developed in Wales. This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it focusses on how agencies worked together and on how practice can be improved. The DSCB commissioned training on the use of the methodology which was well-received and led to a greater understanding of how the approach is applied in practice.

The Case Review Group has commenced four such reviews relating to 7 children. A further review is planned relating to a further two children. Three of the reviews are still ongoing, the fourth is complete and an action plan is being implemented. The presenting problems included:

- Assault of a young person by another young person
- Self-harm and attempting to take their own life
- Persistently going missing and the use of secure accommodation

The learning identified from the completed learning lessons reviews and case reviews included:

- Practitioners recognising and working with disguised compliance
- The need for a more robust approach to neglect
- Improved understanding of thresholds
- Improved understanding of early help and the lead practitioners role
- The need for professional curiosity
- The importance of professionals attendance at case conference
- The need for a discharge planning protocol

- Information sharing, particularly with GPs at a CIN or early help level

Impact

As a result of the reviews training has been updated to include information on disguised compliance and professional curiosity. A neglect strategy has been developed with supporting tools and training on the use of the tool has been provided. An audit will take place in the autumn to ensure this has become embedded in practice.

A suite of training has been provided on early help, thresholds and the role of the lead practitioner. The recent audit undertaken by DSCB showed that thresholds are now generally understood and are embedded. There continues to be a need to broaden the take-up of the lead practitioner role by professionals in some agencies, and to improve the effectiveness in the way the role is carried out (see Section on Early Help).

A pathway has been developed to ensure that GP information is shared appropriately, however an audit has identified that this is not yet embedded and therefore more work is required to ensure professionals know what the new process is.

A new discharge planning protocol has been developed to ensure health and social care partners establish joint planning meetings to safeguard children when they are discharged home from hospital.

Work has taken place to improve attendance of partners at case conferences and this is now evident in attendance figures.

1.4 Child Death Overview Panel (CDOP)

Activity of the CDOP

In 2016/17 27 child deaths were reviewed by the panel, a slight increase from 24 in the previous year. Nationally approximately two thirds of reviews completed were for deaths of children under the age of one year a figure that remains consistent year on year. Locally 62% of the child deaths reviewed were for children aged under the age of one year, which is a broadly similar proportion to the national figure

The panel tries to review all child deaths as quickly as possible. However, there may be reasons outside the panel's control that result in a delay between the date of death and the date of panel review. The panel met five times in 2016/17 which is the same frequency as in 2015/16. 49% of child deaths were completed within 12 months compared to 70% last year. This downward trend is in contrast to the national timeliness figure which has increased to 76% from 70%. However this has not led to a backlog of cases.

Reviews generally take longer if modifiable factors are identified in the death. Of the 27 reviews undertaken 51% took over 12 months to complete and the number of child deaths with modifiable factors has increased from 6 in 2015/16 to 11 in 2016/17.The local process is comparable to the national trend in this respect. Despite this increase in idenitification of modifiable factors and the ongoing temporary arrangments for the designated paediatrician for the panel the number of deaths awaiting review has fallen from 28 at the 31st March 2016 to 19 at the 31st March 2017. This is of course heavuly influenced by the actual number of child deaths and for 2106/17 this figure fell to 17, the lowest on record.

Category Event and Location of Death

The CDOP is required to record a category of death. The largest proportion of deaths both nationally and in Doncaster are as a result of medical causes these include chromosomal, genetic and congential abnormalities, perinatal and neonatal evetns, infection, malignance, acute medical or surgical conditions and chronic medical conditions. Given the small numbers in the remainder of categories the use of percentages is not particularly helpful.

- None of the deaths reviewed in Doncaster was categorised as being caused by "deliberately inflicted injury abuse or neglect". Nationally 47 children were thought to have died as a result of this.
- None of the child deaths in Doncaster was as a result of "suicide or self-inflicted harm". Nationally 101 children were believed to have died in this way.
- Only one death in Doncaster resulted from "sudden unexpected, unexplained death" which forms part of a national picture of 260.
- 4 deaths were classified as being as a result of trauma and other external factors; there being 210 deaths nationwide.
- 18 children died as a result of medical causes which is in keeping with the large proportion of deaths nationally in this category.

Future trends in relation to this data will be monitored however at this point the Doncaster numbers do not give cause for concern.

With regard to location of death, in keeping with the national data the majority of children died as a result of health problems having been admitted to either an acute hospital or hospice. 23 out of the 27 deaths reviewed locally were in this setting. One Doncaster child died in a public place; this case had modifiable factors. Most (51%) of the 148 child deaths across the country in a public place were considered to have a high proportion of modifiable factors generally stemming from road traffic accidents or collisions..

Modifiable Factors

Since 2012 there has been an increase in the number of modifiable factors identified in child deaths. This is in keeping with the national trend. The Statistical First Release identifies "Reviews of similar deaths in subsequent years may have resulted in different assessments of whether there were modifiable factors. Decisions may have changed as the process evolved and as panels built a consistent approach to understanding 'modifiable factors'. In addition local trends may have begun to emerge which would suggest that deaths should be assessed as having had 'modifiable factors' when previously this would not have been the case."

Of the 27 child deaths reviewed in 2016-17 11 were found to have modifiable factors. Although these factors are idenitifed as modifiable, this does not mean the factors fully explain the child death but are considered contrubuting factors.This is a higher number locally than last year. Some examples of the modifiable factors found in the reviews include:

- Smoking during pregnancy or by the parent or carer in the household
- Parental mental health
- Domestic violence in the household
- Underlying health conditions
- Access to medical services

This categorisation does not indicate any implication of blame on any individual party but acknowledges that where factors are identified, the death may have been preventable if that factor had been addressed. Nationally the trend has been for a gradual year on year increase in the percentage of child death reviews identified as having modifiable factors 24% compared to 20% in 2011. Doncaster is higher with the number of reviews with modifiable factors equating to 40%. Longer term comparisons are difficult with the local figure for 2011 as only 18 deaths were reviewed in this year with 3 of those classed as having modifiable factors representing 17%.

Child Deaths Referred for Consideration of Serious Case Review

Nationally serious case reviews were carried out for 3% of all child deaths reviewed in the year, which is slightly higher than in previous years. No child deaths reviewed this year were found by the DSCB to meet the threshold for a Serious Case Review.

Activity as a result of a Child Death Review

Following the review of a child death the CDOP has the ability to take action or make recommendations. In the last year the CDOP has:

- Produced 1000 safer sleeping prompt cards to support multi-agency practitioners in advising parents/carers. These are promoted through training and seminars. This complements the Safe Sleeping Campaign.
- Raised awareness of road traffic accidents through sessions with young people at educational establishments. The SDCB has reviewed the accident prevention work to ensure that the appropriate measures are in place to reduce the number of road traffic accidents.
- Produced a bereavement support leaflet that provides information on how to access the local bereavement support offer.

Working of the Panel

Overall attendnance at the panel by members has been good. The majority of agencies have achieved 100% attendance at the Panel meetings with the exception of midwifery, the lay member and the Rapid Response Team. The reasons for non-attendance have include capacity issues within the midwifery service and the need to reschedule meetings due to the commitments of the chair and the designated paediatrican..

Relative strengths of the Panel

There are a number of relative strengths of the Doncaster CDOP:

- The panel generally has a high level of attendance indicative of strong multi-agency engagement
- Recording of ethnicity has improved although there is still some inconsistency in respect of this.
- CDOP procedures have been reviewed to ensure that notifications are made to the appropriate agencies to ensure support can be provided timely and appropriately.
- Bereavement support to ensure families are supported has been process mapped to ensure adequate provision.

- Information is now shared from the Rapid Response Team at panel meetings to ensure there is no delay or blockages in reviewing cases.
- The number of child deaths awaiting review has fallen to 19.
- Learning and engagement with other panels within South Yorkshire is continuing. This is done via quarterly meetings and newsletters. An audit of modifiable factors across South Yorkshire has taken place to ensure greater scrutiny of modifiable factors and ensuring that local practice reflects national practice.

Areas for Development

- Secure on-going designated paediatrician input to the panel
- Links are continuing to be established with other LSCBs in the region to observe their operation and consider what can be learnt from these areas.
- To ensure consistent approaches with the new review processes for child deaths through either suicide or children with learning disabilities. .
- A formalised bereavement support process to be finalised and implemented that links to the local bereavement support offer.
- Explore the potential for regional collaboration in order to enhance learning from the reviews.

1.5 Learning from Practitioners

One aspect of the Learning and Improvement Framework is to ensure that there are effective communications with practitioners about the work of the Board and that Board members have an understanding of the issues affecting front-line practitioners.

Communication with practitioners is achieved mainly through the DSCB website. This provides a wide range of information and links to other sites. Links to the DSCB multi-agency procedures are available on the site along with Early Help tools, signs of safety tools, the neglect strategy tool and links to good practice on CSE. The new website was launched in January 2017 but since that time a wide range of material has been posted on the site. Work will be undertaken to evaluate the impact of the website and consider how we can increase the number of 'hits'.

In the last year practitioner views have been sought routinely through the DSCB multi-agency audit process. Practitioner events were also held for two learning lessons reviews to gain their views on the cases. These events were well evaluated. An area for improvement is to ensure that feedback from the reviews to practitioners is provided. Learning from case reviews has been disseminated through training and at the DSCB Conferences (see section 1.8).

The Board has established a Practitioner Forum to enable direct feedback to and from the DSCB. The purpose of the Forum is to provide a clear link between the Senior Leaders and the Practitioners across the Children's Workforce. The group is facilitated by the Training and Development Manager and John Harris, the Independent Chair always attends to give an overview of strategic initiatives and provided a clear link between practice and the Safeguarding Children Board.

The remit includes:

- assessing how well actions agreed at Board level are being implemented and sustained across the multi-agency partnership.
- informing and advising the Board on what strategies are working effectively, on blocks and barriers with recommendations and proposals as to how these can be overcome.

The Forum has good representation from across all of the agencies working in Doncaster. For the coming year a standard agenda has been developed to structure the meetings and give greater clarity of purpose. The impact of the Forums has been significant particularly in relation to the clear link they provide between the strategic partnerships and front line practitioners working with families.

Summary of the Practitioner Forum 2016-17

April 2016
The initial Practitioner Forum was very well attended with groups discussing the top five safeguarding challenges they face. This was then compared to the exercise undertaken at the Performance Accountability Board with senior managers and a discussion ensued about views at different levels of organisations. Practitioners' views were then used to inform the reports produced at PAB relating working with families with challenges and information sharing. One of the key outcomes stemming from this exercise was the change to the IT systems ensuring that information was accessible across both the Early Help Module and the Integrated Children's System used by DCST. The benefit of this is that practitioners working across the system have a greater understanding of the child and family's history and can make better decisions. The forum were also consulted on the Board's Neglect Strategy and Toolkit.

July 2016
The second forum focussed on Appreciative Enquiry and this was led by a Board member focussing on the Signs of Safety approach as a key aspect of the DSCB Business Plan. Practitioners were encouraged to think through the model and its benefits for practice. Feedback regarding the model was very positive particularly given its emphasis on looking at areas of good practice as well as those that need to be improved.

October 2016
The Forum focussed in detail on the effectiveness of Early Help in Doncaster. Practitioners raised issues in relation to duplication of processes at the "DCST front door". This fed into the PAB and the outcome was that a single point of access would be established from January 2017. Practitioners also formulated key questions to be shared with the wider children's workforce via Survey Monkey. The Forum also contributed to the Government's consultation on mandatory reporting.

January 2017
The results of the highly successful children's workforce survey were discussed in detail. In all, 450 practitioners from across a broad range of agencies responded providing a detailed level of data regarding the key issues and challenges affecting early help provision in Doncaster. A copy of the survey was also shared with key senior managers helping to inform the shared strategy for managing demand across the partnership formulated by the PAB. One of the key questions relates to whether the balance is right for lead professionals across the agencies. The forum had detailed discussion regarding this issue with input from the Board's independent Chair. Given the broad scope of the issues involved planning was undertaken to consider what factors influence a case being re-referred to social care in the form of a workshop at the next forum.

1.6 Allegations against Professionals

Working Together to Safeguard Children' (2015) states that;

'County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation. Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise), to be involved in the management and oversight of allegations against people that work with children'.

The role of the LADO (Local Authority Designated Officer) also includes responsibility for the management and oversight of individual cases: providing advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure they are dealt with as quickly as possible, consistent with a thorough and fair process.

DSCB provides guidance in respect of any allegation that a person who works with children or young has:

- Behaved in a way which has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way which indicates that he/she is unsuitable to work with children.

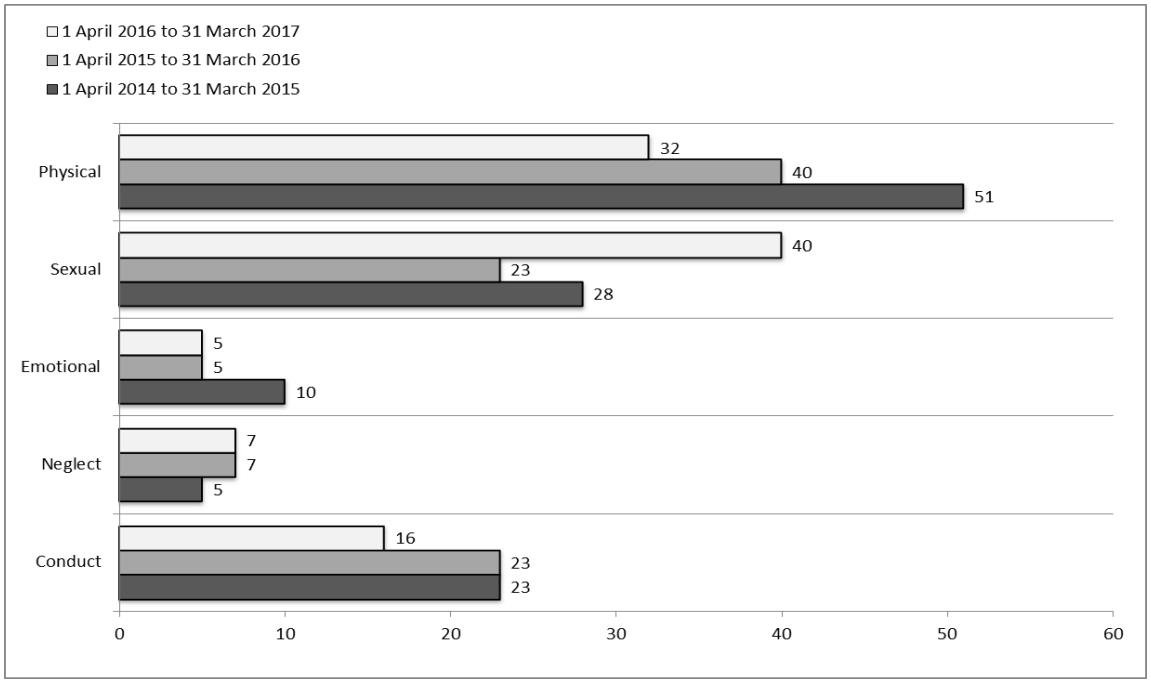
In Doncaster the LADO service is part of the Safeguarding, Standards and Policy Unit of DCST and there has been a consistent LADO since November 2013. The LADO is based at Mary Woollett Centre in close proximity to the Multi Agency Safeguarding Hub (MASH), Children's Social Care Referral and Response Team, Police Local Referral Unit, Adult Safeguarding, Police Public Protection Unit (PPU) and Child Sexual Exploitation (CSE) Team. The LADO has developed close working relationships with these teams which has greatly assisted in joint decision making and timely completion of cases. The LADO is supported by the Child Protection Conference Chairs who provide cover when the LADO is not available.

Work has continued to raise the awareness of the LADO role across a number of agencies, which has resulted in an increase in overall referrals. When compared to 2015/16, the numbers of referrals to the LADO has increased by 15%. However, the number of referrals that have reached the threshold to hold a strategy meeting has only increased by 2%. This is as a result of the advice given by the LADO to organisations at an early stage to assist them in undertaking a fact find process which has resulted in less cases progressing to a LADO strategy meeting.

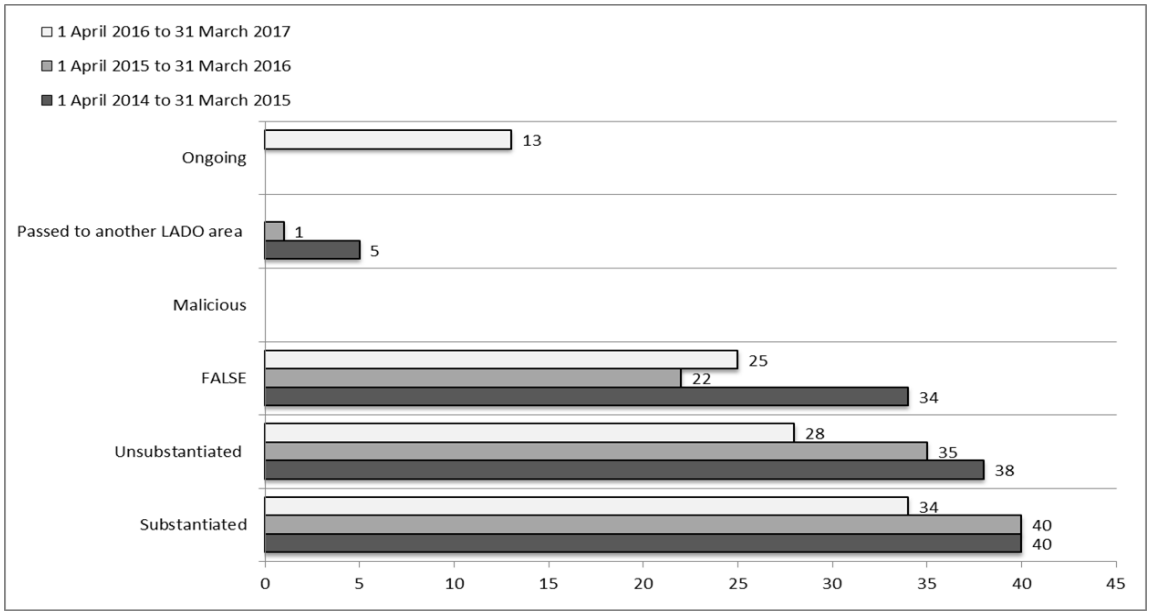
This has been the third full year that records have been kept in relation to the number of referrals that have not met the threshold. Prior to this information was only kept for those referrals where strategy meetings were held.

Period	Referrals	Met Threshold	% That Met Threshold
1/4/16 to 31/3/17	602	100	17%
1/4/15 to 31/3/16	518	98	19%
1/4/14 to 31/3/15	506	117	23%
1/4/13 to 31/3/14	N/A	115	N/A
1/4/12 to 31/3/13	N/A	103	N/A

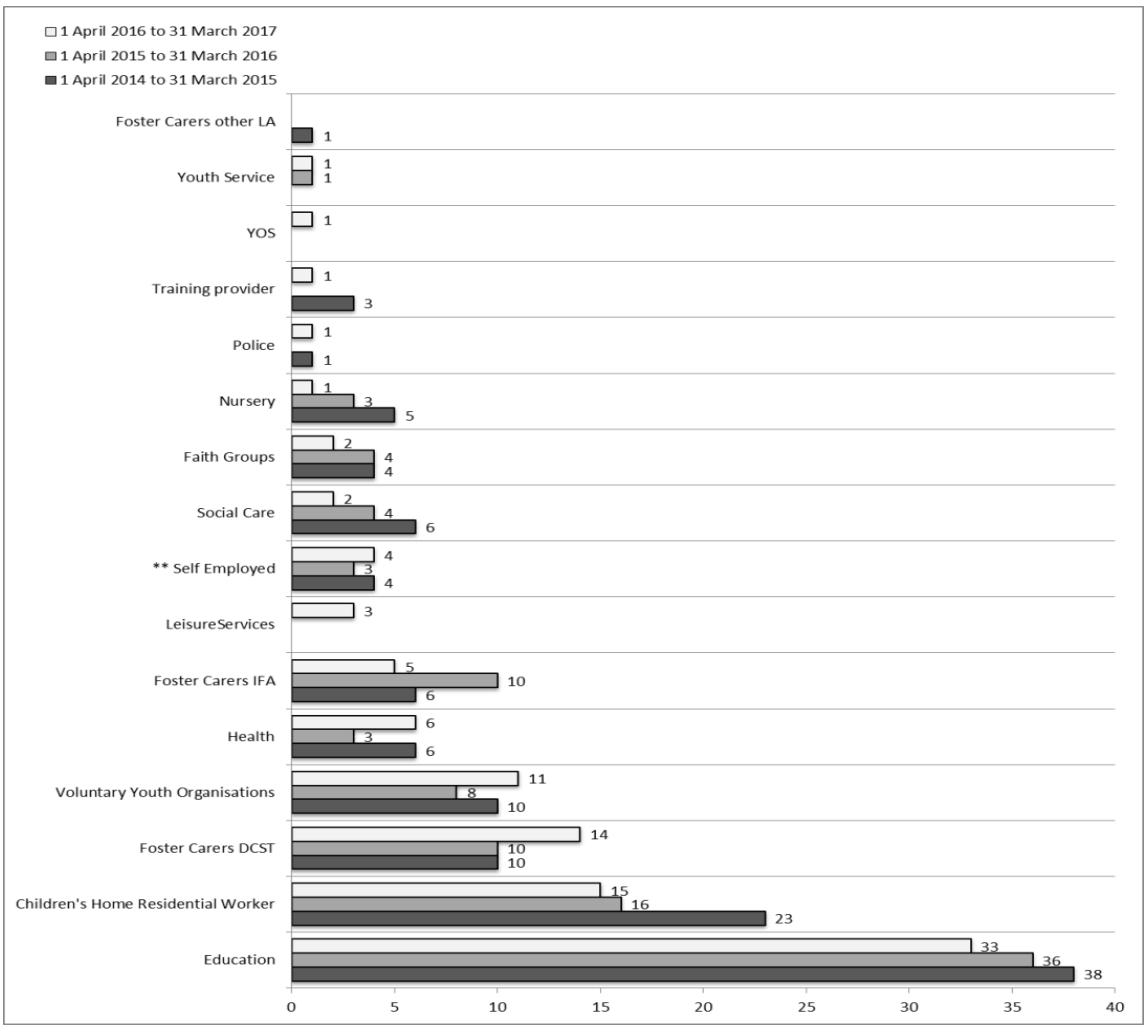
Referrals that met the threshold ordered by primary category of concern



Referrals that met the threshold ordered by outcome of allegation



Referrals that met the threshold ordered by primary agency of accused adult



Working together with other agencies

There is clear evidence of good working together with other agencies as LADO strategy meetings are regularly attended by the Police, children's social care, adult social care and other key agencies as necessary.

The LADO has also formed close links with the Adult safeguarding team and information is shared between the two services, as appropriate, to ensure the right service area is dealing with safeguarding allegations whether this involves children or adults at risk of harm. There have been occasions when the two service areas attend each other's strategy meetings. An example of this has been where an agency is caring for disabled children and there is a period during transition into adulthood and a longer term placement has not been identified before the person reaches the age of 18yrs. There are other settings that care for adults where individuals have been placed before they have reached 18yrs old.

Developments in 2016/17

The LADO referral form has been amended to make it easier to use and is now available on the DSCB website. The 'Procedure for Responding to Allegations Against Staff, Carers and Volunteers' located on DSCB online procedures has also been reviewed and updated to reflect

current practice. The archive paper LADO files are being scanned into electronic folders with the intention of all information being held electronically by the end of 2017.

Regional and National

The regional LADO group has continued to meet and provide support to each other with matters related to thresholds, best practice, consideration of new national guidance and sharing information about perpetrators who move between areas etc.

The LADO has attended the national LADO conference which provided opportunity to compare practice across the country and to develop more collaborative ways of working with other local authorities. In March 2018 the National LADO conference is being hosted by the Yorkshire and Humber LADO region and will be held in Doncaster. The Doncaster LADO is chair of the working group organising this event.

The LADO also represents the local regional group at the national LADO network which provides a central point of reference for all LADOs. This group is developing a handbook and standards for LADOs to be used across the country and is liaising with DfE and Ofsted in order for the handbook and standards to be recognised by these statutory bodies.

The LADO is also part of the Safeguarding in Sport regional group that considers safeguarding across a wide range of sports groups across our area.

1.6.1 Local Operational Themes

1. A permanent individual LADO, with support of Child Protection Chairs has resulted in a more consistent approach when dealing with allegations and provides a central point of access to organisations.
2. Having a dedicated business support administrator to coordinate the booking, minute taking and administration of all LADO meetings ensures good continuity and implementation of systems and also provides a central point of reference for partner agencies.
3. Good collaborative working with key agencies including the police, health and adult social care has been beneficial in the handling of a number of cases. The location of LADO in the same building as the Police Public Protection Unit, MASH, Referral and Response Team, Domestic Abuse Advisors, Child Sexual Exploitation Team and Adult Safeguarding, has aided in the facilitation of strategy / evaluation discussions and meetings and in ensuring a timely outcome of cases.
4. The confidentiality of accused adults has been protected through rigorous adherence to the local and national guidance. As a result potentially inappropriate media attention has been avoided during the course of investigations.
5. Early consultation and intervention has prevented negative impact on professionals' careers when allegations have been false or malicious.

Areas for Development

There are two main areas of key developments to be addressed over the coming 12 months and beyond.

1. Further development of a system for auditing the work of the LADO that reflects the national handbook and standards.
2. Develop a system for gaining feedback from those involved in LADO evaluation / strategy discussions / meetings.

1.7 External review and inspections

The DSCB receives feedback from the inspections of all partners. Although there have been no specific reviews of the DSCB, inspection reports have been received in relation to Doncaster College. As Doncaster Children's Services received inadequate judgement at its last inspection in 2015, there have been a number of monitoring visits have been undertaken by Ofsted to ensure continuing progress. These visits have all been reported to the DSCB and regular updates on progress have been provided at the Performance Accountability Board. Additionally the DCST commissioned a Peer Review to provide external challenge on progress. This too was reported to the DSCB.

An Independent review of South Yorkshire Police handling of child sexual exploitation was also shared with the Board in April 2016.

1.8 Workforce Development 2016-2017

The period 2016-17 saw a continuation of the significant progress over the last three years in relation to multi-agency workforce development. The Workforce Development Sub Group (WDSG) has reviewed its Terms of Reference and these are now more specific and defined. Moving forward the group will focus on the production of a quarterly report detailing both multi agency and single agency training delivered. Additionally, the group will provide a gap analysis in relation to specific workforce competencies and key performance indicators are also being developed.

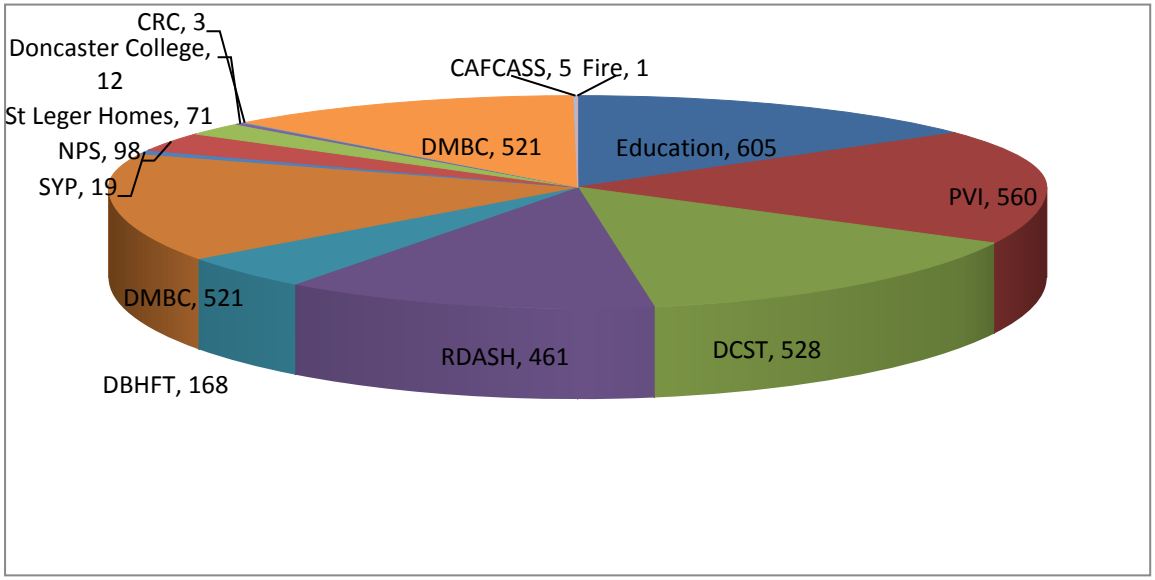
The Board has a strong commitment to multi-agency training and continues to invest in developing a multi -agency training pool. The role is supported by a person specification and job description. There have been significant contributions from members of the multi-agency training pool and the training pool continues to deliver high quality training. The DSCB training offer continues to span a range of safeguarding subjects outlined in the table below:

Range of Courses Delivered by the Doncaster Safeguarding Children Board 2016-17

Courses Delivered	Number of Sessions
Effective Partnership	22
Neglect	7
Child Sexual Exploitation	4
Delivering Early Help	36
Parental Mental Illness	1
Recognising and Responding to Sexually Harmful Behaviour	1
Signs of Safety Roadshows	15
Modern Day Slavery	2
Domestic Abuse Seminars	6
Mock Signs of Safety Child Protection Conference	8
Role of the Lead Practitioner	15
Learning Lessons from Local SCR	4
Cultural Competency	2
CDOP Seminar	2
Early Help Outcomes and Plans	4
Total Number of Courses	**129**

3181 Training Places delivered by DSCB in 2016-17

Distribution by Partner Agencies



Post course evaluations based on the "Guskey" model continue to demonstrate a positive effect. During the course of the year the DSCB moved to a standardised evaluation tool for all courses to assist with comparison. The Training Strategy 2015-17 has been updated. It continues to incorporate a focus on the impact of the training on practice. The Workforce Development Sub Group endorsed a standardised evaluation and impact tool and invested in Survey Monkey so that this could be administered electronically. A significant area of development for workforce development is to support the Signs of Safety Strategy. The Board delivered 15 Roadshows led by the Training Manager introducing the model in various localities across Doncaster which received a very positive multi agency response. Over 450 professionals attended with a clear impact being the embedding of Signs and Safety as a universal language. Feedback has been very positive as indicated by the quotes below.

Modelling of danger and safety goal statements enlightening

Concise and to the point with use of simple language and not jargon!

Course content, pace and style of delivery very useful

Charging for non-attendance has been implemented since the previous annual report. This has generated an income and also had the desired effect of improving attendance at training. The use of the electronic booking system Engage Doncaster has been highly beneficial with over 3700 professionals registered on the data base. This represents a significant increase of 1200 professionals from the previous year. This positive engagement allows key messages and information to be easily shared. One of the key aspects in ensuring training has an impact on

practice is to achieve “critical mass” in terms of agency engagement. The figures below demonstrate strong engagement from across all of the key agencies involved in children’s safeguarding. . A detailed gap analysis has been undertaken regarding Signs of Safety training to measure the number of practitioners in each organisation requiring the training against the number who have attended.

Content of Training

In April 2016 it was agreed that Effective Partnership would be reduced to a one day course focussing on the core Safeguarding processes and that professionals would then be able to select courses from the broad range picking those most appropriate to their learning needs. Effective Partnership ran on 22 occasions during the year and also received very positive evaluations. For example:

Very informative, thought provoking, interactive and very relevant to my role
Increased knowledge of referral thresholds and also the learning from SCR was invaluable
It made me aware it is acceptable to challenge professionals in the interest of the child.
The training was the most interesting, informative and most well-presented that I have attended in a long time. Well worth attending

Four different modules were run throughout the year to support the Early Help Strategy: Delivering Early Help; The Role of the Lead Professional and Early Help Outcomes and Plans were delivered jointly throughout the year by the Early Help Coordinators.
CSE is a further strategic priority for the Board. It continues to be delivered at Level 3 by an Independent Trainer and the CSE Team to receive positive evaluations.

The training was brilliant and the CSE team need to be commended for linking the training to real life and helping me to remember so much of the information they gave us. This training has been one of those life changing days.

The training delivered by the DSCB complements the awareness raising briefings that are delivered by the dedicated CSE team. These briefings are targeted at a much broader audience including parents and young people as well as professionals. The CSE team has engaged with a wide range of participants including the industries sector where there is a significant preventative benefit to raising awareness of the signs to look for that would indicate that a young person is being exploited.

The DSCB commissions two online training courses from the Virtual College; Basic Awareness and Safer Recruitment. The strategy allows individual agencies to source their own training or alternatively to access the DSCB provision free of charge. Moving forward the DSCB is negotiating a Total Training Package which will allow all practitioners across the children’s workforce to access a range of 51 online courses. The Junction Project delivers a course annually on behalf of the DSCB entitled Recognizing and Responding to Sexually Harmful Behaviour.

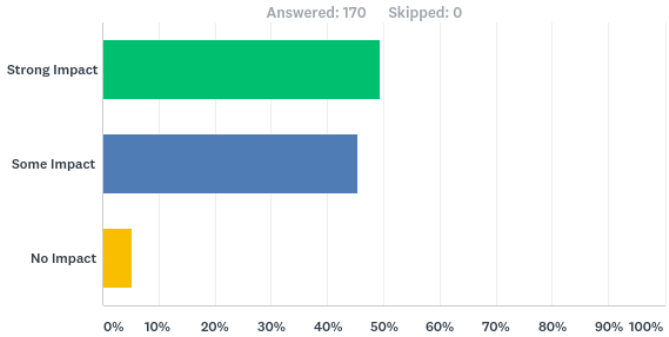
Two sessions of GP training have been delivered. In total 160 GPs attended. The training consisted of three 45 minute workshops with each GP attending all of them. In accordance with the strategy the subjects covered were Signs of Safety, Child Protection Conferences and Family Group Conferencing. Outcome based evaluations were used and they demonstrated a positive effect in terms of increasing GP’s knowledge and skills relating to Safeguarding Children. The period April 2016 to March 2017 saw a broad range of courses being delivered. These varied in length in accordance with the Board’s approach to flexible learning. This

allows participants to be selective in choosing which courses they wish to undertake matching them to their individual learning needs.

Impact of the Effective Partnership Course on Practice

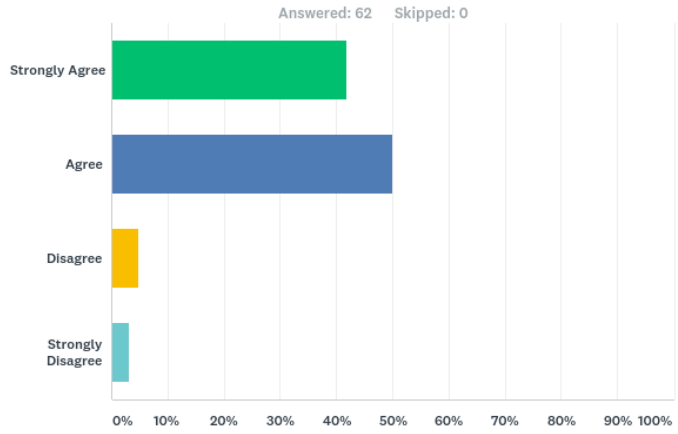
The DSCB has invested in Survey Monkey to improve the returns on reflective logs. During the year 170 were returned. Each participant is asked a series of questions relating to how the course had impacted on their practice. The results were very encouraging with the vast proportion of respondents indicating that the training had either strong impact or some impact on the practice. The training utilizes a detailed chronology from a national serious case review which allows delegates to develop their understanding of how poor multi agency working and communication allow risks to escalate to a child. The consequences of the failure to speak to the child alone or to challenge parental self-reporting are graphically highlighted by the tragic outcome. The reflective log asks delegates a series of questions two months after the course. A sample of the questions is included below. During the year the Board published the Serious Care Review into the death of Child A. The significant learning from this related to practitioner and organisational understanding of professional curiosity and disguised compliance. Aspects of this were already included in the Level 3 Effective Partnership training however in response to the learning from Child A the emphasis on this was amplified. Of the 170 people who completed a reflective log the vast majority stated that the training had either had a strong impact or some impact which is encouraging. Workshops on disguised compliance and professional curiosity were also incorporated into the DSCB Spring Conference.

Q6 What impact has the training in relation to disguised compliance and professional curiosity made to your practice?



A further Serious Case Review highlighted the need to ensure that parents were able to protect their children from Persons Posing a Risk (PPR's) and also the need to ensure that vital information was not lost between agencies and different Local Authorities when families moved between them. This Review was undertaken by another Local Authority and the decision was made not to publish to protect the anonymity of the child. The DSCB organised three seminars which were well attended by 150 participants and positively evaluated in terms of impact on practice as indicated below. The learning from this review has now been incorporated into the Effective Partnership training and is being delivered on a regular basis.

Q5 The training will have a positive impact on my Safeguarding practice



The DSCB has identified the following strengths and achievements:

- Significantly improved engagement with training the number of customers has increased by nearly 50% to 3,700. This represents a critical mass of practitioners and gives the DSCB a strong brand identity.
- Adoption of standardised evaluations based on an established impact model using Survey Monkey supports an improved quality assurance strategy.
- Reflective log process provides detail of actual impact of training on practice.
- Training has provided positive learning opportunities and promoted improvements in morale and confidence alongside a better understanding of other roles and greater mutual respect.
- Range of course provision reflects key strategic priorities.

The DSCB has identified the following areas for development:

- Planned provision for 2017-18 reflects increased emphasis on learners undertaking individual training needs analysis through the professional development review process.
- Development of standards for courses ensuring that all DSCB courses have clear objectives and methods for evaluating these.
- Development of a new training strategy to update the current one.

DSCB Conferences

During the year the Board ran two conferences at the Keepmoat Stadium. Both conferences were very well attended by the range of agencies represented on the Board. Both the conferences were attended by over 180 delegates from the statutory, voluntary and private sectors. The Spring Conference welcomed Professor Jane Barlow, Warwick Medical School as a guest speaker and she delivered a well-received presentation on 'Emotional Neglect and the Impact of Parental Mental Health in the first two years of life'. This linked into the SP2 of the

Business Plan regarding effective arrangements are in place for responding to key safeguarding risks including early help and neglect.

The Autumn Conference was similarly well attended by a range of agencies. Our key note speaker was Professor Brid Featherstone from Huddersfield University. She delivered an inspiring presentation around “Working with Mothers and Fathers and why it matters for Children”. Conference evaluations were extremely positive. The Conference also heard from parents who are experts by experience about their experiences of services and the levels of support they received. Again a series of workshops were offered linked to the strategic business plan and the Child A SCR. These include sessions on self-harm in young people: using the Signs of Safety approach and healthy scepticism.

2.0 Impact of the Board – Responding to Challenge

The Board has continued to have a growing impact on the way services are delivered and assuring its-self of the effectiveness of safeguarding in Doncaster. It does this through its performance framework, by receiving regular assurance reports from partners and by providing effective challenge through the Board and its sub-groups.
Numerous challenges have been made and these have been logged in the DSCB Challenge Log. Examples of these are:

- Changes to the Doncaster Healthy Schools Programme – concerns were raised about how young people would be provided with education on such topics as CSE given the proposal to cancel the schools carousels. Challenges by the Board resulted in this being reinstated
- Elective Home Education – the Board asked for assurance about how we know which children are being educated at home. This raised a challenge to health to ensure child birth data was shared with DMBC. This has highlighted the need for an information sharing protocol which is now being developed. An additional grade 8 Education Home Officer is to be provided by DMBC to support with resource issues
- A challenge was raised to ensure that all Partners understand what they are being asked to deliver in terms of Early Help, as a result a framework of expectation was developed and progress with partner agencies to operate within this framework is reported and discussed at the DSCB Performance Accountability Board.
- A challenge was brought from SYP regarding a number of young people who frequently go missing – The Performance Accountability Board undertook an in depth look at this issue to ensure the approach if effective. DCST now run the service which provides return home interviews for young people and the quality and timeliness of these interviews are improving. The Children Missing Operational Group has now been reviewed and superseded with the protecting Vulnerable Young People Group which is monitored by the CSE sub-group.
- A challenge was raised about Health visitor attendance at Children Protection Case conferences – this has led to joint work with DCST and RDASH to improve the timeliness of invitations which has resulted in improved attendance
- DBHFT challenged DCST in regards to its information sharing in relation to neo-natal service. A small task group met who took a solution-focussed approach and agreed some key actions which have resolved the issue.

The DSCB has received regular assurance reports:

- MASH
- Early Help
- Mental Health and Wellbeing Transformation Plan
- CPIS
- Domestic Abuse
- LADO
- IRO Annual Report
- Director of Public health Annual Report
- CDOP Annual Report
- Stronger Families Progress report
- Signs of Safety
- Safeguarding in Sport
- An independent review of SYP Handling of CSE 1997-2016