Sefton LSCB Annual Report 2019–2020

CONTENTS

	Section	Page
1	Introduction	1
2	Governance and Leadership	1
3	Funding and Support	3
4	The Priorities for the LSCB 2019/20	4
5	Evidence of activities that have support safeguarding priorities 2019/20	4
6	Supporting Statement for the Business Priority 2019/20	9
7	Partnership Evaluation of Practice	9
8	Performance Management and Monitoring	13
9	Learning and Development	17
10	Key Priorities for 2020/21	23
11	Independent Scrutineer Conclusion	24

1 Introduction

Sefton LSCB remains steadfastly committed to ensuring that the whole partnership works together to safeguard its children and young people. Below are details of the work we have undertaken together in the time period April 2019-March 2020. This report has been independently scrutinised prior to publication, falling within the roles and responsibilities of our Boards Independent Chair. Throughout the report you will see the Chairs' (acting as independent scrutineer) written reflection of board activity, progress and suggested developments moving forward.

2 Governance and Leadership

Sefton LSCB is well supported by senior leaders across the partnership and is one of the few boards in the country which has a membership broader than the expected key statutory agencies. In Sefton, members are vocal in their belief that this extended inclusion of membership is what brings added strength to our board and partnership working relationships. Agreement to maintain this level of participation at the highest level was cemented when we published our MASA arrangements in 2019 and the board has continued to benefit from the active involvement of the wider partnership.

"The recently implemented and revised multi-agency safeguarding arrangements have maintained an independent chair. Members of the LSCB are very proud to have a wide representation of partners that is broader than the expectations of key statutory agencies, and this now includes representation from schools. There have been recent challenges in progressing the work of the LSCB due to capacity within the board's business unit. Positively, partners have taken responsibility to rectify this and have invested in the recruitment of two posts to progress the work of the LSCB."
Joint targeted area inspection of the multi-agency response to children's mental health in Sefton. September 2019

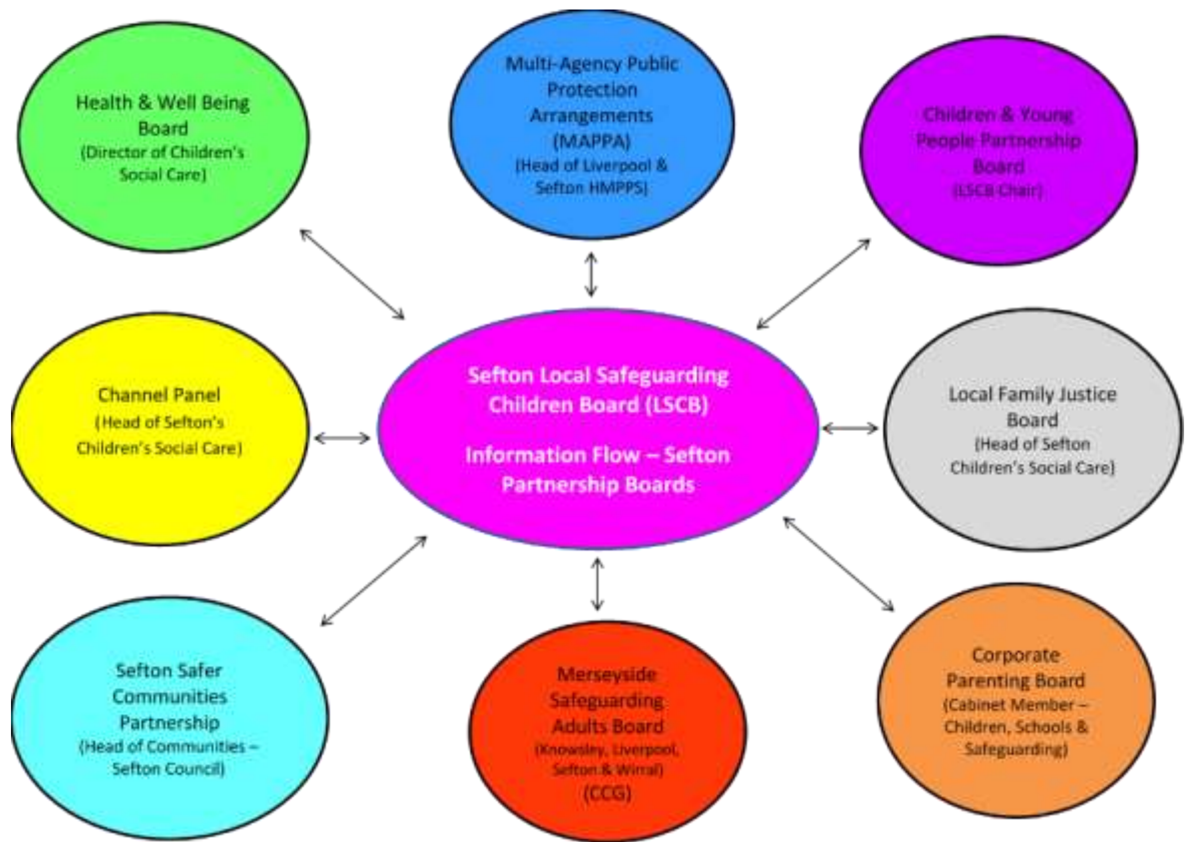
The LSCB has a clear internal structure designed to manage and respond to the business areas of the Board and this is available to see on our website and can be accessed on the link below.

Sefton LSCB Structure - https://seftonlscb.org.uk/lscb/about-us/lscb-governance-and-structure

The structure of the board is only one element of the governance and leadership and includes an agreed Memorandum of Understanding (MoU) in keeping with Working Together 2018 guidance which states:

To be effective, these arrangements should link to other strategic partnership work happening locally to support children and families. This will include other public boards including Health and wellbeing boards, Adult Safeguarding Boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs. (p73)

Whilst this MoU has been in place for some time it was previously covered on the main board agenda under 'any other business' and often, information exchange of this nature was not readily forthcoming. As a result, we have now raised the profile of this expectation and have this activity as a standing item on the agenda of the LSCB Main Board meetings, giving strategic leaders a dedicated time slot to share connecting work from other boards they sit on that links into our safeguarding children agenda.



Board Member Annual Appraisals

LSCB Member Appraisal conversations were held by LSCB Chair with individual LSCB Main Board members (undertaken between January-March 2020). The LSCB Chair summarised the outcomes and findings which included the following areas identified for further action/consideration:

- Name plates for board meetings
- Referral forms for services be located and downloadable in a central place on LSCB website
- Embed LSCB executive minutes and all sub group minutes in main board agenda for information.
- Provide a list of membership of sub groups and MASH steering group to evidence the significant engagement from all agencies and services and to support the identification of any potential gaps
- Health providers forum – is it sufficiently explicit where and when issues are escalated? Suggestion of an annual report to main board?
- Seeking assurance how learning has been taken forward, translated into actions, improved practice and how this is or will be evidenced?
- From the Serious Case Reviews (SCR's) – an audit request to members that asks a) can you detail 3 actions taken as a result of the learning. b) what impact has this had on practice and c) how can you evidence this.
- Increase awareness of board members roles by introducing a table of members pen pictures

- Board members to undertake frontline visits to increase their visibility around the partnership services
- To support a greater understanding of the community (voluntary) services through presentation at main board
- How can the faith community have stronger links? Scope and recommend

Feedback from members in relation to the Independent Chairs scrutiny role were:

- Suggestion this role is enhanced by undertaking 'temperature checks' at points across the system in order to check operational practice against strategic information.
- Chair to meet with Designated safeguarding leads (schools). A key group of professionals who will have direct experience of practice and issues.
- Consideration to be given to combining CCG quality visits and Section 11 visits to permit further triangulation of findings for Health agencies.
- Deep dive a cross section of action plans arising from sec 11 audits.
- From Community Rehabilitation company and the National Probation Service - receive summary report from their respective QA audit processes.
- To seek views from the INNOVATE social work company (manager) on effectiveness of partnership working in CIN cases.
- Chair to meet with Independent Reviewing Officers and Child Protection Chairs as they have detailed operational roles with oversight of the effectiveness of multi-agency working for children.

All of the above will be addressed through LSCB work flow.

Independent Scrutineer Comments:

The clear structure supports a positively developing culture within a wide partnership. All of whom remain committed to work together with transparency and energy to focus on continuous improvement. Membership has been stable, attendance is very good thus relationships are strong, mutually supportive and appropriately challenging.

The process sitting behind the board to support delivery of core business is robust. For example, the consistent reporting up from sub groups to exec to main board (by exception) means that work flow is reviewed regularly. The Chairing of subgroups is appropriately owned and shared by the partnership.

The Head of Communities with responsibility for the Local Authority's Early Help Offer has joined the membership of LSCB Main and Executive Board. Their active representation across the board has allowed for an improved coordinated response and provided clarity in relation to the Early Help Offer.

Regular feedback from leaders represented on other boards and forums requires strengthening. Although Memorandum of Understandings are in place (MoU) opportunities to share information may have been missed. The change to the main board agendas to have specific standing items is welcomed and it is expected will strengthen regular contribution.

3 Funding and Support

In March 2020, the 3 key strategic leads met to consider the funding for the LSCB for the next financial year. Agreement was reached to retain the level of funding equal to that in 2019/20 for 2020/21. The strategic leads will meet quarterly to review the arrangements with a plan to transfer any underspend back to the contributing organisations. Due to financial pressures, the 3 key strategic leads who have financial responsibility to fund the local safeguarding arrangements were not able to commit financially to the LSCB, beyond 31st March 2021.

Sefton schools have agreed to financially contribute to Sefton LSCB for a further 3 years.

Income from Agencies for 2019-20	
Sefton Council Children's Services	North West Boroughs Health (NWBH)
Merseyside Police	Sefton Schools
HM Prison & Probation Service (HMPPS)	Independent Schools/Colleges
Merseyside Community Rehabilitation Company (CRC)	Income from LSCB Training
Southport & Formby/South Sefton CCG(s)	Contributions from agencies towards SCR Learning Events
CAFCASS	
	Total Income: £238,942

LSCB Expenditure 2019-20	
LSCB Business Unit Staffing Costs	Contribution towards Merseyside Child Death Overview Panel (CDOP)
Independent Chair Fees	Independent Services & Fees
Training and Development	Expenses
Marketing and Public Relations	Miscellaneous
Facilities Hire	
	Total Expenditure: £218,985

	Independent Scrutineer Comments:
	Whilst acknowledging there is no national funding formula it is hoped that the current funding level can be sustained and agreed on a longer-term basis. The year on year financial discussions create inherent risks in driving the key business and priority work at pace. The education sector is commended for their financial commitment being agreed for three years. I would wish to highlight the significant contributions of support 'in kind' from across the partnership evidenced in the membership of sub groups, training pool, the overall responsiveness to LSCB business, particularly the multi-agency audits and case reviews.

4	**The priorities for the LSCB 2019/20 were:**
	Safeguarding Priorities: 1. To ensure the partnership drives impact and outcome focused practice which will be evidenced through single agency and a partnership Performance Management 2. Evidencing the response to the voice of the child and the community and the impact this is having within safeguarding 3. To continually support and contribute to staff development through training and audit activities by increasing the learning across the partnership through training and audit activities.
	Business Priority: 4. To ensure a controlled and formal transition from the LSCB to the renewed safeguarding arrangements.

5	**Evidence of activities that have supported safeguarding priorities 2019/20**
	S11 Audit undertaken (in partnership with St Helens, Knowsley and Liverpool) and analysed Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Sefton LSCB has evaluated agencies' safeguarding arrangements against Section 11 standards by means of an annual section 11 audit. Detailed information is further on in the report.

S175 Audit undertaken and analysed by LSCB
Section 175 of the 2002 Education Act requires local education authorities and the governing bodies of maintained schools and FE colleges plan to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children. (Section 157 of the 2002 Education Act and the Independent School Regulations 2003 convey the same responsibilities on all other non-maintained settings.)

Sefton Local Safeguarding Children Board facilitates an annual school's safeguarding S175 audit. The audit is an online self-assessment which supports schools / education settings to demonstrate that their functions are carried out with a view to safeguarding and promoting the welfare of children. Audit findings can be found further on in this report.

Driving the Multi-Agency Model of Practice requirement
In 2018 Sefton LSCB commissioned a report to review children subject to a child protection plan for a second or subsequent time. One of the recommendations contained within that report reflected on the practice model used across the children's partnership and to consider the progress made so far through the implementation of Signs of Safety.

A further report was then presented to the LSCB Executive in March 2019 that specifically looked at how well we had adopted Signs of Safety and considered what would be the benefits and costs of implementing it fully. In addition, this included a summary of pros and cons of other accredited practice models used across other Local Authority areas and explored whether adoption of one or more of these, would be beneficial to us locally in Sefton. The Board considered the report and whether to invest further in the Signs of Safety Model which has been partially implemented or whether a 'mix and match' model would be preferable.

In May 2019, the Board received a paper from the Interim DCS reflecting on the current safeguarding practice model used across the children's partnership. The paper recommended the development of a *"mix and match*" model of practice in acknowledgement of the absence of a model of practice common to the whole partnership. Consequently, a working group was convened to:

1. Commit to the implementation of an agreed mix and match model
2. Commit to the shared cost of purchase both in cash and kind.

Other influencing factors have emerged since the task and finish group convened, namely the Strengthening Families Protecting Children Programme bid and the opportunities to bid for training funds from the Merseyside Violence Reduction Unit both of which demonstrate a commitment to finding resource to support the introduction of an agreed multi-agency model of practice. This will be governed through the Children and Young Peoples Partnership Board, the LSCB Board remains committed to support the partnership in their endeavours.

Completion of three Serious Case Reviews within the time frame
What is a Serious Case Review (SCR)?
LSCBs are required to undertake reviews of serious cases and extract lessons to be learned. A serious case is one where abuse or neglect of a child is known or suspected; and either a child has died or been seriously harmed and there is cause for concern as to the way in which agencies have worked together to safeguard the child.

During the year, the LSCB have published 3 Serious Case Reviews.

Two innovative learning events for the entire children's workforce were delivered in June and November 2019 using AFTA Thought (bringing training to life through drama) www.aftathought.co.uk and delivered the learning from SCRs. The event was titled 'going forward without fear' used as a supportive focus to professionals who are often working in an emotive and challenging environment. All of the resources on the day were sensitively designed through a task and finish group of the LSCB and feedback on their powerful impact was relayed back to the board by those who attended. The learning event was a reminder to all staff

about the importance of hearing the voice of the child and considering the child's lived experiences from the child's perspective. Approximately 1000 participants from across the partnership attended the sessions which included frontline staff, a wide range of senior leaders and a member of the national Child Safeguarding Practice Review Panel. There was a further repeat event commissioned from our education sector to approximately 200 staff members within schools.

The impact of these events was evidenced via Sefton LSCB newsletters (**Special Edition Newsletters (July & December 2019)**

Materials produced for the Learning Events are available **CLICK HERE**

Formby Learning in Partnership (Schools) commissioned the event on 18 March 2020

Established a Child Sexual Abuse in the Family Environment (CSAFE) Task and Finish Group

In response to findings from a multi-agency audit Sefton LSCB agreed that Child Sexual Abuse (CSA) in the Family Environment is a partnership themed priority for 2020-22. To progress this, work a task and finish group developed a strategy and an associated work plan. Having achieved this, the LSCB partnership will progress activity across five strands:

- Improving Prevention
- Improving Awareness, Recognition and Response
- Improving Information Sharing and Decision Making
- Supporting Children, Young People and Families
- Monitoring and Evaluation

Multi-Agency Audit – Children Living with Mental Ill Health

Sefton LSCB evaluated safeguarding practice in respect of Children Living with Mental Ill Health. This area was selected to align with the Joint Targeted Area Inspection (JTAI), undertaken by Ofsted (September 2019), of the multi-agency response to children's mental health in Sefton. The LSCB used a new reporting template that embraces the boards vision that all of our activity is centred around our understanding of the child's lived experiences and how, upon reflection, we can improve our understanding of the impact this is having on a child and the services we offer in response. This exemplar is now be used for future audits a model of good practice.

Review of the Escalation Procedure

The LSCB has had an escalation policy in place for a considerable amount of time but what became apparent through SCR findings and conversations during the Joint Targeted Area Inspection was that whilst we had a policy in place, we did not understand enough about how this policy was being used to support practice and successfully resolve safeguarding concerns. To address this, the policy has been simplified and promoted, providing the workforce with a clear step by step chart of expectation. Escalation was also a strong focus in the content of the SCR learning events. In addition, we have introduced a feedback mechanism in order that we can understand if the escalation process is effectively used. This is now monitored through the Performance and Quality Assurance sub group which in turn is fed up to the executive group for a required action.

Refresh of Level of Need Guidance

Sefton 'Level of Need' Guidance sets out an agreed approach to provide timely support for children and families. It is the local framework to assist everyone working with children. It provides information with examples to support all practitioners from all agencies so that you can identify when it will be appropriate to work individually with a child and family and when it will be better to coordinate skills and call upon other agencies to work together to support children.

The guidance details some of the most common indications of additional needs and risks for vulnerable children. For each level there are identified planning responses and a range of possible services.

Sefton LSCB held an open consultation event for contribution to the refresh of the level of need guidance. The session was extremely well attended and there was representation from all corners of the partnership. Not only is this approach good practice, but staff tell us that they felt heard and valued by the invitation to contribute to such important guidance. This will be launched in July 2020.

Information Sharing from the Board

The board continues to regularly supply the children's workforce with a relevant stream of safeguarding resources. We utilise all communication streams available to us which includes:

- LSCB website
- LSCB twitter account @seftonlscb
- LSCB newsletters
- LSCB 7-minute briefings
- LSCB training materials which includes practice and research materials from other places
- LSCB practice guidance

The board has long benefitted from the positive support and praise from across the workforce in relation to the communication we provide and below is a small sample of what we receive:

I just want to drop you a quick email to register with you and the LSCB team, my sincere gratitude for producing and distributing what I can only describe as an enormously informative and helpful newsletter. As a member of Merseyside Army Cadet Force (MACF) based in the Sefton area, this newsletter is exactly what we need to keep up with the ever-developing issues surrounding children's welfare and safeguarding across the Sefton area and beyond.
The newsletter offers a plethora of different subjects and topics and helps tremendously to keep our organisation better informed when working with young Cadets.
The newsletter documents news and updates coupled with the very helpful links, it not only serves as a newsletter but also a portal to many various high-profile topics across the safeguarding universe.
(Merseyside Army Cadet Force)

The level of communication from the LSCB, particularly the newsletters and 7 minute briefings is very positively received by the education sector in Sefton. The newsletter is truly multi-agency and appropriate for a wider audience eg circulation to governors.
(Sefton Primary & Secondary Headteachers)

I found the LSCB newsletter very informative and useful to know what areas you're looking at / partners you're working with.
(Police staff)

https://seftonlscb.org.uk/lscb/news/sefton-lscb-newsletters

Working Together to Safeguard Children Training

A significant amount of work has gone into the refresh of materials and training approaches to this two day course and the participant feedback is telling us that we have the right formula. We have shifted the focus to include the wealth of learning we received from the Serious Case Reviews, as well as incorporating key messages from the findings of our multi-agency audits, national reviews and associated activities. We have also strengthened the coverage of child protection conference roles, responsibilities and expected contributions.

The consistency of delivery of Working Together training is starting to show clear impact on those professionals who attend Child Protection Conferences. Their feedback is that they feel more confident and better equipped to contribute from a child's perspective and to challenge as a professional:

Early Help Practitioner- '*I will definitely be more child focused and ensure that the child's voice is always represented by me at meetings'*

Further Education College Safeguarding Co Coordinator – '*I will now feel a lot more confident to put my opinion of how I believe a child is being impacted on by what may be going on at home'*

Young Person and Family Support Co-ordinator Specialist Education- '*I will be share training with safeguarding team and explore how to raise/gain Voice of the child in annual reviews/family work/referrals etc'*

Adult Caseworker '*Resources will help me work with parents to tune in more with their child's experience and see the child's perspective'*

Primary Headteacher '*Include Rights of Child on referrals, make voice much more powerful'*
Safeguarding Officer/Merseyside Police' *Continue to challenge in ICPC'S when my gut/Voice of the Child says different to the consensus…'*

Paediatric Doctor 'Will use more: In my opinion based on developmental stage of child they are likely to be saying….. and then articulate the voice of the child better'
School Nurse/NWBHS 'I think as a new school nurse this training will benefit my assessments and engagement with children'

Moving forward LSCB will continue to develop ways to support professionals in adopting a robust cascading model back to their organisation.

Introduction of a Working Together Forum for professionals

Having analysed the impact of the LSCB training we have recently introduced a new forum-***Working Together Forum***. The forum's main aim is to empower the workforce with confidence and includes learning opportunities as well as hearing professionals, sharing their knowledge and expertise. Impact of training, and in response to feedback from SCR Learning events, we wanted to be more proactive in supporting the multi-agency workforce. It is intended that the Working Together Forum will provide a platform to engage further and to embed the principals and expectations of Working Together (2018) in ensuring safeguarding practice across the partnership is robust. This will also give a further opportunity for practitioners to share their perspectives of safeguarding practices that can then in turn feed into the relevant board meetings for consideration. This flow of communication is in its infancy, there is an intention to adopt a model which demonstrates that consultation with the frontline workforce has took place. This will continue to happen at all training events but there is now greater scope to formalise this during Working Together Forums. Here information and feedback can be gathered, analysed and presented up though the structure of the partnership via LSCB Training Pool and LSCB Learning and Development Subgroup to ensure we appreciate and adopt any new approaches or lessons learnt for future learning and then via LSCB Executive Group to Main board to ensure the workforce and their voice can influence and shape decisions that need to be made at a leadership level to benefit the partnership.

Supporting trauma informed practice

The LSCB Learning and Development sub group continues to oversee the promotion of the Adverse Childhood Experiences (ACEs) programme through the inclusion of ACE awareness into routine safeguarding training and identification and sharing of best practice, e.g. the Recovery Toolkit. ACE's has enabled the partnership to understand and promote the importance of 'Trauma Informed Practice' which continues to be an area of priority for the children's workforce.

	Independent Scrutineer Section Comments:
	A Model of Practice has been rightly recognised as key in supporting practitioners to effectively work together and deliver interventions and support to children and families. The Children and Young Peoples Board has responsibility to oversee this work. It has stalled and requires renewed focus and pace. The LSCB should remain committed to actively support this. The learning events linked to the Serious Case Reviews have proved to be an excellent model to deliver learning. I have heard directly from practitioners the impact this had had on their practice and examples are amply evidenced in LSCB newsletters. The refreshed level of need guidance is significant and although delayed as a result of COVID19, this has provided an opportunity to strengthen the descriptors which are so important to front line staff. The LSCB has demonstrated a responsive and can-do attitude when specific safeguarding issues require increased attention. For example, as a result of findings in a multi-agency audit concerning Child Sexual Abuse in the family a task and finish group completed in a timely way a comprehensive plan to drive forward work in this area. I recommend the LSCB considers further use of the task and finish model but ensures it has in place clear governance to take forward the associated work. The communications from the LSCB are of a high standard, consistent and welcomed by practitioners and good links have been made to ensure LSCB safeguarding messages are disseminated through a wide range of forums. For example, during COVID 19 the LSCB has provided the council lead in Education with information to disseminate though daily communications with all educational settings. The training and development offer through a dynamic officer and training pool has been a demonstrable improvement from the LSCB. Set against the ever-increasing demands on practitioners it is essential strategic leaders continue to support and develop their staff. This is a key strength for the partnership. Notably the working together forum provides a new opportunity where the partnership can learn from frontline practice which in turn can strengthen how we gather evidence when practice has improved and give further confidence in challenging and escalating concerns. The forum is intended to scaffold and strengthen the principals of multi-agency working together practices.

6	**Supporting statement for the business priority 2019/20**
	Sefton LSCB strategic leaders made clear their intention for the board to remain as uninterrupted as possible during the transition into the new MASA arrangements and this has been achieved. To some extent, this was because the board had taken a stepped approach starting in 2017 in preparedness for the new legislation and had clear priorities set for this to be accomplished. We also proudly maintained our name and brand so were not distracted in a whole sale re-branding strategy. The board, just prior to the changes, had also re-aligned its statutory focus and safely redirected the operational responsibilities back to the strategic owners and accountable forums allowing the LSCB to concentrate on its core strategic aims. Whilst agency leaders recognised the need for the partnership to continue to work better together across a multi-agency footprint, rather than lose the development of cross agency operational relationships, a decision was made to create a practitioner forum and continue to work together in a direct way that resolves any operational blockages.

7	**Partnership Evaluation of Practice**
	"….the LSCB has appropriately prioritised the dissemination of learning from recent serious case and learning reviews. A strength is the development and publication of '7-minute' briefings. The briefings identify key learning from serious case and learning reviews and they are distributed across the partnership, providing key information for staff in an easily accessible and concise format. Staff report that they read the briefings and find them useful to their practice. To correlate and support the briefings, the safeguarding board

promoted the use of a theatre company to deliver the messages learned from serious case reviews. The sessions were performed from the child's perspective and had a powerful impact on staff.

(Joint targeted area inspection of the multi-agency response to children's mental health in Sefton. September 2019)

SCR JANET (published April 2019)

Key Findings:

1. The partnership needs to be robust in identifying Early Help provision for families who would benefit from it.
2. Information sharing and risk assessment needed to be more effective.
3. Co-ordination between nursing and GPs needed to be more joined up.
4. When transferring information between GP surgeries, identified safeguarding risks were not highlighted.
5. Lack of systems and processes in place within hospital Emergency Departments that support accurate assessments and responses to safeguarding risk.
6. The partnership lacked professional curiosity when accessing information.
7. Risk factors around 'hidden males' was not fully considered.
8. Systems and processes within some agencies that support staff to accurately assess, record and respond to safeguarding risk needed to improve.
9. Lack of joined up IT systems between health professionals to communicate effectively.
10. There was no evidence of any independent structured review process being undertaken by the Police as part of the investigation into the unexpected death of a child that may have enhanced the investigation.
11. Agencies lacked sufficient detailed recording of decisions made as well as the rationale behind them on the case records.

SCR MATILDA (published October 2019)

Key Findings:

1. There was a negative impact for professionals through parents' attempt to conceal information.
2. There were a number of gaps in information sharing within the partnership.
3. Understanding individuals and family circumstances could have been explored further by professionals.
4. The children within families need to be fully understood by offender management organisations who are working with the parent(s).
5. The recording and management of information within Children's Social Care relating to individuals who may pose a risk to children needs to be reviewed to ensure it is effective. Within this, clarity needs to be given around the processes for risk assessments and the alert system currently in place.
6. The strategy meeting did not include all relevant staff missing an opportunity for those agencies to positively contribute to planning.
7. Practitioners across the partnership recognised the competing demands for professional attention was impacting on their quality of practice

SCR BEATRICE (published March 2020)

Key Findings:

1. In general, it would be good practice for local authorities to liaise around support to care leavers living across boundaries.
2. Where risk factors are evident the importance of full information cannot be over-emphasised. While the self-disclosure of information is positive it cannot be assumed that this is complete, and confirmation should be sought where possible. Specifically, where there is a history as a care leaver background information should be sought from the responsible authority.
3. It is important for the police to take a more holistic view of a persons' circumstances and, although not yet a parent, to consider information sharing to protect a child, albeit not yet born.

4. Mother's parenting capacity needed to be specifically assessed taking account of relevant research re parenting and Emotional Unstable Personality Disorders.
5. Little information was obtained in respect of father – this is commonly reflecting in reviews where the male partner is almost the invisible male. The absence of more professional curiosity resulted in a lost opportunity.
6. It cannot be assumed that all services hold all relevant information so particular care should be taken to check this out and adopt a "think family"[1] approach
7. An effective pre-birth assessment is key to the development of an appropriate plan to support and safeguarded the well-being of children. Where this is allocated to a student social worker it is important that they are fully supported and supervised and that there are good quality control mechanisms in place.
8. Where a number of agencies are involved, it is important that there is good information sharing. This may be via the Child Protection planning processes, Child in Need frameworks or via an Early Help offer. It is important that a lead professional is identified and that they take on the responsibility of coordination and information sharing
9. Decision making about the outcome of an assessment should be communicated to all relevant parties and should be subject of professional challenge if not agreed or seen as inappropriate.

Illustration of actions taken across the LSCB partnership in response to learning from SCR's

- LSCB policies and procedures updated in light of learning from our reviews. Eg. Pre-Birth Protocol has been developed (pan Merseyside), Concealed Pregnancy protocol has been developed (Pan Mersey), updated LSCB Escalation Procedure and Child Protection standards
- Child Protection Standards have been reviewed and practice expectation has been strengthened in the detail
- Early Help practice standards have been developed in the period and are now completed for introduction along with the development of assessment and referral processes
- High profile SCR learning events undertaken across the partnership
- LSCB Escalation Procedure has been reviewed and simplified alongside a multi-layered communication drive
- MASH Information Sharing Agreement agreed and implemented
- Early Help Strategy has been introduced
- Early Help Partnership group has been established
- Early help practitioners have been allocated to schools for identification of single points of contact purposes
- Alder hey Children's Hospital have undertaken a review of their safeguarding assessment processes and have a training plan in place to raise awareness of professional curiosity, information sharing and holistic assessments
- Production of guidance on 'Hidden Males' for practitioners
- 7-minute briefings swiftly published in relation to learning themes drawn out from the reviews
- Multi-agency Sudden Unexpected Death in Childhood (SUDiC) protocol has been refreshed
- Community Rehabilitation Company and National Probation Service have jointly devised and introduced enquiry forms for both Children's Social Care and Early Help to improve the quality of their 'safeguarding checks'
- Public Health have commissioned a campaign with partner agencies to raise the awareness of the impact of shaking a baby
- LSCB has made representation to the Department of Health concerning the feasibility of developing and implementing a national information technology system that provides greater connectivity between health professionals

[1] SCIE: At a glance 9: Think child, think parent, think family - Published: May 2012; Key messages

Think child, think parent, think family in order to develop new solutions to improve outcomes for parents with mental health problems and their families. Take a multi-agency approach, with senior level commitment to implement a think family strategy.

- All agencies are self-satisfied that they have robust arrangements in place to accurately record case details, with supporting information, including a rationale for the decisions made.
- LSCB has provided advice, guidance and resources, to the partnership that focuses on parental mental health and parenting
- LSCB have revised their training materials to ensure that learning from reviews is clearly illustrated and addressed during multi agency training events
- The board has continued to build the suite of good practice guidance for frontline staff which includes learning from SCR's

Rapid Reviews

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review. The safeguarding partners promptly undertake a rapid review of the case, in line with any guidance published by the Child Safeguarding Practice Review Panel (15 working day timescale for the completion of rapid reviews). The aim of this rapid review is to enable safeguarding partners to:
• gather the facts about the case, as far as they can be readily established at the time
• discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
• consider the potential for identifying improvements to safeguard and promote the welfare of children
• decide what steps they should take next, including whether or not to undertake a child safeguarding practice review

Sefton LSCB undertook a rapid review in 2019-20 that resulted in a local practice learning review. Reviews are led by a member of the LSCB with identified support.

GEORGE

The review brought practitioners involved in the case together to reflect on practice and extract learning and good practice. The rapid review analysis report showed that there were some strengths in the practice including parents having received a lot of support, particularly from early help service, having attended parenting programmes and the children experiencing some direct work. On the other hand, some features of the case were identified in the recent serious case reviews, particularly in relation to; -

1. Information sharing and poor communication between professionals
2. Decision making not taking account of a family's history
3. Engagement with appointments: children not being brought and adult non-attendance
4. Cross local area issues
5. Lack of use of the escalation policy

Review Conclusions/Recommendations
It was acknowledged by the Early Help service that in complex cases, where for example the service involvement had spanned a significant period, that joint working should be considered with agencies known to be involved with the child and family. Furthermore, the importance of good supervision and established mechanisms for ensuring Management Oversight were needed. The Early Help service advised that these processes were being established. The review also recommended the need to consider all cases when open for 12 months and commented upon the usefulness of a 'huddle' (a meeting for multi-agency workers to come together) where 'stuck' cases can be considered.

At the time of writing this report early help have provided assurance to the LSCB that they have since developed documents to support Early Help Quality and performance: Quality Assurance Framework, Practice Standards, 12-month Audit schedule and Quality assurance schedule to include 'focus on practice 'weeks in alignment with Children Social Care. A new audit tool and guidance has been developed to ensure they are capturing the quality of Early Help assessments, plans and reviews.
A Quality Assurance briefing has been shared with Family Wellbeing Centre staff and the intention is to broaden this to all Early Help Partners to further embed the culture of sharing practice and improvement.
Early Help plan, assess, review training has been refreshed and updated.

	Independent Scrutineer Section Comments:
	The LSCB has undertaken a significant amount of work in the year about SCR's and, as identified by the JTAI inspection report, the sharing of the learning from this work has been well-received by the partnership. Through the work of the board there has been effort to encourage agencies and individuals to 'hear the voice of the child' in all that they do and that that is starting to take shape through, for example, case recording, auditing practice and report formatting. Whilst there is evidence that this is now starting to become a working focus across the partnership there is still limited evidence of understanding the journey of the child and how services influence their life journey. This requires a focus on evidencing that what the child communicates to professionals is responded to in a way that enables a child to thrive and: • to feel involved in decisions about their life and their future • understands the purpose of those services who are involved in decisions about them • has the right services at the right time delivered responsively to the needs of the individual child based on their developmental needs

8	*Performance Management and Monitoring*
	Through the work of its Performance and Quality Assurance Sub Group the LSCB continues its drive to ensure that the partnership focuses on how it evidences the impact and outcomes of practice on children and families. Work in this area during 2019/20 was limited interrupted? due to staffing vacancies. Appointment to a quality assurance officer post has allowed important work in these areas to recommence. For some years the LSCB operated a dataset that was significant in scope and accumulated to over 100 performance indicators. In recognition that it was no longer fit for purpose the LSCB agreed to a new dataset of 33 high level indicators, relevant to the remit of the safeguarding board. The success of the new dataset was always dependent upon agency own analysis and commentary of their performance. Since its inception, the renewed dataset has not provided the analysis we had hoped because the commentary of agencies own analysis was either lacking in detail for safeguarding purposes or absent with just the submission of data figures which in themselves told us very little. The Board has recently approved a revised approach to evaluation and monitoring of safeguarding performance. It is anticipated revisions to performance reporting and monitoring will enable the LSCB partnership to: • Have clear lines of oversight and communication with statutory and key agencies. • Be sighted on positive single and multi-agency work being undertaken by partners to safeguard children in Sefton. • Be alerted at the earliest opportunity to areas of concern or risk in relation to safeguarding. • Enable the partnership to improve safeguarding practice through rigorous monitoring of performance against LSCB child protection standards. • Enable the partnership to better hold partners to account for their performance and contribution to effective safeguarding Quarterly reports, in relation to safeguarding performance with accompanying data relevant to the LSCB, will be received from safeguarding partners and key service areas with responsibility for safeguarding across the continuum. Settings will report on; Performance assurance / Areas of concern (internal or external) and actions taken / Positive areas of safeguarding practice / Child and family views of services received. Additionally, biannual reports will be sought from LSCB agencies and the views of front-line staff will be sought on how well the safeguarding system is working from their perspective. Through monitoring, scrutiny and challenge by the LSCB through the Performance and Quality Assurance sub group it is expected that this revised approach to performance monitoring will provide a more reflective and meaningful analysis of agencies' and service areas' analysis of safeguarding practice.

Further work to improve self-reflection, monitoring and scrutiny will take place. This accounts for the views of children and families on services and improvement in how (singularly and collectively) agencies evidence that the services offered to have an impact on the daily lived experience of children and their long-term outcomes, will ensure the development and delivery of more effective safeguarding services in Sefton.

Sefton LSCB Audit Activity

Section 175: It is imperative that education settings can demonstrate that they are meeting key statutory safeguarding duties and are following current statutory safeguarding guidance.
Evaluation of the 2019/20 Section 175 self-assessment returns tell us that:

- Education settings in Sefton actively engage with self-evaluation requirements so that standards for safeguarding are maintained and that actions are regularly taken to review and update practice against standards
- Settings are alert to children's needs and have due regard for the welfare of their pupils and students and will, when necessary, refer concerns to Sefton Children's Services
- Education settings are proactive in identifying and progressing actions for monitoring, reviewing and updating their safeguarding policies and procedures
- Settings ensure that staff are appropriately trained to discharge their statutory responsibilities in respect of safeguarding.

All education settings have: A child protection policy in accordance with LSCB procedures, Keeping Safe in Education and Further Education statutory guidance; A Designated Safeguarding Lead or Deputy is available during term time, for staff to discuss safeguarding and welfare concerns and; a coordinated response for students missing or for following up student absences.

The S175 evaluation also tells us that further work is required to support education settings so that staff are understanding of early help and processes and can identify children's emerging needs and are proactive active in supporting children and families through coordinated early help assessments. Work is also required, by way of additional training, which will assist Governors to quality assure safeguarding practice and to support their scrutiny of setting's safeguarding practice.

Section 11 Audit – Coordinated Findings
As several agencies, with responsibilities for safeguarding, deliver services across different local authority areas in Merseyside the 2019/20 section 11 audit was coordinated across several local authority areas through the respective safeguarding partnerships of Sefton, Liverpool, Knowsley and St Helens. Coordination of the section 11 audit reduced the burden on agencies to complete and submit multiple S11 audit submission to differing safeguarding partnerships for, in turn, differing evaluation.

Agencies subject to cross partner scrutiny for 2019/20 were: Liverpool Women's Hospital; National Probation Service, Merseyside Community Rehabilitation Company; NSPCC; St Helens and Knowsley Health Trust; Mersey Care NHS; North West Borough Health; NPS Merseyside; Alder Hey; Aintree Hospital and Merseyside Police.

Through completion of an online self-evaluation audit agencies evaluated performance against standards relating to: Policies, Procedures & Thresholds / Skilled Workforce (Training) / Skilled Workforce (Recruitment, Complaints, Escalation, Whistleblowing and Allegations Management).

Self-assessment returns were scrutinised and evaluated by a multi-agency panel comprising of senior managers and quality assurance officers, representative of Sefton, Liverpool and St Helens local authority areas. Front line visits to settings were undertaken to validate self-assessment returns. (A number of front-line visits were unable to take place during the period of review due to Covid-19 restrictions)

Evaluation of the Section 11 self-assessment returns tell us that:

- Agencies have been able to demonstrate compliance with the standards measured in the Section 11 process.
- Audit and Front-Line Visits have provided appropriate assurance on agencies' compliance with standards.
- Although all standards have been met where individual areas for improvement are identified agencies have committed to undertaking necessary actions.
- Although demonstrating compliance Adult-facing organisations with less familiarity with the Working Together 2018 legislation struggled to answer some of the questions in the standards.

From the S11 audit agencies should ensure that staff:

- Are understanding of levels and descriptions of need.
- Are competent to carry out their duties for safeguarding in an environment where staff feel able to raise concerns and feel supported in their safeguarding role.
- Receive a mandatory induction, which includes familiarisation with child protection responsibilities and the procedures to be followed if anyone has any concerns about a child's safety or welfare
- Have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time.

Section 11 Audit – Sefton
Agencies outside of the coordinated section 11 approach delivering services within Sefton that completed a section 11 return for 2019/20 were; Southport and Ormskirk NHS Trust (Lancashire Safeguarding Children / Adults audit), South Sefton Clinical Commissioning Group, Youth Offending Team and Children's Social Care. Self-evaluation against Section 11 standards for these agencies tell us that agencies are:

- Fully compliant with safeguarding standards
- Proactive in their review of standards and implementing actions to maintain compliance with standards.

Agencies have identified and implemented actions to ensure compliance in respect of the following areas:

- Training / Safer Recruitment: To ensure all relevant staff receive necessary safeguarding training, including safer recruitment training, and that attendance at training is routinely monitored.
- Polices / Procedures: To ensure that safeguarding policies are accessible to the children, young people and families accessing the service.

Multi-Agency Thematic Audit Activity
Sefton LSCB undertakes multi-agency audit to evaluate the safeguarding practice in response to areas of concern whether nationally or locally. And identify good practice

Child Sexual Abuse in the Family Environment
In response to Sefton LSCB's initial CSAFE multi-agency audit (2019), in which it was found that; the voices of child victims of sexual abuse within the family environment were largely absent, there was a lack of professional curiosity in many of the cases, that information sharing and coordination between agencies was inadequate and that allegations of child sexual abuse in the family environment were not being dealt with as robustly as they should LSCB, a multi-agency CSAFE task and finish group was established to develop a partnership strategy to strengthen Sefton's multi agency response to CSAFE.

A further CSAFE audit has been recently undertaken and initial findings from this audit, to be made available to the LSCB, indicate that:

- Practice was good in many areas audited.
- In a majority of cases risk was identified, responded to and reduced in a timely way.
- Coordination between agencies was effective.

- Practice was generally considered to have improved outcomes for the child or young person.
- All agencies considered that children, young people & families are appropriately involved in assessment, planning and intervention.
- Further work is needed to ensure that support for children affected is made available, that planning for children is consistent in its aims and clear in its outcomes and that multi-agency monitoring of the effectiveness of multi-agency interventions is robust.

Taking into consideration the OFSTED findings from their published report 'The Multi Agency Response to Child Sexual Abuse in the Family Environment (2020), Sefton LSCB has agreed that CSAFE will be one of the areas for greater focus as within its priorities for 2020/21. Development of the multi-agency CSAFE strategy an accompanying action plan will coordinate a more effective partnership response to CSAFE.

Work to be undertaken in 2020/21 will include:

- The capture and analysis of relevant data which will provide a more accurate picture of the nature and extent of CSA in Sefton
- Development and delivery of multi-agency CSAFE training
- Partners and agencies prioritising professional's attendance at multi-agency CSAFE meetings to improve effective decision making.

Children Living with Mental Ill-Health Audit Findings

Completed as part of the Joint Targeted Area Inspection in September 2019.
Audit showed that:

- The Sefton LSCB partnership demonstrated good inter-agency working.
- Multi-agency professionals had a clear understanding of each other's roles.
- Education settings responded well and quickly to the special educational needs of children with mental ill health and provided high quality education provision.
- Children's mental ill health is understood and there is evidence of professional sensitivity relating to this in decision making.

Further work is needed to:

- Strengthen the LSCB Level of Need Guidance in relation to Asylum Seekers.
- Ensure agencies provide effective challenge to support decision making and planning.
- Develop greater collaborative working, through a Think Family Approach, with adult services to improve child and family outcomes.
- Support professionals to identify and respond to Adverse Childhood Experiences (ACEs).

In response to the audit, actions taken have included:

- Revised and re issued the LSCB Escalation procedures to better support effective challenge
- Established within escalation procedures requirements for agencies to record low level escalations and return reports to the LSCB for monitoring.
- Revised the LSCB level of need guidance

Improving the capture of the child's voice and experience

As part of its multi-agency audits LSCB seeks to identify how agencies have improved safeguarding services in response to feedback from children and their families. Although audits have found that agencies are generally good at providing opportunities for the voice of children and their families to be heard, LSCB acknowledges that more needs to be done. To this end, as part of a new and ambitious performance reporting structure, LSCB now requires agencies and services to specifically evidence what it is that children and families are saying about the services they receive and what the agencies or services have done in response to that feedback. It is expected, that by requesting this directly from agencies and challenging where it is not evident, will serve to

	improve greater and more meaningful engagement with children and their families and led to more effective service improvement. **SCHOOL INSPECTIONS (SAFEGUARDING – OFSTED JUDGEMENTS)** Safeguarding training specific to the education sector on behalf of the LSCB provides advice, information and guidance to education settings on their safeguarding arrangements and practice. Up to date training is delivered to the Designated Safeguarding Leads. From 1 April 2019 to 31 March 2020, the 21 schools that have been inspected were judged as having effective arrangements for safeguarding in place which met statutory requirements. All of the reports state leaders have ensured that all members of staff have received appropriate and up-to-date training and understand their responsibilities for ensuring the safety and well-being of all pupils. In those 21 schools, leaders and managers have created a culture of vigilance where welfare is promoted and where timely and appropriate safeguarding action is taken for those who need extra help or may be suffering from harm.
	Independent Scrutineer Section Comments:
	Auditing activity plays a significant role in the board being able to evidence how practice is co-ordinated and how it responds to safeguarding children. Due to lengthy staff vacancy on the board during the year this has resulted in a reduction of the expected auditing schedule. Whilst efforts have been made to get this work back on track and the accomplishments listed above have been illustrated, there is a risk that quality assurance and performance monitoring cannot be confidently planned post March 2020 whilst the future delivery model remains unconfirmed. The Partnership has recognised it requires a step change in its approach to data and performance information. The new approach, if proactively embraced, will provide clearer outcome focused evidence. This in turn will support senior leaders to be proactive in responding to shortfalls in practice. I recommend within this a greater focus on identifying good practice and sharing this across agencies.

9	**Learning and Development**
	The LSCB in Sefton is in a privileged position because we are offering training and development opportunities to a children's workforce who have self-drive and commitment to improve their own development with a strong appetite to develop their practice through our training offer. Consequently, the board regularly has training courses that are oversubscribed because of the high demand. Significant opportunities have been explored and developed to ensure the LSCB priorities are weaved through all areas of learning and development activity and through the delivery of a diverse range of training opportunities. These are modelled and delivered to support professionals in cascading priorities back to the wider workforce to ensure there is a clear and shared understanding that '*Safeguarding is Everybody's Responsibility*'. Establishing and building on existing relationships and partnerships was of paramount importance to develop an overwhelming sense of ownership where professionals develop confidence in their safeguarding responsibilities and practice This has been the underpinning aim and has set the foundations for stronger partnership working. This has been reinforced and supported by the LSCB Training Pool through past, present and future activity. New Impact and Evaluation forms have been developed to gather clearer feedback three months after attendance of Working Together to Safeguard Children Two-day training and includes questions and prompts to support effective completion of the form '*How has the training influenced, supported or changed your practice'?* and *'Are you able to share any examples of how the training has had direct impact for a child'?* It is expected that the board will be able to better evidence the relationship between training for staff and changes in practice that responds to the needs of children and improves our practice as a result.

Evidence of post training evaluation feedback tells us:

*'Having just taken over the role, I had a lot to learn. I now know how to make a referral and which other agencies are available to support me. I haven't had to use this information yet, but I know where to go if I need support or to report an issue'. (*Primary School SENCO Safeguarding Lead)

*'I have included a 'Voice of the Child' Workshop in our next Every Child Matters Forum that is focusing on Early Help. The training made it clear how important the role of the voluntary sector is as 'eyes and ears' on the ground. I share this with the organisations I work with'. (*Sefton CVS)

'It's helped myself when talking to Young People enabling me to see things from their point of view'. - Missing persons / Care Home Single Point of Contact (SPOC)(Police)

'I have held a staff meeting with the employees of the organisation and discussed the processes in which all staff must follow. The staff have been asked to refresh their own knowledge and have been given a copy of the safeguarding policy. During the staff meeting, we have discussed how to escalate any concerns if the staff do not feel management is escalating the concern, they know who to contact further. The senior staff were enrolled to attend the serious case review learning event, the feedback from the staff was very positive and they took away a lot from the training, which the seniors have team meetings and have discussed the importance of responding, recording and reporting concerns. -Youth provision, Voluntary Sector'.

'I have recently made a referral due to a disclosure made by a child, I arranged a meeting with the parent to discuss that a referral had been made. From the discussion, mum disclosed events which had been happening within the home. From this conversation, it opened the channel for conversation and what the wishes of the parents were for their children. Working with the family and constantly phoning social workers to see what services were being offered to the family, this has helped the family to seek support'. 'I now believe the family is accessing early help services and how improved within their situation. This has only been affected due to the positive communication and relationship building, the parent is happy to talk to myself or the senior of the club if they have any concerns or issues they need to discuss. - Young Person Practitioner, Voluntary Sector'.

'I have reviewed Merseyside Army Cadet Force Safeguarding and Child Protection Policy and held a briefing morning to Permanent Support Staff. I am more confident to ask questions to gain more information. I no longer carryout any actions in isolation. 7-minute briefings are used at any safeguarding update and at my weekly meeting'. – DSL, Merseyside Army Cadet Force

Feedback from the SCR Learning Events were overwhelming and extremely positive:

Just wanted to say that the SCR event today was fabulous – I can't stop thinking about it.
I appreciate how much work went into organising it and wanted to thank you.
I think the handout is fabulous too – I love the Hear My Voice one in particular and
I will be using it in work.
Thank you (Sefton Independent Reviewing Officer)

I thought the training was fantastic, very powerful and everyone
I have seen since was talking about it. I definitely think it has made an impact with staff.
(Sefton Council Manager)

Training was amazing.
Great session and so emotive
Fantastic thought provoking production and so much more powerful than
the usual power point training. Well done.
Very powerful, some staff were crying
Best safeguarding training I've ever been on
(comments by Sefton MASH staff)

Training was fantastically received
All the posters were excellent with really powerful messages.
Well done this event took significant preparation and planning. Fantastic
(Assistant Director, North West Borough Health NHS)

The venue was welcoming and provided a relaxed atmosphere.
The event did not apportion blame. The actors brought the children's stories
to life in a such a powerful way. This was an excellent way to reinforce learning.
I was touched by all of the stories; each made me reflect on my own experiences and practice.
The event gave everyone the space to do this in a supportive setting which did not feel
pressured and did not stigmatise any particular agency.
(Sefton Independent Reviewing Officer)

Learning materials **CLICK HERE** **Special Edition Newsletters** **(July & December 2019)**

7 Minute Briefings Feedback

'The 7 minute briefings produced by Sefton LSCB are positively received
by Sefton GP practices in order to share learning and discuss practice issues.'
(CCG)

'The level of communication from the LSCB, particularly the newsletters and 7-minute briefings
is very positively received by the education sector in Sefton.'
(Sefton Primary & Secondary Headteachers)

LSCB Training Programme

Training Courses included below have been analysed to provide evidence of impact. The LSCB Learning and Development Officer post was vacant for a significant period of time and has caused significant disruption to this being implemented across all training. Learning aims and objectives have been reviewed to ensure professionals appreciate and understand the importance of: Confidence in practice is key, use Escalation if needed, be an advocate of the child, bring the child's voice to the forefront, and for every professional to have a shared responsibility in their contributions in multi-agency meetings and in decisions making. Ongoing communication with the children's workforce who have attended training is indicating progress is being made, however more evidence is needed to demonstrate this is making a difference to children and young people's outcomes.

We recognise that it is crucial that a cycle of improvement is used to review learning. There is evidence to suggest that this is developing with principals of honesty and reflection underpinning evaluation feedback from multi agency partners. This has provided opportunities to develop new learning materials e.g. SCR Learning events provided a pathway to engage with the workforce further and lead to the development of a suite of resources and learning materials including the development of a new course 'Hear my Voice' (child's voice).

Feedback includes:

'The training has allowed us to develop our safeguarding policies and procedures and ensure that our staff feel confident in handling safeguarding disclosures, feel confident to challenge and use professional curiosity. The voice of the child model allows us to explore any concerns/disclosures, in an attempt to understand the child's lived experience and the impact to them and other family members. The training allowed us to share best practice and local trends/concerns with professionals from many different sectors, including health and probation – giving us an extra insight into how we can work multi-agency to safeguarding and protect children. We have developed new links with new organisations and professionals we can contact for advice and support'.
(Further Education)

Designated Safeguarding Lead Training -Education

The LSCB responds to the demands of the children's workforce, impact of this is an increased offer to Designated Safeguarding Leads in Education settings, enabling professionals in this role to retain confidence and knowledge. This has contributed to many schools reaching a successful outcome at inspection

Hear My Voice -Newly developed multi-agency training course

This new course was in response to the lessons and recommendations of SCR activity and to reflect LSCB 2019/20 priorities. The course was significantly over subscribed, LSCB are committed to facilitating this course in the future to meet the demand and requests made from across the whole partnership. Evaluation feedback from training activity included the following comments ……

'Bens Shoes' linked to SCR was really powerful'.
North West Health Boroughs (NWHB), school nurse.

'Reinforced the importance of children's voice, thinking how as a therapist we could support other agencies in how to do this or be used in direct work with clients and service users'
(Children and Young People's Therapist)

'I will change the way I make a referral, taking into account the voice of the child'.
(Primary Headteacher)

The plan for offering this training three times a year is on hold due to COVID.

Overwhelming majority of attendees rated this course as excellent using descriptors such as 'educational', 'informative', 'thought provoking', which provides the board with assurance that the course design and content is having an impact on participants and will have a positive impact on practice which will be monitored within the LSCB Learning and Development Subgroup.

Further evidence of impact following attendance at LSCB training events is collated three months after course delivery. This is captured through a newly developed 'Impact and Engagement' proforma form which is shared across the partnership. Feedback on various training courses includes:

'…It was great training and I found it very useful, I'm keeping an eye out for more dates as I would like my whole safeguarding team to attend'.
Hugh Baird College

'Since attending the training we discussed the content, including detail regarding 'the voice of the child', professional curiosity and escalation with our designated safeguarding team. This information was also cascaded within our fortnightly safeguarding group. The learning has been used to update our college staff training ….and will be used to update our policies and procedures'.
Southport College and King George V College (KGV)

'We are currently redesigning our staff development to encompass some of the new learning, including advice from the recent serious case reviews and 7-minute briefings. This will include case studies and assessment to ensure learning has taken place'.
Southport College and King George V College (KGV)

'We are updating our policies and procedures to reflect this learning. We will continue to discuss the voice of the child, professional curiosity and escalation within our daily practice and within our formal safeguarding meetings. We will continue to work closely with our most vulnerable learners and families using these skills and seeking expert advice as needed. We will continue to make timely referrals, using the voice of the child model'.
Southport College and King George V College (KGV)

'*How Serious is Serious'* Training
How Serious is Serious was commissioned was funded by Merseyside Child Death Overview Panel (CDOP) to promote confidence in the children's workforce to enable them to raise the subject of suicide with children and young people that they were concerned about, in a calm and supportive manner. It came about as a consequence of Merseyside Child Death Overview Panel (CDOP) experiencing a significant rise in the number of suicides of young people being reported. The rise reflected the increase in numbers nationally. The SERIOUS materials, developed by Merseyside Youth Association, were compiled with the benefit of input from young people and parents bereaved through suicide. Due to the sensitive subject area and course content the training is delivered to only small numbers of staff and consequently remains oversubscribed.

Those who have attended the training tell us:

'I feel m*ore confident in helping children and families by asking direct questions and spotting the signs for self-harm and suicide'*. Health care professional, Alder Hey Children's Hospital

'This training has enabled me to see where I need to make a change in policies. Secondary Headteacher

'I am m*ore confident in my ability to respond appropriately to the difficult topic of suicide and distress'* Community Adolescent Service (CAS).

'I w*ill be more direct in questions and will use strategies learnt today in my practice'* Associate Practitioner, Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD) Children's Service, Alder Hey Children's Hospital

'*Will be open and ask direct questions. I now know how to respond'* Case manager, Community Restorative Centre (CRC).

Public Health in Sefton have supported this area of work and have funded resource packs. This will continue as a priority piece of work with plans in place to expand the team of trained facilitators from within the LSCB training pool.

KOOTH offers a safe and anonymous online counselling service that provides an emotional well-being platform to support children and young people with mental health concerns. Briefing booked in response to recent JTAI, which took place March 2020. This was the last training event before COVID lockdown and attendance reflected the growing move to social distancing. Analysis of feedback indicated further scope to offer this briefing in the future. Following the recent COVID pandemic it is yet to be realised how much this has impacted on the emotional health and well-being of families and what increased demand may arise as a result. This will need to be factored in when planning for future briefings.

Child Exploitation Briefings
Child Exploitation training is a priority for the LSCB. The delivery has been interrupted as a result of the pandemic. The aim remains to provide the local and national picture to support all professionals to identify, intervene and respond in safeguarding and protecting children at risk of exploitation.

Analysis and Impact of LSCB Training attendance
As stated, the analysis and scrutiny of the impact of training is taking shape. Early evidence indicates some impact is being made but more needs to be captured. This feedback from across the partnership provides an insight to some of its findings which will influence and shape future content and delivery and address gaps in attendance from partners. There has been an overwhelming demand for courses to be repeated which suggests the content of revised training and new developed courses is appropriate and effective in response to previous professional feedback. Overall, engagement data suggests LSCB has made an impact with an increase in professionals attending LSCB training.

The absence of a Learning and Development Officer for the first six months of the reporting period has had a substantial impact on the workforce experiencing a delay in receiving training. The LSCB is now in a much-improved position with an increased training offer and a system in place to evidence the impact that training is having on practice to the benefit of our children and families.

Quality, Evaluation and Impact on Practice
LSCB Learning and Development Officer has prioritised and developed a process to monitor the quality and effectiveness of training initially through observation of engagement as the training is facilitated. Course content has been reviewed and revised to ensure all learners can fully engage, share best practice and find solutions e.g. existing case activity was reviewed and changed to focus on contextual safeguarding. Activity was changed to focus on the daily lived experience of a young person vulnerable to child exploitation. Agencies now must fully engage and find a solution to improving the outcomes of this young person and consider how their service can contribute to improvements to the child lived experience.

Working Together to Safeguard Children training has been updated, each change has been tracked to show direction of travel and enable future reflection and to ensure there is future impact for the effectiveness of delivery. Neighbouring Local Authorities have expressed interest in the revised content and delivery of Sefton's approach.

LSCB Training Pool
LSCB Training Pool has developed there is now wider representation from across the partnership and includes Children's Social Care Principal Social Worker. Strengthening and developing relationships is a priority to ensure all partners have a shared responsibility in the delivery of the LSCB training programme. Extensive plans are needed to build on inspection findings across the partnership e.g. JTAI, changes in legislation, learning from multi agency audits. The LSCB Learning and Development Officer will continue to coordinate and ensure the implementation of the training programme is responsive to this and in line with future LSCB priorities.

Through the training pool, training presentations/sessions are under development with Sefton Young Advisors which will be shared across the partnership to support the capture of the voices of children and young people. It is intended this presentation is shared widely to offer supportive challenge to the workforce to consider and review how they:

- engage in practice with children and young people
- to hear and respond to what they are telling them (directly and indirectly) about their lived experience and
- Collectively explore how services can then be shaped to better respond to the needs of children and young people and result in better outcomes

Challenges
Impact is evident across Learning and Development activity. Although a robust plan is in place to support multi agency engagement across the partnership this will not correlate without longer term investment. Further risks are evident as the post of Learning and Development Officer is a temporary position for 18 months.

Moving Forward
At the end of the reporting period 19/20 COVID-19 lockdown prompted a swift response to meet the needs of the Children's workforce. A diverse programme of support was brought together to ensure professionals could have access to a wide range of online learning and resources. A programme of learning has been researched, developed and presented on the LSCB website. Online tools/resources for supporting 'Parental Mental Health and Emotional Wellbeing' have also been collated in response to SCR-Beatrice.

It was essential the details of this was shared widely to ensure those who need it most could access it. Via the Training Pool and through communications details have been shared to support a varying level of need e.g.

	professionals new to safeguarding, Designated Safeguarding Leads who may need further information to cascade to a team or for induction purposes. Unfortunately, several events are on hold due to COVID restrictions this includes, 'Briefing on Listening to the Voice of Young Carers' (Sefton Carers Venue), 'Supporting Children and families facing substance misuse' (Bootle Life Rooms), Professional Curiosity and Coercion (Marsh Lane Police Station) and briefings on 'Child Exploitation'. Other training is on hold but will be ready to deliver, this includes delivery of 'Two Day Working Together to Safeguard Children', 'Designated Safeguarding Lead (DSL)', Hear My Voice', Rollout of 'How Serious is Serious' and 'Working Together to Safeguard Children Forum'.
	Independent Scrutineer Section Comments:
	Sefton LSCB has set a very high standard in innovation around learning which is exemplified in the work undertaken in learning from case reviews. Linked to longer term funding there is a risk that training cannot be confidently planned post March 2020 whilst the budget is unconfirmed. The board benefits from a strong training pool that creates and commits to training required for the coming year and is responsive to the actions from the Learning & Development sub group. The training pool, most of whom are frontline practitioners, has also been instrumental in the design of training materials and content that are reflective of the needs of the staff on the frontline of practice. There has been the recent introduction of a training impact evaluation process but that now needs to concentrate on capturing how professional training impacts on their service delivery to the benefit of children and families.

10	Key Priorities for 2020/21
	1. The partnership will ensure it holds the child's lived experience at the centre of all that they do, and the impact and outcomes of multi-agency services and support are well understood. The board undertook a significant amount of work in 19/20 to raise the importance of hearing the voice of the child and this specific focus is now embedded in all performance feedback that is returned to the board. The development of this approach moves the partnership to now focus on how they evidence that the delivery of their services is predicated on their understanding of the child's lived experiences. It is acknowledged across the partnership that by seeking out, and tailoring services to meet the individual needs of the child in response to their life experiences to date, there is an increased opportunity to successfully support children in the right way and improve their long- term life chances. 2. To support the partnerships development of a multi-agency model of practice. The partnership fully acknowledges the absence of a working model of practice common to the whole partnership and are strongly committed to the introduction of a model of practice across the children's workforce. This is under the governance of Sefton's Children and Young People Partnership Board. The LSCB have committed to support the implementation of a model of practice. 3. We will continue to support staff development through the delivery of identified multi-agency training needs. Training will remain a strong element of the board's activity. Senior leaders across the partnership recognise and encourage the continuous development of their staff and the importance of delivering training from a multi-agency perspective. Our selected training courses for the coming year will be those that concentrate on the learning we have uncovered through board activities such as thematic auditing, case reviews, professional feedback and quality assurance highlights. 4. A greater focus on specific groups of children where increased safeguarding vulnerabilities are identified. For example, Children Sexually Abused in the Family Environment. This work will complement the themed audit activity undertaken by the board throughout the year and take additional steps to deep dive into specific groups of children whose additional safeguarding vulnerabilities may be less understood. This will include case reviews, auditing, policy and procedure strengthening as well as staff training and development. The current board structure does not have a specific sub group dedicated to this area of practice and will require consideration.

	Independent Scrutineer Section Comments:
	These priorities are broad but are well informed form the work undertaken throughout the year and build on improvements to date.

11	Independent Scrutineer Conclusion:
	At the time of writing this report, the world is experiencing a pandemic. It is important to record the significant collective efforts across the partnership to prioritise safeguarding children. In these challenging times, great leadership across our public services has never been more important. Practitioners look to leaders for support, guidance and direction. I have, through discussions with senior leaders, gained an appreciation of the tough challenges. I have heard of the continued commitment and hard work of key workers and community services. The response and adjustments have been exceptional, and I have been advised frontline workers continue to step up and adapt. Many practitioners speak of improved relationships, greater understanding of roles and improved information sharing. This must be retained and continually improved. The partnership will look now to a 'resetting phase' and no doubt there will be new effective ways of working, Whilst I am sure that agencies will retain a lot of the benefits, they have experienced over the last few months of virtual meetings (both single agency and multi-agency as appropriate) this can be an additional vehicle for engaging more with children and young people but is not a replacement, will always need face to face contact, to be seen and heard. The partnerships shared commitment to continuous improvement has been evidenced in the achievements highlighted in this report. I recommend the key partners consider and acknowledge the impact of the work undertaken via these safeguarding arrangements and mitigate the risks of the current short-term funding arrangements. The question is how will you better achieve and strengthen the statutory responsibilities you hold for children without the key functions undertaken by the LSCB business team? If an alternative is agreed, then a clear plan of delivery and business management to deliver on the priorities will be required this year. Across the partnership there are examples of how agencies are capturing the voice of children but there now needs to be a gathering of clear evidence that demonstrates that agencies are actively listening and where necessary, changing their practices in response. I recommend a shift in focus to making a judgement about what practice with children and families tells you about leadership. This looks less at strategic intent, and more at the quality and impact of leadership on the ground. In turn, the board concentrates on how the partnership involves service users but i recommend you strengthen your practice to engage directly with children to hear first-hand what their views are in relation to safeguarding locally. It is commendable the LSCB has been responsive to emerging issues as well as retaining their focus on core business. For example, the response and detailed work undertaken regarding child sexual abuse in the family environment. In light of the pandemic however, there will be a need to prioritise the preparation, resourcing, responsiveness and delivery of high standard safeguarding services for what is expected to be a significant surge in demand. I recommend the partnership is ambitious but realistic in what can be achieved and suggest a focus on 2/3 key safeguarding issues relevant to the local communities. It will be important to continue to foster the culture of high support and critical challenge as it is a necessary ingredient for partnerships to work better together to improve the lived experiences of children and families.

Paula St Aubyn, the Independent Chair, undertook the independent review of the annual report and observations have been informed by regular meetings with the following;

- Chief Executive of Sefton Council
- Executive Director of Children's Services and Education (Sefton Council)
- Head of Children's Social Care (Sefton Council)
- Detective Chief Inspector Police (Merseyside Police)
- Designated Nurse for Safeguarding (Southport & Formby / South Sefton CCG)
- Service Manager, Quality Assurance Unit (Sefton Council)
- Throughout the year the chair reports to the board on her scrutiny activity in order that it is an informed view and not a one-off activity

Key strengths of the LSCB

- The Safeguarding arrangements (retained the name LSCB) is a recognised and valued brand.
- The LSCB business team are very responsive, they drive and consistently deliver on the core business.
- The delivery of high-quality training valued by practitioners.
- Education has been explicitly recognised as the 4th partner evidenced by active contributors in sub groups.
- Learning from case reviews swiftly and innovatively disseminated. This has been valued by practitioners. The partnership is able to evidence practice improvements.
- The partnership demonstrates a commitment to work together, to problem solve, scrutinise and be scrutinised.

Areas for Development for the LSCB

- Resolve longer term funding or agree alternative delivery and service management in order to deliver on the statutory core business and seek innovation.
- Consider agreeing two/three specific areas of safeguarding to focus, drive and subsequently evidence the impact on front line practice, for example building on and embedding the contextual safeguarding approaches.
- A realistic work plan in order to measure progress and impact aligned to specific areas of work
- Draw out more good practice and share, share, share.
- Greater connectivity with Safeguarding Adult Board and the Community Safety Partnership

Confirmation of Report share:

- Presentation to Sefton LSCB Main Board for agreement
- Circulation from Main Board members into their organisations
- Public facing access store onto the Sefton LSCB website
- Presentation of the Annual Report by the Independent Chair to Merseyside Police & Crime Commissioner (PCC), Corporate Parenting Board (CPB), Health & Well Being Board (HWBB), Sefton Council Chief Executive and Leader of Sefton Council.

Signature of 3 Key Safeguarding Partners

Name/Role	Signature
Vicky Buchanan Director of Children's Social Care (Sefton Council)	V. Buchanan
Jane Lunt Chief Nurse Southport & Formby CCG & South Sefton CCG	J Lunt.
Richie Jones Detective Chief Inspector Merseyside Police	[illegible]