Appendix A

ANNUAL REPORT 2016/17

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1. Foreword by the Independent Chair

I am pleased to introduce this annual report for Somerset Safeguarding Children Board, covering the year 2016-17. This is a public report which sets out the work of the Board and its view of the effectiveness of safeguarding arrangements across the county. The report aims to give everyone who lives and works in Somerset a sense of how well local services and people in the community are working together to keep children safe. The report is also intended to inform the decisions made by those responsible for leading, commissioning and funding local services.

Throughout the year, work has continued to address the shortcomings highlighted by Ofsted in early 2015, when it found that arrangements in place to evaluate the effectiveness of what is done by the authority and Board partners to safeguard and promote the welfare of children were inadequate. At the same time, Somerset County Council's services for children in need of help and protection, children looked after and care leavers were also judged to be inadequate. The Council's improvement partner, Essex County Council, has provided significant support and assistance during this period, with oversight from the Department for Education. My attendance at the quarterly performance review meetings has provided additional opportunity to assess progress with improving the quality and effectiveness of the Council's social care services for children.

Throughout the year, agencies have continued to demonstrate their commitment to safeguarding children through contributing to the multi-agency work of the Board, taking part in multi-agency auditing and challenge activities, and sharing their own data and self-assessments. The Board has also worked in support of the vision of the Children's Trust, focusing attention on areas which present the greatest risk to Somerset's children - child sexual exploitation and going missing, neglect and domestic abuse – and working more closely with other multi-agency partnerships to ensure that the most vulnerable individuals and families are identified, supported and safeguarded. The Board has also worked with organisations in the voluntary, faith and sports sectors, in order to promote understanding of safeguarding responsibilities and improve the effectiveness of safeguarding arrangements.

As in previous years, many of the organisations which contribute to the Board's work have continued to face significant financial pressures, which have entailed difficult decisions about allocation of resources. Where it was felt to be necessary, the Board has challenged decisions made by agencies at both

strategic and operational levels. Despite the pressures, the Board's partners have maintained a focus on developing arrangements and services which enable a quicker, earlier response to children and families who may need additional help. The way that Somerset's schools have embraced this agenda is particularly encouraging. This is an area that will continue to be promoted in the year to come, with the aim of supporting families more effectively at an early stage and reducing the need for statutory intervention as difficulties become more entrenched.

This work will continue during 2017-18, as will efforts to ensure that every child receives a consistently high quality response, whatever the level of need. The year will also see attention paid to putting in place future arrangements for safeguarding children in response to the changed legislative context that has been introduced by the Children and Social Work Act 2017, which gives greater flexibility locally whilst increasing accountability for NHS and police partners alongside the local authority.

The Board has published one serious case review (SCR) during the year covered by this report, which focused on significant harm to a very young infant. Previous SCRs had had a similar focus and the Board was keen to ensure that the right lessons were being identified and properly implemented by all agencies. The review brought increased focus on the need for workers to maintain 'healthy scepticism' at all times, maintaining a clear focus on the child. In addition, individual cases and groups of cases have been reviewed to identify both good practice and areas for improvement. The Board will continue to monitor the impact of the learning from these cases on the quality of local practice.

I would like to thank Board partners for their hard work and commitment in support of the Board over the past year, and their willingness to challenge and be challenged to achieve ever higher standards. In particular, the two community (lay) members have been essential in holding the Board to account from the perspective of Somerset's communities, enabling the Board to stay in touch with local realities and offering a critical friend perspective on all safeguarding issues.

Finally, as ever, there are staff and volunteers who day to day demonstrate their commitment to children and families through their work and dedication. We thank them all for everything they do to safeguard children and promote their wellbeing.

Sally Halls

2. Executive Summary

The SSCB Independent Chair must publish an Annual Report on the effectiveness of child safeguarding and promoting the welfare of children in the local area; this is a statutory requirement under section 14A of the Children Act 2004.

The purpose of the annual report is to provide a transparent assessment of the performance and effectiveness of local services, identifying where improvements are required.

During the course of the year, the Board has listened to children and young people, their families, and the practitioners that work with them and provide services for them.

The report describes the work of the Board and how it has examined individual cases and reviews of practice in circumstances where children have been seriously harmed including through non accidental injury, child sexual exploitation, neglect, and sexual abuse. These reviews were significant in helping the Board to understand where improvements are required and to highlight good practice.

From examining some cases in more depth through multi-agency audits and learning reviews, the Board learnt that more work needs to be done to support practitioners in their use of escalation and resolving professional differences guidance, applying pre-birth guidance, and improving the quality and consistency of sharing information with and between agencies.

The Board received reports and updates on how effective Early Help services are in ensuring that children and their families receive timely and effective help, and has monitored how supporting guidance for multi-agency practitioners has continued to be embedded throughout the year. The report highlights positive progress with this priority and outlines the further work needed to achieve greater consistency of application and understanding by practitioners across the partnership. The Board is aware that further work needs to be done to improve its understanding of the impact of Early Help on outcomes for children, and this will be a key focus for next year.

The Board was pleased to learn that Early Help Assessments had helped practitioners to recognise domestic abuse and its impact upon children, although domestic abuse has continued to feature in reviews of cases where children suffered harm. We will therefore focus work in the coming year on helping agencies to identify and respond to the risks and vulnerabilities within families where domestic abuse is a concern.

Neglect has been the focus of development work this year, and will continue to be a priority during 2017-18, with a focus on equipping practitioners with the guidance and tools to improve their ability to identify neglect and respond to it more effectively.

Referrals to Children's Social Care have decreased over the year and the corresponding upward trend in the numbers of Early Help cases suggests that the Effective Support for Children and Families guidance is helping to improve understanding and familiarity around thresholds.

The number of children subject to a child protection (CP) plan remained stable for most of 2016/17. In addition, the SSCB saw a decrease in the number of repeat CP plans and the proportion of long-term CP plans [2 years or more] gradually reduced. The Board was pleased to learn that the timeliness of the Child Protection (CP) planning conference system including reviews continues to outperform statistical neighbours and the national average in England.

Auditing highlighted positive practice and specific areas requiring improvement. The Board learnt through learning reviews, a MAPPA review and an HMIC Police inspection report that particular attention needs to be paid to the management and assessment of risks posed by registered sex offenders to children they might have access to, sometimes within their own families.

'Think Family' continues to be a key practice approach for the Board and we will continue to work closely with the Somerset Safeguarding Adult Board (SSAB) and other partners to develop 'Think Family' practice across the workforce in 2017/18.

We have looked in depth at Child Sexual Exploitation (CSE) in Somerset through the Serious Case Review (SCR) Operation Fenestra. Although not yet finalised for publication at the time of writing this report, the findings are already assisting the Board in developing improved multi-agency collaboration to progress this critical area of safeguarding work and to drive the CSE strategy and action plan further forward.

The Board has welcomed partners' very positive engagement with the 'Section 11' self-assessment process and plans for further section 11 peer review workshops. This has helped the Board to monitor the effectiveness of organisations in meeting their duties under Section 11 of the Children Act. The new online self-assessment tools have proved helpful to partners in undertaking their own quality assurance with regard to safeguarding and child protection arrangements and practice. Schools, in particular, found the audit tool helpful and the results from the partners' assessments have helped the Board to understand where specific improvements need to be made.

A series of peer challenge workshops will provide extra scrutiny and build upon the positive challenge and support culture developing within the partnership.

We will continue to work with agencies to scrutinise their own practice so that they can improve their safeguarding services for children, through use of the Section 11 peer review workshops and building upon the constructive challenge culture that has developed over this last year.

Work with the voluntary, community and faith sectors has continued to be strengthened; strategic engagement through the Somerset Voluntary, Community and Social Enterprise Strategic Forum planned for 2017/18 will also help to increase engagement with the sector as we move forward.

Information about how ‘Prevent’ has progressed since its implementation in 2015 indicates that a good start has been made to embed ‘Prevent’ in Somerset with a good response from Somerset agencies, particularly schools.

The Board has examined cases of children who have died; reviews of these cases have led to clear identification of improvements which needed to be made. The Child Death Overview Panel (CDOP) which oversees these reviews shared key lessons and made recommendations around asthma deaths. Its review of a small number of sudden infant deaths led to the promotion of a safer sleeping campaign across Somerset. The panel raised concerns with organisations around the sale of nebulisers in supermarkets, and also wrote to the Coroner about post-mortem examinations.

The Board received a report about allegations of abuse made against people who work with children which demonstrated a greater awareness of the Local Authority Designated Officer (LADO) and the notification procedure which has led to a substantial increase in notifications in comparison to last year. Engagement in a new multi-agency forum to risk manage adults who are identified as posing a potential risk to children has been a positive development this year aimed at enhancing the safeguarding system to keep children safe. In the coming year the Board will be interested to understand about the progress and impact of this forum.

Targeted work with schools and communications to raise awareness has led to an increase in the numbers of notifications of private fostering arrangements this year. This is welcome, and needs to be improved upon and expanded. A knowledge gap relating to private fostering was identified as part of the school’s Section 175/157 self-assessments and the Board will continue to build on the work of agencies to address this and further raise awareness in Somerset.

The Board welcomed clear progress made in multi-agency training with strong participation from all agencies across the partnership and the development of a fully traded training unit. The Board will continue to improve methods that capture evidence of impact upon practice and improve assessment of the effectiveness of single agency training.

Clear progress has been made by the Board with communications; resources include an improved website, newsletters and a new learning bulletin, together with the use of social media to get important messages and learning out to both practitioners and the wider community.

Dedicated pages on the website for safeguarding leads and the implementation of a safeguarding leads consultation line in 2016 has helped to improve practitioners understanding of thresholds for intervention and the application of the Effective Support for Children and Families guidance. Practitioners have welcomed these developments, and the Board will take action in the coming year to understand and help improve competence and confidence so that understanding around thresholds continues to increase and thresholds are consistently applied in Somerset.

We have acknowledged the enormous contribution made to the work of the Board by two community lay members who have challenged and enabled the Board to stay in touch with local realities and offering a critical friend perspective on all safeguarding issues. The two members will continue to be supported in 2017/18 and encouraged to make links with others both locally and nationally to build upon their growing expertise and good practice.

The report concludes that overall, the way the SSCB and its partners have worked together to keep children safe in Somerset has improved over the past year. Many children and families are receiving more effective services, often at an earlier stage than previously. The Board is better sighted on the quality and effectiveness of safeguarding arrangements. However, there is still work to do across the partnership to improve the quality and consistency of services, to strengthen early help arrangements, and to promote improvement in key areas such as neglect and the exploitation of children.

3. About the SSCB Annual Report for 2016/17

The SSCB annual report for 2016/17 provides a transparent assessment on the effectiveness of safeguarding and the promotion of child welfare across Somerset and the Board's effectiveness in carrying out its statutory functions throughout 2016/17.

The report provides:

- information about the structures in place that support the SSCB to do its work effectively;
- a clear context for safeguarding children and young people in Somerset, highlighting progress made by the partnership over the last year and the challenges moving forward;
- an overview of the lessons that the SSCB have identified through the Learning and Improvement Framework and the actions taken to improve child safeguarding and welfare as a result of this activity;
- a summary of the actions taken to improve child safeguarding and welfare as a result of learning and improvement and QA activity;
- an insight into the range and activity of the multi-agency safeguarding training delivered and co-ordinated by the SSCB and a brief account of the single agency training delivered by partners;
- the priorities going forward and the key messages from the Independent Chair of the SSCB to key people involved in the safeguarding of children and young people.

The report this year will aim to address three specific questions:

1. What we did
2. How well we did it
3. The difference it has made

In line with statutory requirements, the SSCB annual report for 2016/17 has been sent to the following:

- Cabinet Member for Children and Families
- The Avon and Somerset Police and Crime Commissioner
- The Chair of the Somerset Health and Wellbeing Board
- Somerset County Council's Director of Children's Services
- The Chair of the Safer Somerset Partnership

A copy of the SSCB annual report has also been shared in advance for consultation with Board and Subgroup members.

4. Children in Somerset – The Local Context

In Somerset there are 109,200 children aged 0 to 17 years old, with a third of the population living in the main urban areas centered on the towns of Taunton, Bridgwater, Frome, Glastonbury and Yeovil (Index of Multiple Deprivation (IMD) 2015; *(ONS 2015 mid-year population estimates).*

4.1 Levels of Poverty

Somerset remains a relatively affluent county and experiences lower than national average in terms of overall levels of deprivation (Index of Multiple Deprivation (IMD) 2015).

However the county has a range of contrast with areas recognised nationally as being in the 25 most highly deprived neighbourhoods (IMD 2015), this number has increased from 14 since 2010 and with 38,000 residents living in neighbourhoods categorised as being within the 20% most deprived neighbourhoods in England. In 2014 there were estimated to be 15.3% of children living in poverty in Somerset. This equates to one in every seven children aged under 16. The national average for England is 20.1% (IMD 2015).

The highest levels of deprivation are found within the county's larger urban areas (IMD 2015), with the most deprived areas of Somerset being the Lambrook and Halcon areas of Taunton and the Sydenham and Hamp areas in Sedgemoor.

West Somerset communities are the most rurally isolated in the county and rank amongst the 15% most deprived local authorities nationally. In a report published by the Social Mobility & Child Poverty Commission (January 2016), West Somerset was ranked 1 out of 324 local authorities for social mobility.

4.2 Children with Child Protection plans

There has been an increase in the number of children who have been made the subject of a child protection plan. At the end of March 2017, there were 413 (279 children in the previous year) children with child protection plans from 204 families (143 in previous year) living in the county. This is approximately 37.9 (25.6 in the previous year) per 10,000, which is lower than the 43.1 national average in England 2015/16. During 2016/17, there were 38 children (47 in previous year) with a child protection plan from 26 families (31 in previous year), who were temporarily living in Somerset during the year.

Within the reporting period, 2.0% (9/447 plans) of child protection plans lasted for two years or more, a reduction from 4.8% in the previous year and lower than the national average in England of 3.8% for 2015/16. 22.4% (110 plans) lasted between 1 and 2 years with most lasting between six and twelve months (42%-188/447).

At the end of March 2017, in Somerset, children were subject of a child protection plan for the following reasons:

- Emotional abuse 89 plans 21.5% (31.2% in 2015/16)
- Neglect 288 plans 69.7% (57.7% in 2015/16)
- Physical abuse 7 plans 1.7% (4.7% in 2015/16)
- Sexual abuse 6 plans 1.4% (0.4% in 2015/16)
- Multiple factors 23 plans 5.6% (6.1% in 2015/16)

4.3 Children Looked after

At the end of March 2017, there were 479 children in care, compared with 503 in 2016; this equates to 43.8 per 10,000 children for 2016/17 compared to 60.3 per 10,000 in 2016.

Of Somerset's children looked after, there were 192 fostering or residential placements (involving 148 individual children) in 2016-2017, which were commissioned from providers other than the local authority (e.g. other local authorities, other public provision, private provision or voluntary/ third sector provision). Of these 192 placements, 94 were within the borders of Somerset and 98 were outside the county boundary.

During 2016/17, 34 (50, in the previous reporting year) children were secured permanence through adoption and a further 30 (13) left care as a result of Special Guardianship Orders.

The number of children looked after under the age of 18 placed in Somerset by other local authorities stood at 199 on the 31st March 2017, (179).

The number of residential providers in Somerset during 2016/17 was 41.

Of those operating during 2016/17, Ofsted rating them as follows:

- 16 'Outstanding' or 'good'
- 4 'requires improvement'
- 2 as 'inadequate'
- 2 'awaiting' outcomes at the end of March 2017

There are 16 fostering providers, Ofsted rated these as:

- 2 ‘Outstanding’ with 14 ‘good’
- zero inadequate (or awaiting confirmation)

Ofsted rating for homes outside Somerset, where a Somerset child was placed during 2016/17 were as follows:

- 10 rated as ‘Outstanding’ or ‘good’
- 1 rated ‘requires improvement’
- 1 rated ‘Inadequate’
- zero ‘awaiting outcomes’ at the end of March 2017

4.4 Somerset Safeguarding Snapshot 2016-17 figures

- 109,657 Children aged under 18 [2016 year population estimates]
- 20% of the Somerset population
- 15.3% of children living in poverty – [2014 data, latest available]
- 10.6% of primary school Somerset children are in receipt of free school meals, the national average is England: 14.1% (Based on January 2017 school census)
- 1959 open EHA assessments (as at 31/3/17)
- 1731 referrals/EHA’s to the Early Help hub
- 92 TAC meetings were held in the 2016/17 academic year
- 44 children identified as being at risk of CSE (with CSE banner) as at 31/3/17
- 71 of Somerset children identified as going missing from care
- 992 incidents of children and young people missing from home
- 468 Return Home Interviews were conducted (47.1%)
- 30,120 contacts to Somerset Direct across 2016/17
- 5,001 referrals to CSC, 1,040 re-referrals [20.8%] took place
- 5,185 C&F statutory social work assessments started 2016/17
- 4,920 C&F assessments completed in 2016/17 at an average of 29 days
- 645 ICPCs completed in 2016/17
- 413 children on a CP plan as of end of March 2017 (279 in previous year)
- 1,738 CIN cases as at end of March 2017
- 10,845 in receipt of SEN Support as at 31/3/2017,
- 875 in receipt of Education Health and Care Plans [EHCP], as at 31/3/2017,
- 729 with a Statement of Special Educational Needs as at 31/3/2017,
- 479 children and young people were looked after as in 2016/17
- 612 HIGH RISK domestic abuse notifications made to the police during 2016/17
- 755 children were associated with these incidents

- 25% repeat incidents of HIGH RISK domestic abuse during 2016/17
- 478 notifications of allegations of abuse made against staff working with children
- 3 private fostering arrangements as of March 2017
- 1,108 professionals attended SSCB multi-agency training

5. The Board

The Somerset Safeguarding Children Board (SSCB) is the key statutory body that oversees multi-agency safeguarding arrangements across Somerset as required under the Children Act 2004; and in accordance with statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board Regulations 2006. The SSCB draws its membership from a range of organisations. The Board is supported by a range of subgroups that draw their membership from across statutory, voluntary and community sector agencies that work with children and families. The SSCB Constitution (see link below) sets out how the partnership works, its governance arrangements, and the roles and requirements of its members.

http://sscb.safeguardingsomerset.org.uk/wp-content/uploads/SSCB-Constitution-updated-December-2016.pdf

The SSCB meets quarterly and focuses its attention on areas of safeguarding challenge and concern and the implementation of the SSCB Business Plan.

5.1 Improvement context

The context for the Board's work since 2015 has been one driven by the significant improvements that were required following the **'Review of the effectiveness of the local safeguarding children board'** (Ofsted, 27 March 2015), which found that:

> *"The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate".*

Since then, the SSCB has focused its energy and resource to address the shortcomings identified in the report. Over the last year the Board has:

- reviewed and strengthened its governance arrangements;
- held agencies to account more consistently;
- assured itself in relation to the early help arrangements;
- improved the effectiveness of partners' contributions to the child protection process;
- influenced the quality of practice across the partnership; and
- developed data and performance reporting arrangements.

5.2 Independent Chair

In order to provide effective scrutiny, the SSCB is expected to be independent. The role of the independent chair is to hold all agencies to account. The current Independent Chair, Sally Halls, has chaired the Board since 2012. The Independent Chair is accountable to, and meets frequently with, the Chief Executive of Somerset County Council; with the Cabinet Member for Children's Services and with Somerset County Council's Director of Children's Services. She also meets regularly with senior leaders from partner agencies.

5.3 The Board's Business Unit Team

The team consists of three full time staff (Business Manager, Senior Business Support Assistant and Training Manager) and three part-time staff (Training Administrator, Child Death Overview Panel Administrator and Quality Assurance and Audit Officer. Work has focused upon developing the capacity of the Business Unit team and resource to support the activities of the Board's business. During the year the Business Unit has increased in capacity and has received support from the local authority's Business Change Unit.

5.4 Designated professionals

In England, Wales and Northern Ireland, clinical commissioning groups (CCGs) are required to employ, or have in place, a contractual agreement to secure the expertise of designated professionals for safeguarding. Designated professionals, as clinical experts and strategic leaders, take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the area, providing support to all providers and linking particularly with named safeguarding health professionals, local authority children's services, Local Safeguarding Children's Boards (LSCBs), and the NHS Commissioning Board. The list of Somerset Designated Professionals can be found through the link below:

http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/

5.5 Relationship with other Boards

During 2016/17 the SSCB strengthened links with other key multi-agency partnerships – Somerset Health and Wellbeing Board (HWBB), Somerset Children's Trust (SCT), Somerset Safeguarding Adults Board (SSAB), Somerset Corporate Parenting Board (SCPB) and the Safer Somerset Partnership (SSP). The Working Together Protocol for Strategic Partnership Boards in Somerset sets out how the boards relate to each other. This has

helped ensure that the voice of children and young people and their need to be safeguarded has been kept firmly on the agenda with regard to multi-agency work with vulnerable adults, the local response to crime and safety and also within the context of health and wellbeing.

The Somerset Working Together Protocol for Strategic Partnership Boards in Somerset can be found through the link below.

http://sscb.safeguardingsomerset.org.uk/wp-content/uploads/2016/02/Working-Together-Partnership-Protocol-2016-17.pdf

The business managers responsible for both the children's and adult's boards have shaped joint priorities and jointly co-ordinated developments such as multi-agency presentations around Think Family and provision of a safeguarding presentation with a focus upon neglect and domestic abuse to the local dentists' association.

The Independent Chair of the SSCB is a member of the Children's Trust and attends the Health and Wellbeing Board regularly.

5.6 SSCB Vision and Values

The Board development day in 2016 focused upon Board effectiveness. As a result the constitution was enhanced by the development, led by the Community members, of a Team Charter for the Board to communicate the SSCB partnership values and behaviours (see link below).

http://sscb.safeguardingsomerset.org.uk/wp-content/uploads/Team-charter-web-version-Nov-2017.pdf

5.7 SSCB membership and attendance

The SSCB was reconfigured in 2015. Partner's attendance at the SSCB has improved from 77% in 2015/16 to 82% in 2016/17.

In April 2016 the SSCB reshaped its meeting structure; this change took place in response to Ofsted's feedback which recommended that the SSCB should: '*Ensure that all partners regularly attend and that they are purposefully engaged in the work of the Board'*.

SSCB members have regarded this as a positive move which resulted in increased participation, collaboration and agency challenge.

The SSCB met four times in 2016/17. The attendance rates by agency are set out in table 1 overleaf:

Table 1: SSCB attendance 2016/17

Agency	Apr -16	Jul-16	Oct-16	Jan -17	No of attend -ances	% attend -ance
Avon and Somerset Constabulary	Yes	Yes	Yes	Yes	4	100
Children & Family Court Advisory and Support Service (Cornwall, Devon and Somerset)	No	Yes	No	Yes	2	50
Somerset Clinical Commissioning Group	Yes	Yes	Yes	Yes	4	100
Community members	Yes	Yes	Yes	Yes	4	100
Community Rehabilitation Company (Somerset Local Delivery Unit)	Yes	No	No	Yes	2	50
Somerset County Council, Children's Social Care	Yes	Yes	Yes	Yes	4	100
Somerset District Councils	Yes	Yes	Yes	Yes	4	100
Somerset County Council, Education	No	Yes	Yes	Yes	3	75
National Probation Service Somerset Local Delivery Unit Cluster	Yes	Yes	Yes	Yes	4	100
NHS England (South West)	No	Yes	No	No	1	25
Somerset County Council, Public Health	Yes	Yes	Yes	Yes	4	100
Somerset Partnership NHS Foundation Trust	Yes	Yes	Yes	Yes	4	100
Taunton & Somerset NHS Foundation Trust	No	No	Yes	Yes	2	50
Yeovil District Hospital NHS Foundation Trust	Yes	Yes	Yes	Yes	4	100
Somerset Youth Offending Team	No	Yes	Yes	Yes	3	75

Partners have been challenged to address the need for consistent and regular attendance which has resulted in improved attendance.

A list of the SSCB members can be found in Appendix A.

5.8 SSCB Structure

A structure chart which outlines the groups in place that support the SSCB to do its work effectively can be found in Appendix B.

5.9 Finance to deliver impact

Partner agencies have continued to contribute to the SSCB's budget for 2016/17, in addition to providing a variety of "in kind" resources, for example, staff time and the provision of free training venues.

In 2016/17 agency contributions totalled £216,533, with the Local Authority providing 62% of the overall SSCB budget. Table 2 below gives a breakdown of the contributions.

Table 2: Agency contributions 2016/17

Agency	Actual contribution 2016 / 2017
Avon and Somerset Constabulary	£16,022
Somerset Clinical Commissioning Group	£56,626
National Probation Service (South West)	£1,421
Community Rehabilitation Company (Somerset Local delivery unit)	£1,000
Somerset County Council	£134,590
CAFCASS	£550
Taunton Deane and West Somerset District Council	£1,581
South Somerset District Council	£1,581
Mendip District Council	£1,581
Sedgemoor District Council	£1,581
Total Income	**£216,533**

There was some reduction in contributions from partners in 2016/17 in comparison to the previous year, by:

- Avon and Somerset Constabulary - £3,559
- National Probation Service - £670
- The Community Rehabilitation Company - £1,000

5.11 SSCB Training Budget

Throughout 2016/17, the SSCB training budget transitioned into a commissioned model covering the costs of venues, specialist trainers and resources. This change of activity created a step change in the SSCB's approach to training and development. The income generated from the training has been used to offset 50% of the salary costs of the training team, including the training manager and administrator.

In addition, in kind arrangements have been developed with partners. This has encompassed the free use of training venues and the provision of practice expertise to deliver in training. For example, the access to free training venues was provided by the acute trusts in exchange for fully subsidised training places. This arrangement created a saving of £3,400 for 2016/17.

In 2017/18 the plan is for the SSCB's training function to operate as a commissioned, traded unit; with income generated to offset 100% of the training team's staff costs.

6. Assessing the effectiveness of child safeguarding and promoting the welfare of children in Somerset

The SSCB has a statutory duty to scrutinise and evaluate the effectiveness of the safeguarding system and individual agency contributions to safeguard and promote the welfare of children.

The SSCB uses a range of methods for evaluating and improving its effectiveness of safeguarding arrangements. Key elements include:

- Scrutiny of data and performance information
- Monitoring risks and issues (through risk register and challenge log)
- Section 11 audit
- Section 175/157 audit
- Capturing and using the voice of children
- Multi-agency audits
- Inspection reports

6.1 Scrutiny of data and performance information

At the quarterly SSCB meetings an assurance section around a specific SSCB business priority is scrutinised, following multi-agency presentation of data evidence including, assurance reports, case examples, performance data, evidence from multi-agency and single agency audits. The presentations are followed by interactive table top discussions to evaluate effectiveness, determine how well the Board is assured, and identify what further action needs to be taken as an outcome of the assurance debates.

Similarly, at each Business Planning Group meeting, a formal report is presented by the chairs of each of the subgroups and progress against the SSCB's business plan is scrutinised. The Business Planning Group is able to determine what action needs to be taken to improve safeguarding arrangements and how the work of the subgroups dovetails, to drive learning and improvement forward.

6.2 Monitoring risks and issues (Risk register)

The SSCB manages the risk register and challenge log to formally record concerns around multi-agency safeguarding arrangements and action taken to resolve them. A number of challenges were made and actions taken during the reporting year, some of which resulted in the Board receiving assurances

around improvements to address the concerns raised. A small number of issues are on-going.

6.3 Agency self-assessment of safeguarding arrangements

Section 11 (Children Act 2004): This section places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out, are discharged having regard to the need to safeguard and promote the welfare of children (*Working Together to Safeguard Children* 2015). Under section 14 of the Children Act 2004, Local Safeguarding Children Boards (LSCBs) are required to monitor the effectiveness of organisations implementation of these duties. As such, in the reporting year the SSCB adopted an online safeguarding audit tool, 'enable', which was used as the mechanism to establish assurance and to help partners undertake their own quality assurance process in regard to safeguarding and child protection.

175/157 (Education Act 2002): In fulfilling its statutory objectives under Section 14 of the Children Act 2004, the SSCB is also required to ensure that schools are meeting these duties effectively. The 'enable' tool was therefore adapted for use by all independent and maintained schools to assist them to self-evaluate their performance in discharging their functions set out in Sections 175/157 of the Education Act 2002, and provide a 175/157 audit return. This was achieved using an agreed framework developed by the Local Authority's Education Safeguarding Team.

Audit findings from both the section 11 and the 175/157 education provider returns will enable the SSCB to better understand where the needs and gaps are in safeguarding children and young people across the different agencies and the schools community in Somerset.

6.4 Section 11 audit

The development of the section 11 framework took into account specific improvements that needed to be made; the SSCB issued the section 11 audit tool across the partnership in May 2016. Although resource intensive to establish the model, with advice and guidance being provided to single agencies, the process resulted in an improvement in providing the SSCB with a greater level of detail than received in previous years.

Organisations used four grades with which to assess their own performance against eleven standards, with multiple sub-standards:

- Outstanding
- Good
- Requires Improvement

- Inadequate

The result of these self-assessments put agencies in the following categories:

- Outstanding 4
- Good 16
- Requires Improvement 5
- Inadequate 0

With, in addition:

- National agency returns 5
- Nil return 1

At sub-standard level, seven agencies reported one or more “inadequate” gradings. The challenge to systematically incorporate the “voice of the child” emerged as a common theme across all S11 audit returns.

Next Steps

S11 Peer challenge workshops - A programme of section 11 peer challenge workshops will commence in the new financial year to include a representative sample of respondents selected for further analysis and validation. This will help the Board to moderate and standardise responses as well as identify improvements in future S11 audit programmes.

Organisations rated ‘Outstanding’, will be required to provide additional information regarding inspection results from appropriate authorities (OFSTED, CQC, HMIC), to assist with validation and calibration of the overall S11 process.

Organisations rated ‘Requires Improvement’, will also be expected to provide evidence of action plans to address inadequacies, together with a progress report.

Validation - The sample set to be validated will include all “Outstanding” agencies as well as those that identified an “Inadequate” rating at standard/sub-standard level. A desk-top review and full analysis of returns will be completed and reported to the Board in 2017/18.

Section 11 Audit Timeline

6.5 Education 175/157 audit report

In previous years, the SSCB co-ordinated the education providers safeguarding audit (175/157), which asked for returns to be submitted on paper. This system did not enable an effective process of gathering data, scrutiny or monitoring. Additional issues that arose using the paper format included:

- no clear submission date to the local authority;
- three different types of audit forms in use across the local authority;
- some boxes/questions left blank by education providers; and
- a lengthy process of auditing for the local authority.

The education providers 175/157 self-assessment audit tool was developed by the safeguarding advisory team. The audit was based upon agreed benchmarks and standards to provide all education settings working with children and young people aged 4-18 years old with a base line of safeguarding expectation for Somerset.

Launched in September 2016, the process was initially challenging for all involved with education providers feeling unsure of the new online process and expectations. However, feedback after the submission from education providers was positive with reports that the audit tool provided a valuable aid to ensuring safeguarding is at the forefront of their work and processes. The Somerset education audit has since been adopted by other local authorities and used in an article to promote Virtual College audits nationally.

“I found the audit a really useful tool and feel it is a great way of clarifying what needs to be in place, as well as providing an action plan to continue embedding all elements of safeguarding. Please pass on my thanks to your team - it is a vast improvement on the previous report!”
Assistant Principal and Designated Safeguarding Lead

During the reporting year 97% of education providers submitted an audit return, compared with the previous year’s 82%.

The remaining 3% of schools were subsequently followed up and cited reasons for non-submission as relating to IT issues or had overlooked the request.

The return rate from Local Authority maintained state funded schools, Somerset independent schools (fee paying) and further education colleges was 100%.

SEN independent providers, pupil referral units and early year’s returns were lower with 57%, 75% and 56% respectively however there were technical issues for a few of these providers gaining access to the Virtual College platform.

Anti-bullying practice - 92% of providers reported working at either good or needs improvement.

Whistleblowing - 98% of schools self-assessed as working at grade 1 or 2; five schools identified that more work was necessary to be compliant with statutory requirements in relation to whistleblowing.

Private fostering - As part of the audit, schools were asked to consider their understanding of what constituted private fostering and the procedure to follow when they become aware of a private fostering arrangement. Whilst 86% of schools assessed themselves at Green (good) against this question, a significant proportion of schools (21 in total) indicated that staff were not aware of what private fostering was and the need to refer such arrangements to the local authority.

***In response**: action has since been taken by the education safeguarding team to address the knowledge gaps identified. These included, targeted communications through the bi-monthly education newsletter, promotion of a private fostering awareness raising event in December 2016, and reiteration through education networks including community learning partnership and designated safeguarding lead meetings.*

Early Help - The structure of the audit tool did not enable effective collection of data about education provider's involvement in Early Help Assessments, child in need and child protection cases. This has led to the reconfiguring of the tool itself to enable this data to be collected in the forthcoming years audit. To evaluate progress of education providers involvement in Early Help, cases inputted by individual providers were reviewed, and where a low ratio of safeguarding concerns were inputted, providers were followed up to quality assure effectiveness of the provider's safeguarding practice to assess alertness to signs of child abuse and neglect.

First time questions within the 175/157 audit

The 175/157 audit introduced some first time questions for settings, these included:

- **Whistleblowing procedures to help capture** reporting concerns about the behaviour of an adult working or volunteering at the school, staff and volunteers should feel able to raise concerns about poor or unsafe practice and potential failures in the school safeguarding regime.

- It is the first year that the annual safeguarding audit incorporated a question about **Child Sexual Exploitation (CSE).** Education providers indicated that 82% of schools self- assessed as good with providers stating that they were unclear about the procedure to follow to protect a child at risk of or suffering CSE.
  In response: *the Board delivered a CSE practitioners conference in March 2017 which targeted education providers. The conference, targeting designated safeguarding leads, included training input around assessment and screening procedures. Regular targeted communications from both the Board and the education safeguarding team have since been implemented to support providers in their response to addressing CSE.*

- **Female Genital Mutilation** was a new topic introduced in the audit. With 37% of returns indicating that their school was operating at red (requires improvement).
  In response*: All providers were subsequently followed up by the education safeguarding advisor who provided guidance including linking providers to an online training module on FGM. The module has since been made available to all education and early years settings.*

Next steps

- Continue to work with schools to improve understanding of CSE and how to address it.
- Continue to raise awareness around private fostering with schools staff

and leadership teams.
- Further develop the education providers 175/157 audit tool to provide data around provider involvement in Early Help Assessments, Child in need and Child Protection cases.

6.6 Voluntary, Community and Faith sector.

In 2016/17 further links were developed across the Voluntary, Community and Faith sectors.

Somerset Active Sports Partnership - SSCB established links with Somerset Active Sports Partnership (SASP) to review safeguarding action plans and determine how the breadth of sporting clubs and organisations across Somerset can further develop their safeguarding arrangements, in light of the national reports of abuse in sport. As a result, SASP are developing arrangements to broadly disseminate the NSPCC's Child Protection in Sport Unit's (CPSU) self-assessment audit to all its affiliated groups and clubs. SASP also developed a safeguarding toolkit for clubs to use which includes:

- Policy example/templates
- Information on self-assessment and the benefits for clubs
- Template posters and codes of conduct
- Example scenarios for safeguarding training
- Examples of good practice
- Video of young people's experiences and views on safeguarding

Next steps
The SSCB will continue to work with SASP to support them further developing their assurance and monitoring arrangements and promoting the use of the CPSU audit by national governing bodies (football, cricket, netball and hockey) in Somerset. In addition, targeted training for sports welfare officers by the LADO and SSCB training manager are planned for 2017/18.

Work with the Faith sector: The SSCB was notified of the audit of the Diocese of Bath & Wells, which was carried out in 2016 by the Social Care Institute for Excellence (SCIE). SCIE were commissioned to undertake an audit of the safeguarding arrangements of each diocese of the Church of England. The SSCB received an improvement plan from the Diocese of Bath and Wells, which responds to the considerations recommended within the report.

Next steps
The SSCB's Quality and Performance subgroup will monitor the Diocese improvement progress.

Links with Voluntary, community and faith sector will continue to be

strengthened in 2017/18 through linkage with the Somerset Voluntary and Community Sector Forum.

6.7 Capturing the Voice of Children

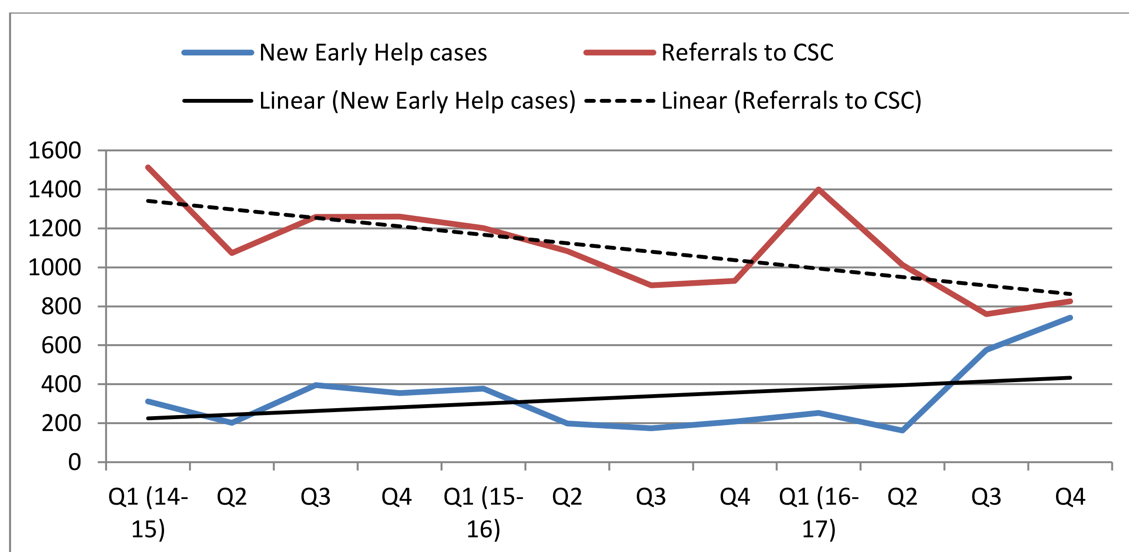
The SSCB developed links with the Children's Trust participation network to help inform it about the views of children and young people in Somerset. The priorities from the various groups were also shared with the SSCB to inform its business planning for the following year.

As part of the section 11 self-assessments, SSCB Partners were asked to provide evidence around how services and cases are informed by the views of children and families. Interim analysis of the returns demonstrated that this will be an ongoing development area for the SSCB. The section 11 peer QA process did evidence however examples of broad agency engagement with children and young people across the partnership which, in comparison to previous years, places the SSCB in a better position to draw upon and inform its work moving forward. See Appendix C for further details.

6.8 Overall effectiveness of the Child Protection system in Somerset

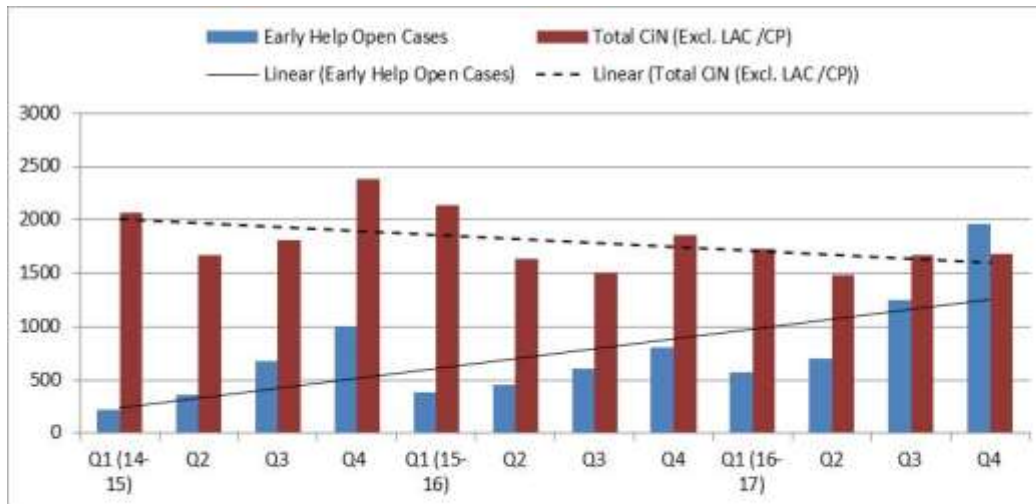
Referrals to Children's Social Care: During the reporting year, the 'Effective Support for Children and Families in Somerset' was launched in 2016 and the data over the last three years indicated that there is an increasing familiarity in the application of thresholds which continued to become embedded within the reporting year. See table 3 below.

Table 3: New early help cases and referrals to CSC (2014/15 to 2016/17)



The general downward trend of referrals to Children's Social Care over the reporting year mirrored a general, upward trend of new Early Help cases. This suggests that many of the cases previously worked at level 3 within Children's Social Care became subject to Early Help support. This trend further pointed to increased understanding and embedding of the Effective Support for Children and Families guidance and the use of the Early Help Assessment.

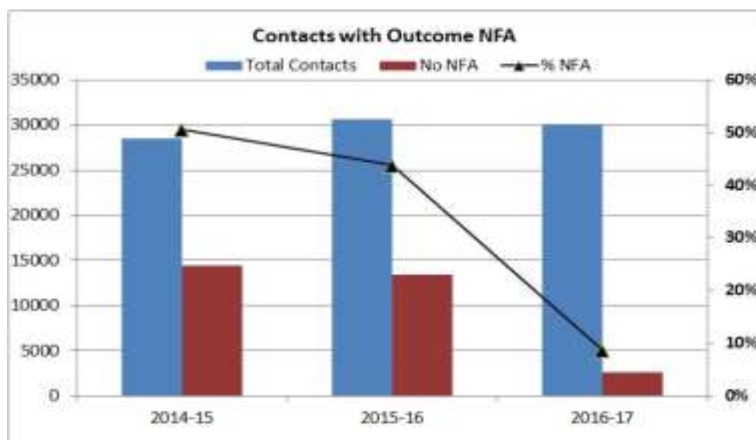
Table 4: New early help cases and Children in Need (CIN) 2014/15 to 2016/17



The decrease in total Children In Need (CIN) numbers (excluding Children Looked After / Child Protection) since 2015/16, similarly reflected that cases at the top of level 3, were more likely subject to support through Early Help services within the reporting year.

Re-referrals to Children's Social Care: In March 17, figures of referral rates (within 12 months of a previous referral), stood at 20.8%, this was a decrease in the number of re-referrals received in 2015/16 of 23.8%. The outturn percentage figures for both statistical neighbours and the English national average were not available for comparison at the time of writing. However, Somerset exceeded its 2016/17 target of 22%. This again, suggests that thresholds continued to become more understood, with an increase in consistency of application across 2016/17. Similarly, where cases were stepped down from Children's Social Care, fewer cases were referred back into Children's Social Care for additional support.

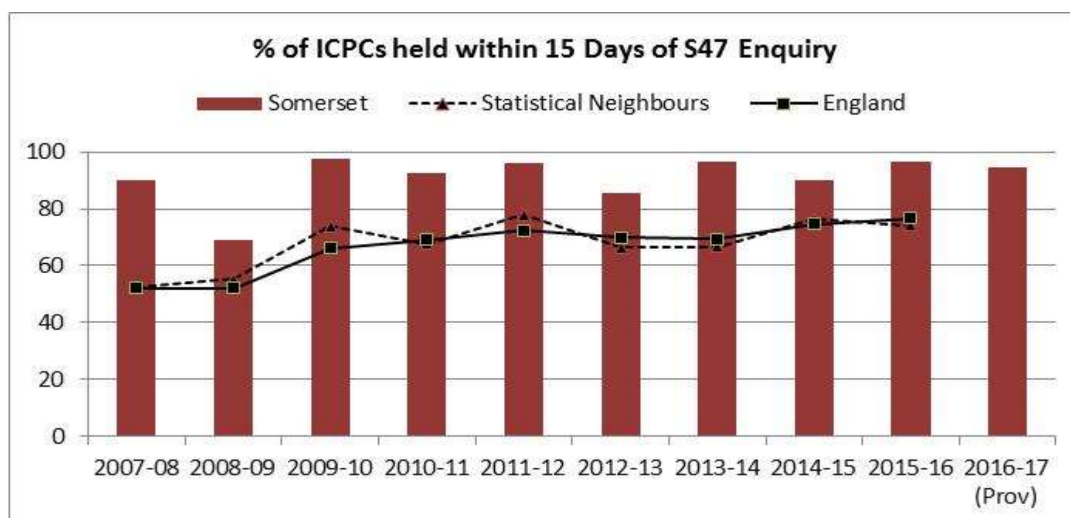
Table 5: Contacts to Children's Social Care (CSC) resulting in No Further Action (NFA)



The dramatic drop in NFA numbers for 2016-17 was due to a change in recording practices, and increased numbers of cases where advice and information, was provided. With a greater understanding of thresholds, fewer cases were subject to NFA reported in 2016/17.

Timeliness of multi-agency Child Protection conferencing system: The percentage of ICPCs held within 15 working days of S47 enquiry in Somerset in 2016/17, stood at 94.7%. This was a slight decrease from the previous year's figure of 96.4%, but continued to outperform both the national rate in England of 76.7% and Statistical Neighbours average rate of 74.1%. See table 5 below.

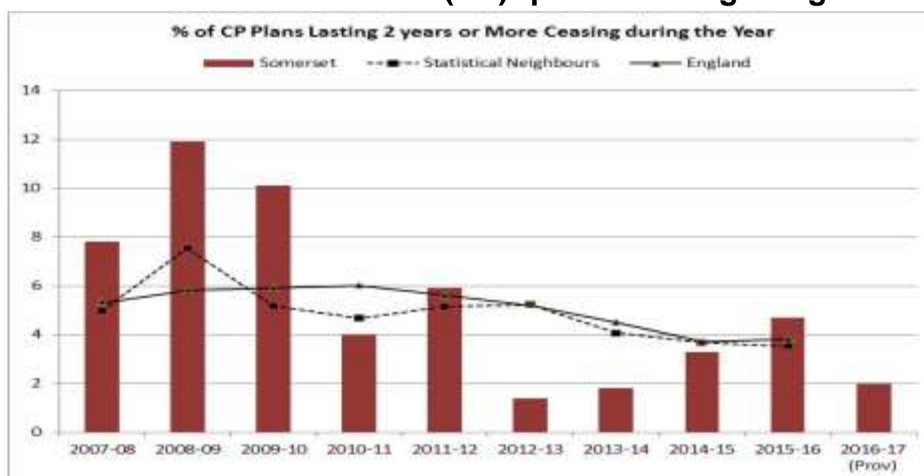
Table 6: Percentage of ICPCs held within 15 days of s 47 Enquiry



Child protection review conferences (RCPCs): Timeliness of review child protection conferences remained high in percentage at 98.5%. Somerset continued to outperform statistical neighbours (91.1%) and national statistics in this regard (93.7%).

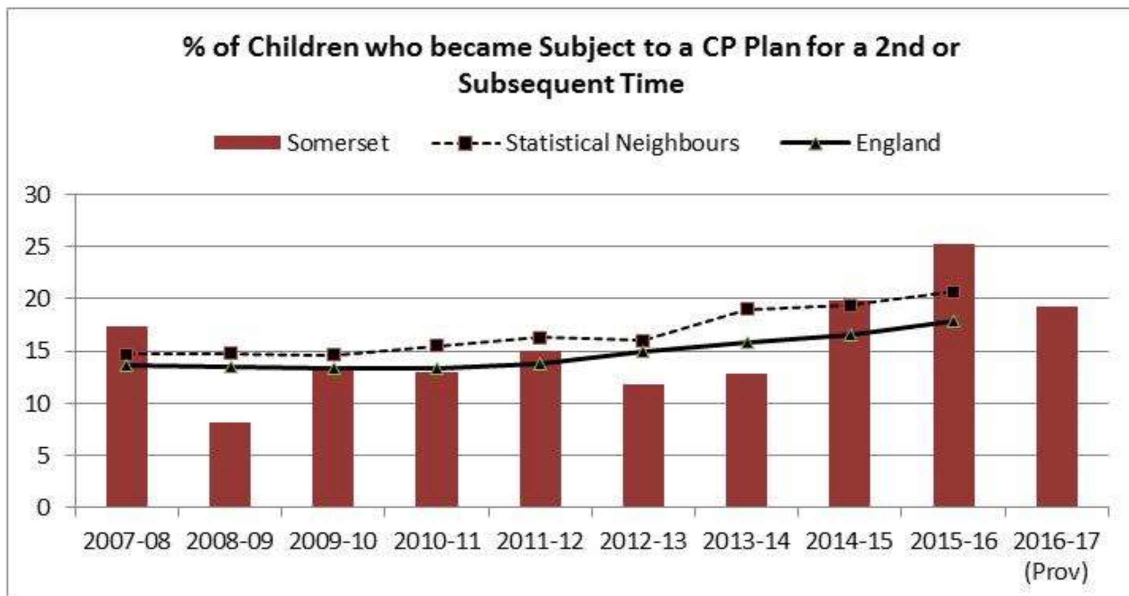
Duration of Child Protection Plans: Somerset achieved the target of 2% (9 children) for the number of children subject to Child Protection Plans for longer than 2 years, a clear reduction from 4.8% in 2015/16 and lower than the national average statistic of 3.8%. This was attributed to countywide child protection panels supporting appropriate escalation and de-escalation of cases and improved use and monitoring of SMART plans.

Table 7: Child Protection (CP) plans lasting longer than 2 years



Children subject to a CP Plan for a second or subsequent time: Children subject to a Child Protection plan for a second or subsequent time, within 2 years of the previous plans end date: in Somerset, during 2016/17 this stood at 19.3%. Whilst this is a reduction from 25.3% in the previous year, the 2016/17 figure remains above target of 15%. The national average is 17.9% and the figure for statistical neighbouring authorities is 20.7%. See table 8 overleaf.

Table 8: Children becoming subject to CP Plans for a second or subsequent time 2007/08 – 2016/17



Quality of Child Protection Conferencing: Child Protection Chairs reported in 2016/17 that they were working to make the child's lived experience more evident within multi-agency meetings. Plans also included the systematic gathering of feedback from families and professionals. A revised family feedback system was developed and launched.

Family involvement in child protection conferences: Following development of the family feedback form, of 153 forms received from families following engagement in child protection conferences, 19% felt the voices of the children had not been listened to well, or completely.

> "Tina, aged 12 was fully included in the assessment process by her Social Worker, including an understanding of the scaling process in Signs of Safety.
> Tina was able to share with her social worker that despite recent improvements in her family life, and the adherence by her mother and step father to the safety measures in the child protection plan, her own sense of safety was still at a '4'. Tina was able to say that she would feel safer once those safety measures had been tested for longer. The conference was able to make a decision that fully included and listened to Tina's voice."

Next steps: The child protection conference chair's service plans to increase participation in child protection process in 2017/18 and raise the profile of the child's voice by:

i) an increase in the use of advocates through telephone contact between the chair and the family prior to ICPC;
ii) the creation of a consultation document for social workers to use with children and young people who are the subject of child protection;
iii) the introduction of child and young people only conferences where this may be more appropriate.

The service reported plans to continue to develop and collect voice of the child data and quality feedback from families, around their experiences of multi-agency child protection processes. The outcomes from the feedback data will be fed into the Board's Quality and Performance subgroup in 2017/18.

6.9 SSCB audits of Multi-agency casework

Practitioners and managers working with families are routinely involved in multi-agency practice audits. In 2016/17 four multi-agency case work audits took place.

The audits resulted in outcome-focused action plans. These were monitored by the Quality and Performance subgroup, to assure the Board around the quality of practice and standards, and to track and evidence improvements in frontline practice.

<table>
<tr><th>Q1 - May 2016</th><th>Unborn Babies</th></tr>
<tr><td colspan="2">STRENGTHS:
• Majority (7/8) of cases referred at appropriate time, once risks became known;
• Evidence of effective use of the escalation policy.</td></tr>
<tr><td colspan="2">KEY LESSONS:
• Inconsistent information sharing prior to case closure;
• The requirement for practitioner guidance to be strengthened
• Professional focus upon adults needs.</td></tr>
<tr><td colspan="2">IMPACT:
• Early Help Assessment work has taken place across the partnership to ensure child's needs considered as central;
• Somerset Direct procedure was changed to ensure the current situation is clarified with partner agencies prior to closing cases where NFA is decided;
• A pre-birth protocol drafted in addition to improved and expanded policy guidance made available through the South West Child Protection Procedures.</td></tr>
</table>

Q2 July 2016	Children of Parents in Prison 8 cases audited where children of various ages had a parent in prison.

STRENGTHS:

- A mixed picture overall but some evidence of good planning and of well-engaged parents.

KEY LESSONS:

- Some services not always aware of child's home situation or possible risks, including release date information relating to offenders;
- Sharing information with agencies following strategy discussion was inconsistent;
- Voice of the father not always heard.

IMPACT:

- Briefing provided to CSC on outcomes of the audit and information sharing practice particularly with schools. Briefing prompted CSC to determine how agencies are alerted to the risks posed by individuals, to the child;
- Multi-agency practitioners were reminded to include specific actions within strategies, stating specific agencies and individuals that need to be informed;
- The importance of keeping agencies up to date has been followed up with National Probation Service (NPS) staff to support multi-agency planning in preparation for the release of offenders from prison.

Q3 September 2016	ICPC's and core groups 8 cases were audited which examined multi-agency practice with children prior to their initial child protection conference (ICPC), and also looking at the first core group in each case.

STRENGTHS:

- Good practice evident from a variety of agencies for their reports to conference;
- Audit group reported some outstanding practice in voice of the child work and the child's lived experience.

KEY LESSONS:

- Consistent approaches of signs of safety scaling;
- Some confusion around core group membership and its leadership.

IMPACT:

- Good practice highlighted with agencies;
- Learning points were communicated through the SSCB learning bulletin.

<table>
<tr><td>Q4 March 2017</td><td>‘Strategies’, with a focus upon young, vulnerable parents.
The audit linked to the SCR for Child L and Child J.
8 cases were audited in total</td></tr>
<tr><td colspan="2">STRENGTHS:
Audit group reported evidence of good practice, including:
• Well organised and effectively recorded strategy;
• Appropriate attendance and agency input found to be clear;
• Evidence of interim planning which addressed the risks to the child;
• Evidence of health involvement in all cases.</td></tr>
<tr><td colspan="2">KEY LESSONS:
• Greater consistency required in distribution of notes to agencies and quality of interim safety planning;
• Inclusion of GP’s and relevant housing officers in strategy meetings.</td></tr>
<tr><td colspan="2">IMPACT:
• Guidance for partners around strategies was reiterated through SSCB newsletter;
• Audit outcomes reported to partnership with further development work expected in the new financial year.</td></tr>
</table>

Next steps

Single agency audits - In order to assure itself further of partner’s practice, the Board’s Quality and Performance subgroup plan to review outcomes from single agency audit activity to cover the period 2016/17 and to request planned audit schedules for 2017/18 from agencies.

6.10 Assurance and Inspection reports

See Appendix D for single agency assurance reports on:

- Police effectiveness in Somerset
- CCG effectiveness
- Assurance report from the Early Help Commissioning Board
- Somerset District Councils effectiveness
- Radicalisation and extremism

7. Child Death Overview Panel

7.1 What was done?

The Child Death Overview Panel (CDOP) is chaired by a Public Health Consultant and enables the SSCB to carry out its statutory functions relating to child deaths.

7.2 Numbers reviewed during 2016/17

- CDOP were notified of 24 child deaths (26 notifications in previous year) and 27 deaths were reviewed by the panel in 2016/17 (37 in the previous year).
- 59% of the deaths reviews were expected, 41% unexpected.
- CDOP identified modifiable factors in 41% of the deaths reviewed.
- 70% of deaths were reviewed within 6-12 months (from death to review).
- 26% of reviews took over 12 months.
- 4% of reviews were completed within 6 months.

7.3 Impact

Safer sleeping - The panel identified modifiable factors present in a small number of Sudden Unexpected Deaths in Infancy (SUDI) cases. These included unsafe sleeping positions such as bed sharing or in a car seat or on a sofa overnight, smoking and alcohol use. Promotion of safe sleeping and smoking cessation messages have continued across health services particularly Midwifery and Health Visiting as in recent years. The National Safer Sleep campaign was also promoted locally https://www.lullabytrust.org.uk/ in 2016.

Asthma deaths - The panel reviewed a small number of asthma related deaths. The outcome was compiled and a number of recommendations being made and shared across health providers.

Housing support - As a result of last year's report a presentation was made to the strategic housing partnership. Housing partners assisted (with rehousing/ support) families where vulnerable children with health conditions were accommodated in poor housing.

Medical imaging - The issue of medical professionals not being able to access children's' medical images in different care settings has now been resolved. CDOP addressed communication between secondary and tertiary care and followed up with NHS England. The SSCB are now reassured that hospitals are working towards a permanent and failsafe way of sharing images across Trusts.

Sale of nebulisers - CDOP has written to the Medicines and Healthcare products Regulatory Agency who regulate medical devices in the UK raising our concern regarding the sale of affordable nebulizers in supermarkets.

Post mortem concerns - The CDOP Chair has written to the Coroner raising the panel's concerns regarding the lack of post mortem examination for 2 of the asthma related deaths.

Learning and Improvement - One case was referred to the SSCB Learning and Improvement subgroup for consideration as a Serious Case Review. The decision was taken that CDOP was an effective review process for taking the learning from this case forward with relevant agencies. Learning from CDOP is now incorporated into SSCB newsletters and there are plans to include this in the CCG Safeguarding Children Team newsletters.

7.4 Issues

- CDOP identified 6 cases in 2016-17 where children died unexpectedly in Hospital and the Rapid Response process was not undertaken.
- CDOP also noted inconsistency in application of pre-birth guidance across agencies.

7.5 Next steps

In regards to the recommendations the report makes, next steps for 2017/18 agreed include:

- meeting with coronial service to discuss post mortems of children where death has been sudden/unexpected;
- investigate rapid responses, including service level agreements in place;
- carry out asthma audit in order to evidence compliance with the standards set out in the CDOP report.

8. Serious Case Reviews

In 2016/17 the Learning and Improvement Subgroup monitored the progress of three Serious Case Reviews which had been agreed and initiated in 2015/16. The group also scrutinised nine formal Serious Incident Notifications in 2016/17.

8.1 Serious Case Reviews

Serious Case Reviews (SCRs) are undertaken to learn lessons and improve how practitioners and organisations work together to safeguard and promote the welfare of children and young people. The SSCB must always undertake a SCR when the criteria specified in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, are met.

A serious case is when:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The SSCB progressed two SCRs during the reporting year and published one.

8.2 SSCB SCRs published in 2016/17

Child L and Child J

The SCR was undertaken by the SSCB with full co-operation of Somerset agencies, and covered the period November 2013 to February 2015, which represented the first presentation in pregnancy of Child L through to the injuries of Child J. The SCR was published in December 2016 following the conclusion of the criminal case.

The Background: Child J lived with biological mother and father and older half sibling, Child L. Child J was six weeks old when the injuries were discovered.

Safeguarding Concerns: There were previous concerns identified to Child J's sibling. Child L was subject to a Child Protection enquiry after presenting at hospital with a torn frenum (mouth injury) at five months old. This was ten months before the injuries to Child J were identified.

The Incident: Child J was taken to the child's doctor for a routine six week check. The GP discovered bruising, and further investigations revealed other injuries, consistent with non-accidental injuries sustained on at least two

separate occasions. As a result of the injuries to the younger child, both children were accommodated and care proceedings commenced.

Findings from Child L and Child J

The SCR identifies lessons in the following areas:

- Understanding and reviewing family history;
- Over reliance on the word of the parents;
- Understanding of normal child development;
- Closer liaison between agencies working with the same family;
- The need for effective supervision and managerial oversight.

The review also noted examples of good professional practice, including:

- The GP raising concerns about Child J, having noticed bruising;
- The housing support worker providing continuing of care to the children's mother;
- The health visiting service maintaining a relationship and responding flexibly to the needs of the family and including the male partner and father to Child J.

Impact of the SCR Child L and Child J

Learning was disseminated via:

- the SSCB *Things you should know* (TUSK) learning bulletin.
- 4 x Multi-Agency Practitioner Interest Group (MAPIG) sessions were delivered in summer 2016 to cascade messages to approximately 100 multi-agency practitioners;
- presentations to single agencies delivered by Board members;
- SSCB level 3 delivery of Working Together safeguarding training for designated safeguarding leads.

The multi-agency action plan resulted in:

- revision of SSCB escalation policy;
- strengthened guidance around strategies;
- targeted 'child development' training for police;
- dissemination of *Guidance for Partners on Corresponding with the Police Safeguarding Co-ordination Units* (Police);
- development of practice standards for Social Work assessment (with a specific focus on disguised compliance);
- strategy audits undertaken by CSC managers to check agency compliance and engagement;
- learning disseminated through CSC 'Quality Matters';
- revision of 'Step down' guidance;
- training provided to 'Housing support' and frontline staff;
- targeted training using case study, for the GP Education Trust Sessions;

- domestic abuse now included in CCG standards for safeguarding;
- acute Hospital Trusts now report on IDVA activity and staff receive training on domestic abuse awareness;
- CCG policy for General Practices for recording, flagging and sharing information in General Practice for patients who are known to be at risk of domestic abuse, ratified and circulated to all practices through the GP bulletin;
- roll out of Level 3 safeguarding training for targeted staff across the health community.

8.3 SSCB Serious Case Reviews in progress 2016/17

Progress of Child Sam SCR
The SSCB Learning and Improvement Subgroup commenced the SCR into Child Sam in 2016 following notification of the significant harm suffered by the child. Child Sam had repeated contact with a range of health professionals before being taken to a Somerset Minor Injury Unit by members of his family. Sam had suffered extensive non-accidental head injuries which left Sam with significant brain damage and life-long impairments. Child Sam's stepfather was subsequently convicted for grievous bodily harm in January 2017. The review will conclude with publication in 2017/18.

The Serious Case Review in respect of Child Sam is ongoing. Criminal proceedings were concluded in January 2017 and the Final Report will be published later in 2017.

Child Sam emerging findings included:

- improved practice and guidance around Multi-agency Pre-birth work to Safeguard Unborn Babies;
- the need for agencies to identify and respond to the risk and vulnerabilities within families where Domestic Abuse is a concern in order to further safeguard children;
- staff training [health] around measuring, recording and plotting growth measurements in particular head circumference and weight, in order to recognise when cases may need to be referred for specialist management;
- safeguarding training for health care professionals to highlight the presenting signs and symptoms of brain injuries in young babies;
- agencies to demonstrate that for any unavoidable change of practitioner working with an individual or family, during an episode or intervention is supported by a full and formal recorded handover consistent understanding and application of thresholds for intervention at tier two;
- identification of risk within the wider family context, including assessment of the impact of risks on children;

- information to be shared within and across agencies to facilitate safeguarding of the children.

Fenestra

The SSCB Learning and Improvement Subgroup were notified in 2015 of nine children who were involved in sexual exploitation from a group of individuals identified through a police investigation into a case of child sexual exploitation.

The case involved two children who had suffered significant harm which resulted in serious mental health problems, including suicide attempts. In addition, both children had several pregnancies, ending in miscarriage and termination, prior to both having a child by one of the perpetrators. There was also learning from several of the other children who were involved in this case.

The case involved historical abuse of the children concerned from 2010 until 2014. In 2014 the police investigation intensified. This resulted in the prosecution and conviction of two perpetrators in November 2016, for sexual offences against children. Agencies involved provided information about their involvement with each child and an agency report. Children and young people were directly involved in the SCR process.

The purpose of reviewing this case was to learn how to promote rapid change in the effectiveness of multi-agency practice and response to child sexual exploitation (CSE). The type of CSE suffered by both children was an 'inappropriate relationship' model.

Emerging findings for Fenestra include:

- The confusing stance in national policy to adolescent sexual activity and the impact on professionals leaves professionals struggling to distinguish between 'inappropriate relationships' and permitted consensual sexual activity;
- The impact of short term interventions on perceived parenting deficits, without taking sufficient time to listen and hear the parents’ concerns;
- The requirement for a multi-agency investigative model in CSE investigations;
- The critical importance of linking information within and between agencies;
- Children who have experienced or are at risk of experiencing CSE need accessible, timely and sufficiently experienced support for their emotional and mental health problems;
- The need for good multi-agency collaboration in this complex area;
- The arrangements nationally in relation to piercing and tattoo salons does not adequately address safeguarding risks for children;

- There is scope for further development of education provision around relationships and CSE for both children and parents;
- The practice in this case has indicated some scope for increased sensitivity to cultural issues.

9. Other learning reviews in 2016/17

Neglect - 'Failure to thrive' – Following a review of the information submitted by each agency, the SSCB held a learning event in May 2016. The majority of the 20 participants had direct experience of working with one or other family. The review was co-facilitated by an Independent Reviewer and a Consultant Paediatrician / Named Doctor.

Child K and Child Q were young babies from different families, but the issues are similar so these cases were looked at together. These two babies were a few weeks old when admitted to hospital following significant starvation.

Findings for Child K and Child Q

- Neglect - a reluctance by practitioners to see the lack of weight gain as a manifestation of neglect;
- Compliance – both families were resistant to intervention by agencies;
- Hostility - workers attempted to be flexible and accommodating in the face of verbal aggression, the balance between support and challenge was hard to maintain;
- Parents' own issues - both families had complex dynamics with different family members in receipt of services from different agencies;
- Professional communication - the infant's own 'Red Book' was not always made available or updated properly, causing a lack of continuity in the recording of concerns;
- Pre-birth Planning - Pre-Birth guidance was limited;
- Use of escalation policy - there were pre-existing concerns and evidence of lack of cooperation and lack of progress, but escalation procedures were not used.

Sexual exploitation – appreciative enquiry: A learning review was held in April 2016 to examine the case of a vulnerable young woman placed in foster care. On leaving care the young woman refused to receive support from both Bristol and Somerset local authorities and was at continuing risk of CSE. The findings from the review concurred with the key themes outlined in the Somerset Learning Review into the Death of Vulnerable Young Adults.

MAPPA SCR – Child P: A learning review was held in 2016 in relation to a child sexually abused by her father who had been subject to a Sexual Offences Prevention order (SOPO).

Findings from MAPPA SCR - Child P

- There was a lack of appropriate assessment at the right time and involving the right people.

- An outdated risk assessment was used for Child P, and the SOPO exempted the child from the conditions as the child was not considered to be at risk.
- Mother's protective capacity was not questioned or assessed.
- Disguised compliance was evident for many years.
- The prison reported concerns over the Father's behaviour to Child P on a visit (prior to disclosure); there is no evidence this was followed up.
- Opportunities to work with the family were not taken up when father was in prison.

Child S – non-accidental injury: The review, led by the CCG, involved the case of a baby who at 10 weeks old presented at hospital following an out of hospital arrest. The baby had suffered a bilateral subdural haemorrhage and large skull fracture. The family had contact with a number of agencies. The baby's parents were vulnerable young adults and hidden harm factors were present. Findings included areas of development for specific agencies: Getset, Bristol Paediatric Department and Yeovil District Hospital.

Next steps for multi-agency learning reviews and SCRs in 2017/18

- SSCB and Somerset Safeguarding Adults Board (SSAB) to jointly revisit 2014 thematic learning review in deaths of vulnerable young adults, to consider the subsequent deaths of 6 vulnerable adults (care leavers) who have died since the 2014 review – to compare whether lessons identified in 2014 have been actioned or remain.
- Publication and dissemination of learning from SCRs Child Sam and Fenestra.
- Learning review into a case of neglect to commence in early 2017/18.

10. Progress against SSCB priorities

Every year the SSCB considers progress made against SSCB priorities set in the previous year and determines priorities moving forward. Priorities are driven by need, developments, and key improvement areas. The Ofsted rating in 2015 of 'inadequate' determined improvements to be made and specific areas for the Board. The priorities in this plan have been identified as a result of:

- improvement areas identified through inspections and through quality and performance reviews;
- evaluation of the SSCB business plan 2015/16;
- themes from serious case reviews and other learning reviews;
- national and local priorities;
- issues emerging from practice, identified by those working with children, young people and their families in Somerset;
- issues raised by Somerset children, young people and their families.

10.1 SSCB Priorities for 2016/17:

1. Early Help - Children and families receive good quality and timely multi-agency help to keep children safe and promote their wellbeing.
2. Children are safeguarded though effective multi-agency partnership working.
3. Neglect - children who are experiencing or at risk of neglect are identified and safeguarded.
4. Child sexual exploitation - Children who are at risk of, or subject to, sexual exploitation and abuse (including children missing [from home, school or education]) are identified and safeguarded.
5. Board effectiveness - to ensure that the SSCB is effective and supported by a sustainable business unit.

Priority 1 - Early Help - Children and families receive good quality and timely multi-agency help to keep children safe and promote their wellbeing

What was done?

Quarterly progress updates were reported to the SSCB on Early Help developments across Somerset, which are delivered by a range of partners including, schools, the local authority 'getset' services, children's centres, GPs and a range of health services as well as other local service providers including the voluntary and community sector. The Early Help strategy was launched in April 2016 and arrangements have continued to develop across 2016/17. 2016

also saw the launch of the Early Help and thresholds guidance, 'Effective support for children and families in Somerset' and the launch of a safeguarding leads consultation line. The Effective Support for Children and Families guidance includes:

- the process for the Early Help Assessment and the type and level of early help services to be provided;
- the criteria, including the level of need, for when a case should be referred to children's social care for assessment and for statutory services.

Impact

The Early Help guidance and supporting tools have continued to be systematically driven and embedded across the partnership throughout the year, with the central focus upon children and families receiving good quality and timely multi-agency help and ensuring the right help is provided at the right time and in the right place. Embedding the effective support guidance has also progressed well via SSCB multi-agency Working Together training. Awareness of Early Help guidance and use of assessment tools amongst practitioners across the partnership has increased significantly and the number of Early Help Assessments (EHAs) has continued to rise sharply across 2016/17. The SSCB also noted that EHAs have increased the recognition of domestic abuse and its impact upon children and young people.

The overall usage of the safeguarding lead consultation line in its first year helped increase practitioner understanding and application of thresholds for intervention.

Although positive impact can be evidenced for individual children, the SSCB require multi-agency evaluation tools to help the partnership judge the effectiveness of the early help services provided.

Next steps

- Continue to seek assurance that there is consistent application of the SSCB Effective Support for Children and Families guidance by all practitioners across the partnership;
- Increase the Board's understanding of the impact of Early Help through impact data and multi-agency evaluation.

In order to understand the quality of help children and families are receiving, it was agreed that Early Help remains a key SSCB priority for 2017/18.

Priority 2) Children are safeguarded though effective multi-agency partnership working.

What was done?

The number of children subject to a child protection plan remained stable in Somerset, for the most part of 2016/17. In addition, the SSCB saw a decrease in the number of repeat child protection plans and the proportion of long-term child protection plans (2 years or more) gradually reduced. The SSCB multi-agency audit subgroups carried out four case audits to contribute to assessment of progress of this priority; audits included contacts and referrals for unborn babies, initial child protection conferences (ICPC) and core groups, strategy discussions involving young, and cases of children who have a parent in custody. The audits highlighted aspects of both positive practice and specific areas requiring improvement and areas where increased Board focus was required.

A serious incident review and audit findings from an audit into initial child protection conferences and core groups highlighted that reports to conference were a key area for development. The introduction of area based child protection chairs was piloted to address the quality of agency engagement in child protection planning. The role of the area chairs being is to support the participation and engagement of multi-agency partners with child protection conferences.

Throughout 2016/17 Safeguarding conversations provided a valuable opportunity for Board members to engage directly with practitioners through discussion of child protection/Child in Need (CIN) cases. The conversations enabled the Board to shine a light on good practice around this priority, as part of the learning and improvement framework.

Two Safeguarding Conversations took place, with two separate cases reviewed in 2016/17. These provided an opportunity for Board members, alongside practitioners to consider all aspects of practice, including what training or additional guidance may have helped them or would have been useful.

- One case focused upon neglect in the case of child subject of a Child Protection Plan under the category of neglect.
- The second case focused upon an infant subject of a Child in Need plan.

Learning highlighted from the conversations was disseminated through the SSCB Things You Should Know ('TUSK') learning bulletins.

The conversation events continue to receive positive feedback from practitioners and will continue into 2017/18.

The Resolving Professional Differences (RPDs) protocol was updated in 2016/17 and data around its use has continued to be reported to the SSCB. Escalation themes indicated the need for the SSCB to:

- continue to progress improvement in workforce understanding and application of thresholds for intervention;
- prevent drift and delay in case work;
- address the need for appropriate overnight accommodation for young people being dealt with by the Police.

Next steps

- Refine performance information about the quality and consistency of agency engagement with child protection planning processes is an area for further development.
- Conduct child protection conference review observations by SSCB members as a routinely scheduled activity to assist SSCB in monitoring progress against this priority in 2017/18.
- Secure an effective multi-agency safeguarding system remains a priority for SSCB in the business plan for the coming year.

Priority 3) 'Neglect' - Children who are experiencing, or at risk of neglect are identified and safeguarded.

What was done?

Neglect was identified as a priority for the SSCB in 2016/17 because of the serious impact it has on the long-term chances for children.

In Somerset, as in all four countries of the UK, neglect is the most common reason for a child to be subject of a child protection plan. Neglect was the initial category of abuse for 64.4% of children who became subject to a Child Protection plan in the year ending 31st March 2017. This is an increase from 57.7% in the previous year.

Learning from multi-agency case reviews featuring neglect: The Learning and Improvement Subgroup commissioned a practitioner learning event in May 2016 to examine 2 separate cases of neglect which involved the cases of two infants who had been malnourished. The majority of the 20 participants had direct experience of working with one or other family. Findings from the review (Child K and Child Q Neglect - Failure to thrive) are referred to in section 8.2 above.

Feedback from the SSCB July 2016 Board also suggested (via the domestic abuse assurance questions exercise) that partners did not have sufficient evidence to be confident that their practitioners are fully trained in identifying

neglect. The Board were not assured around multi-agency effectiveness in early identification and subsequent planning for cases of neglect.

This was despite findings from the 2016 SSCB Section 11 audit which identified that 84% agencies that provided a response to S11 standard 8.3 *“Appropriate staff and volunteers are trained to recognise signs of abuse and neglect”* grading themselves as good or outstanding; (21 out of 25 agencies). In addition, 88% of agencies that provided a response to S11 standard 11.4 *“The organisation has in place a programme of internal audit and review that enables them to continuously improve the protection of children and young people from harm or neglect”* also grading themselves as good or outstanding (22 out of 25 agencies).

To assure itself further the SSCB commissioned a multi-agency group to develop a neglect strategy for Somerset, in addition to a neglect practitioner toolkit. The purpose of the strategy and toolkit was to establish strategic aims, objectives and priorities for Somerset in tackling neglect. This work is well under development and will be launched in 2017/18 having been developed by SSCB partners. The strategy and toolkit will apply to all agencies across all sectors working in Somerset.

Following findings from recent SCRs, pre-birth planning guidance has been further developed through South West Child Protection Procedures (SWCPP) and made available on both the SSCB and SWCPP websites. A multi-agency working group was established to develop local multi-agency practitioner guidance. This work will continue into 2017/18.

Impact
The strategy and toolkit have benefitted from a high level of multi-agency practitioner engagement; impact will be tested once launched in 2017/18.

Next steps

- Finalise the Neglect Strategy, action plan and toolkit and launch via multi-agency conference ‘Working Together to Tackle Neglect in Somerset’;
- Incorporate into single and multi-agency training programmes;
- Baseline and improve practitioners understanding of neglect and ability to identify and address issues early in order to improve outcomes;
- Disseminate learning from multi-agency case review/audits and guidance across the partnership.

The strategy and accompanying practice guidance will enable practitioners across all agencies to identify features of neglect and prevent neglect by being

able to identify risk factors, and to respond early when indicators of neglect are identified.

Neglect will remain a priority for the SSCB for the forthcoming year

Priority 4) Child sexual exploitation (CSE) - Children who are at risk of, or subject to, sexual exploitation and abuse (including children missing (CM) [from home, school or education]) are identified and safeguarded.

What was done?

2016/17 was a transitional phase with regard to the SSCB establishing assurance around responsibilities for CSE and missing children and it recognised and acknowledged failings in multi-agency responses to safeguard children and young people from CSE. This recognition enabled the SSCB to progress some key developments to implement actions and assess impact. The SSCB has:

- ✓ Continued to implement, monitor and embed the local CSE strategy and action plan.
- ✓ Used feedback from peers to develop and ensure the action plan focussed on the key issues to drive improvement for children in Somerset.
- ✓ Combined the Missing and the CSE subgroups to ensure greater collaborative working and focus; refreshing the terms of reference and membership.
- ✓ Used intelligence and problem profiles to understand local patterns of offending and ensure our work activity in Somerset was focussed in the right areas.
- ✓ Responded to feedback from a baseline survey from 2016 which indicated that local knowledge of professionals needed improving.
- ✓ Delivered two multi-agency conferences and a training programme of CSE training were delivered to raise practitioner awareness, increase skill base and capacity – conferences were well received with good to excellent feedback.
- ✓ Worked collaboratively across the partnership to raise community resilience and awareness with taxi drivers and night time economy workers.
- ✓ Developed a performance framework for CSE/Missing Children.
- ✓ Developed a champions group to improve awareness in their own workplaces across Somerset.

A stocktake report in 2016 provided the SSCB with an overview of the distance travelled regarding Somerset's practice and response to Child Sexual Exploitation, since 2015.

Alongside this a workforce baseline survey provided the SSCB with a broader understanding of the professional practice issues and understanding of CSE within Somerset. Findings of this survey were considered alongside other inspection/review reports at the time, within the partnership (namely; Ofsted single inspection of LA children's services and review of LSCB Jan-Feb 2015, HMIC Inspection report 2015 and CQC thematic improvement review 2015). Findings helped to focus the Board's action plan in some important areas and targeted work has helped address actions in response to findings such as:

- improved and proactive education engagement with CSE;
- the need for consistent messages and information sharing within agencies;
- improved association of 'missing' as a CSE risk;
- the need for practical skills training;
- localised information sharing to be improved.

An executive group was formed to boost the governance of the action plan, based upon the three government priorities *Prevent", "Protect", "Prosecute and Pursue", with the local authority providing overall strategic leadership.

The Effective Support for Children and Families document was launched in February 2016 and later in 2016 refreshed to ensure sharper focus on exploitation (including CSE, missing and radicalisation) and clear practice guidance to assist decision making and professional thinking.

Additionally, the SSCB CSE screening and risk assessment tools were reviewed following task and finish work undertaken by the Strategic Subgroup to provide more robust screening and risk assessment based on best practise.

CSE practitioner guide: A multi-agency CSE practitioner guide was developed through Somerset Partnership and was adopted as good practice by the rest of the SSCB partnership. This guide has added real value in assisting practitioners in their assessments of risk around CSE and what to do next. The guidance was also woven into the first refresh of the Effective Support for Children and Families in Somerset document.

CSE - Innovative work around practitioner and public awareness: Avon and Somerset Constabulary developed a targeted campaign strategy to raise awareness of CSE. The first part of this campaign targeted practitioners' awareness and comprised of a poster campaign containing messages from young people: "Ask me, ask me again, keep asking" and "CSE is happening". In addition, the Local Authority published a double page spread in "Your Somerset", which is delivered to every home in Somerset; to raise awareness

across the county with parents and carers.

CSE - Training and conferences: The SSCB commissioned Barnardo's BASE to deliver a mix of half and full day training to practitioners working with children and young people in Somerset. The courses covered basic awareness, working with parents and practice skills development. CSE champions were also trained to cascade these training packages within their own agencies.

Initial learning from the Fenestra SCR began to convey messages for Somerset around CSE in a rural county, in relation to the models emerging which included the "boyfriend model", akin to interfamilial sexual abuse and the 'inappropriate relationship' model. SCR focus groups with children and young people helped the Board to gain a deeper understanding around the rural nature of Somerset and impact of social media.

Two multi-agency practitioner conferences, 'Working Together to Tackle CSE', were held in the reporting year targeting 170 designated safeguarding leads. The events provided an opportunity to raise awareness, develop skills in assessment and identification and for learning messages from the SCR Operation Fenestra to begin to be shared. The conferences also featured the launch of the multi-agency SSCB CSE practitioner guidance.

CSE Champions: A multi-agency CSE champions' network was established to assist the approach to tackling CSE within 2016/17; the approach was taken in response to the baseline survey findings. The CSE champions were nominated across the partnership in recognition that having named individuals within organisations would help raise and inform the practice standards that safeguard those children and young people who are at risk of, are victims of or in recovery from experiencing sexual exploitation.

CSE Champions act as:

- a key contact for people within agencies who practitioners could go to for support and advice in relation to CSE;
- a practice lead contacts who can train, share updates, resources and examples of good practice within agencies and across the partnership.

The CSE Champions are supported and co-ordinated through the SSCB CSE/CM subgroup.

CSE – JSNA: Somerset Joint Strategic Needs Assessment – Child Sexual Exploitation was updated in 2016. The JSNA in 2016 focus on vulnerable children and young people information captured on the JSNA included:

- recorded CSE tagged crimes in Somerset increased to 76 in the year

to August 2015, compared to 50 in the previous 12 months;
- rise is similar to the increase (+53%) in the number of tagged crimes across the Avon and Somerset force;
- likelihood is that officers, police staff and partner agencies are getting better at recognising the warning signs;

CSE - Work with licencing authorities: District councils undertook innovative work with taxi-drivers and social landlords across 2016/17. Specifically, Taunton Deane Borough Council who led and mentored other district councils; produced a handbook for taxi-drivers, highlighting the signs of CSE and what action they should take to alert authorities of any suspicions.

CSE - Children's Voices - Young people's stories: The stories of child victims of sexual exploitation in Somerset were heard by practitioners and agency leads through the CSE Summit, held in April 2016, the SSCB Board and the CSE strategic subgroup in April 2016 and also as part of the Fenestra SCR focus groups with children (both victims and non-victims). These powerful and profound accounts, along with key messages from children worked with as part of the Fenestra serious case review have enabled the SSCB to focus its work on outcomes for children and shape service provision.

Messages from Children and Young People included:

- *It's very hard for us to see ourselves as victims and to understand if and what help we need.*
- *Know it is really embarrassing to talk about sexual things to adults, especially if those sexual experiences have hurt you.*
- *Understand that if we do talk about sex it is really important that you must not look embarrassed or go red, this just shuts us up. Your embarrassment stops children talking.*
- *Some people became really important to us leading up to court and when the trial is over we miss them.*
- *Be clear that it is so hard to say what is happening and we really worry it will get back to our families; we are also worried that we may get hurt by some of the people who did this if they found out I/we had told*
- *It is difficult to trust teachers, as soon as you speak, we worry they will ring our family and this will get back to the perpetrators.*
- *Having BASE (Barnardo's CSE project) there was really good, we met others in the same situation and workers are kind and listened to us but also we did stuff, like cooking and making things, at CAMHS they just want us to talk about the past and that is too difficult.*
- *Let counsellors talk to you and help you sort your head out*
- *Having someone work with your Mum and family really helps*
- *If you feel someone is not safe (what was described as the Jimmy*

Saville feeling) tell someone, you are almost certainly right.
- *Speak to teachers*

Children missing (from home or care): Section 13 of the Children Act 2004 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. This includes planning to prevent children from going missing and doing everything possible to ensure their safe return when they do go missing. More recent legislation and guidance required the SSCB to take steps to understand why individual children go missing and how they and their families or carers may reduce the probability of further incidents.

How well it was done
Progress has been made across the year but there remains much to do to ensure that CSE is recognised and responded to effectively. The recent development of a performance framework will assist in benchmarking progress and planned multi-agency audits for this year will provide qualitative feedback.

What difference has it made?
CSE is starting to be recognised as something that happens in Somerset, not just elsewhere, with communities and practitioners being more alert to the indicators it presents. The feedback from the practitioner conferences held in December 2016 and March 2017 demonstrated an increased understanding of the local perspective through the sharing of local data, extracts from a problem profile and early findings from a Serious Case Review where CSE was a factor.

Evidence of impact and effectiveness
There are effective partnerships in Somerset and the embedding of a robust performance framework to accurately measure impact and effectiveness will remain a high priority for 2017/18.

Next steps
- Continue to strengthen strategic leadership and ownership to drive the strategy and action plan forward;
- Embed CSE/CM performance framework and continue to improve workforce understanding of the complexities of CSE and capacity to build expertise through the use of the Champions Network;
- Consider how the SSCB CSE strategy may align in the context of other criminal exploitation in Somerset, to take into account intelligence links between Dangerous Drugs Networks, trafficking and CSE which will require greater development as we move forward.

11. Other activities and functions of the SSCB

In addition to its work via the subgroups, SSCB has other responsibilities, which are set out in 'Working Together' (2015). These include:

11.1 LADO - Allegations management

What was done?

The role of the Designated Officer involves the management and oversight of allegations of abuse made against people who work with children. An allegation may relate to a person who works – this can be in either a paid or voluntary role, with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

(Ref: *'Working Together to Safeguarding Children…'* (2015),

There were 478 (353 in 2015/16) notifications of allegations during 2016 / 17 consisting of:

- 220 allegations of physical abuse (46% of all allegations)
- 110 allegations of sexual abuse (23% of all allegations)
- 98 allegations of neglect/inappropriate behaviour (21% of all allegations)
- 50 allegations of emotional abuse (10% of all allegations).

How well was it done?

Individual cases were managed and overseen by the Designated Officer in conjunction with Children's Social Care and the Police with an improvement in the time to investigate and conclude notifications received. This means allegations against people who work with children are not dealt with in isolation and the welfare needs of children are prioritised and co-ordinated.

A quality assurance process was developed to evaluate the consistency and quality of decision-making by the Designated Officer in managing individual cases.

Further work was undertaken in order to promote the managing allegations procedures particularly with sports clubs e.g. Somerset FA, County Sports Partnership.

In partnership with Children's Services, Police and Somerset Partnership a multi-agency forum has been developed to risk manage adults who may be a risk to children in the community.

Impact

Targeted promotion of the managing allegations procedure resulted in significant increase in notifications received. This reflected the success of promoting the procedures and the importance of identifying, reporting and taking pragmatic decisions and actions to manage inappropriate behaviour of staff / volunteers.

The creation of a multi-agency forum to risk-manage adults who were identified as a potential risk has helped enhance the child protection system to ensure children are kept safe.

A 35% increase in notifications compared to last year indicated greater awareness of the procedure.

What next steps will be taken?

- Continue to raise awareness of the managing allegations procedure.
- Work effectively with partner agencies to improve the timeliness in closing cases.
- Increase the number of notifications received within one working day.
- Utilise the multi-agency forum at every opportunity.
- Further delivery of the nationally accredited safer recruitment course.

Issues to highlight

There has been lack of notifications from some large scale employers delivering services to children in Somerset.

11.2 SSCB Multi-agency Training

What was done?

This year, a total of 50 courses were delivered across 2016/17.

A total of 1,093 training places were provided, in addition to 328 attendees at 12 Multi-agency Practitioner Information Groups (MAPIG) sessions and 170 attendees at 2 Multi-agency Practitioners conferences, *'Working Together to Tackle CSE'*.

Participation by agencies can be found in Appendix E SSCB multi-agency training attendance:

Introduction to Child Protection and the refresher courses are no longer delivered by the SSCB but continue to be overseen by the Training Manager to ensure the key messages both local and national are embedded in the learning outcomes.

The multi-agency Working Together and update modules for agency safeguarding leads, continued throughout the year to reflect the recommendations and learning from the serious case reviews, learning reviews and safeguarding conversations. The Working Together training takes delegates through the complexities of a family who initially need the support of early help to the escalation of concerns which require the involvement of child protection services, drawing out issues of neglect, CSE, Prevent, and physical, sexual and emotional harm.

Participants consider the impact of hidden harm and disguised compliance on the welfare of the children. The Voice of the Child is recognised through the case study and the process and benefit of Early Help Intervention is a strong theme running throughout the training.

The Working Together course continued to be supported with input from a multi-agency pool of experts from across the partnership, including health, children's social care, police, independent safeguarding review officers and targeted youth support. The course also benefitted from input from the Prevent coordinator who promoted awareness of safeguarding in the context of the Prevent strategy.

Arrangements with partner agencies ensured appropriate multi-agency expertise was available to contribute to the multi-agency safeguarding training. The Working Together modules included a focus this year upon the use of early help assessments. This aimed to support greater consistency of application and understanding of thresholds across the partnership, promote the role of the lead professional and understanding requests for involvement from children's social care services.

Specialist themed courses were offered throughout the reporting year and were applicable, provided by a pool of trainers expert in Child Sexual Exploitation, parental mental health and its effect on children, and online safety. All delivery is underpinned by 'Think Family' approaches to practice.

The vision for this approach was to build a skilled group of trainers able to respond to safeguarding training needs across the broader Somerset children's workforce. This also helped to standardise approaches to training, opportunities for peer review and a forum to share practice case examples.

2016/17 Multi-agency Practitioner Interest Group (MAPIG) sessions focussed on 'Think Family' approaches and joint working between the safeguarding Children and Safeguarding Adults Boards. These sessions were repeated in each of the four areas of the county. The Think Family sessions were delivered by the business managers from both Adult and Childrens Safeguarding Boards, representatives from children and adults social care and public health.

The aims of the sessions were to:

- enable practitioners to gain a greater appreciation of the national and local context around the 'Think Family' agenda

- explore themes to emerge from recent serious case reviews in Somerset and how these impact on local practice

- provide an opportunity for the workforce to feed-into and feedback to both Safeguarding Boards.

Summary of messages
'Think Family' Q1 MAPIG Practitioners told us that:

- They find multi-agency events really useful and would like to have such joint adults/children events more frequently.
- They believe things are moving "in the right direction" in relation to 'Think Family' in Somerset.
- Information sharing and consent, with multiple systems that don't interface with each-other can make effective safeguarding and risk assessment difficult.
- They would like to develop stronger working relationships with staff in other agencies, and enhance their awareness of other services how they can work together for/with families.
- They worry vulnerable children and families may "fall through the gaps" as a result of service thresholds, and are concerned about risky young people on the cusp of adulthood who don't meet eligibility criteria for children's or adult services.

'Vulnerabilities of adolescence' Q2 MAPIG
Four MAPIG workshops delivered to 112 staff across the county (Glastonbury, Yeovil, Bridgwater and Taunton). These MAPIGs revisited learning from the jointly commissioned SSCB/SSAB SCR into the 'deaths of vulnerable young adults' (2014).

The aims of the sessions were to:

- Test out with practitioners distance travelled, since the review in 2014.
- Provide practitioners with a greater understanding of the national and local context.

- Enable an understanding of the themes that have emerged from this learning review and how these impact on local practice.
- Help to establish a multi-agency approach across the children and adults workforce so all understand the vulnerabilities that may present hidden harm and help address the issues within the family, not just the child or the adult.
- Provide practitioners with an opportunity to feed-in and feedback.

Summary of messages Q3 MAPIG - Practitioners told us that:

- Research should be publicised more prominently.
- Multi-agency discussions were rich and really valuable opportunities to engage across services.
- It was really interesting to hear insights from other agencies.
- The workshops provided a fantastic opportunity to reflect on practitioners own practice and children/young people/adults/families that they are currently working with.
- The multi-agency setting and presentation gave people the impetus to work and share together.

Transitions- 'Choices for Life' - Q4 MAPIG

This topic was created in response to findings from the previous session: **Safeguarding Vulnerable Young Adults.**

The aims of the sessions were to:

- Explore the role of multi-agency teams involved in the "challenge" of transition.
- Introduce views of young people regarding Choices for Life with a focus on the 5 How's and re-framing of transitions in Somerset.
- Identify areas for improvement with agencies and how they can implement this thinking into their working practice.

Summary of messages

The response to the 'transitions' session suggested that attendees left feeling motivated and identified that the approach professionals should be taking towards transitions should be under-pinned with aspiration and the 5 how's:

- How can I choose my next school or college?
- How can I find a job and keep a job?
- How can I live more independently?
- How can I find things to do in my spare time?
- How can I stay safe and healthy?

What difference has been made?
The learning and improvement framework and model of training delivery supports the delivery already provided to primary care practice sessions. Examples of evidence of impact has seen prompt referral to children's services for injuries to infants and young children, including urgent referral for two infants by GPs who were later subject of a serious case review.

What next steps will be taken?

- To strengthen the links with adult safeguarding around shared priority areas such as 'Think Family' approaches to practice, transitions for vulnerable young people and CSE.
- Continue to incorporate learning from serious case reviews commission workforce learning and development audits from agencies.
- Obtain impact data to assess transfer of learning into practice, which includes good practice examples and the voice of the child.
- Obtain assurance on single agency activity.

11.3 Private fostering

Private fostering remains of significant importance following the enquiry into the death of Victoria Climbie in the year 2000. The *Lord Laming Report*, in 2005 increased regulation and strengthened requirements, introduced minimum standards, and improved its own monitoring of local authority services. In 2005 the National Minimum Standards for Private Fostering and the Children (Private Arrangements for Fostering) Regulations 2005 came into force. These regulations, alongside the Children Act 2004, placed additional responsibilities on local councils to raise awareness about, and address the needs of, privately fostered children.

What was done?
Historically the numbers of privately fostered children in Somerset have been low; in 2016/17 thirteen notifications were received.

This is an incremental improvement following ten notifications in 2015/16 and only five notifications in 2014/15.

Somerset meets its responsibilities for children who are privately fostered through the implementation of a private fostering assessment, completed by a qualified social worker from within the area assessment team.

All private fostering arrangements have been assessed and are subject to regular visits as required by the Private Fostering Regulations.

Impact

In 2016, the private fostering factsheet was revised by the SSCB and disseminated to schools. In September 2016, correspondence was sent to boarding/independent schools, host families, organisations to remind these organisations of their statutory responsibility in relation to private fostering.

The majority of the 2016/17 notifications (7/13) were regarding children who were placed by their family following family breakdown.

The rest of the notifications (6/13) were from the education department regarding students from abroad studying in Somerset schools living with host families. There were (2) from the South of England exchange for foreign students, (1) from a boarding school, and (3) notification's from other schools.

6 were notifications ended when the students became 16 following positive assessments.

6 notifications were ended for other reasons listed below:

- One child was transferred to another LA and currently an open case to Bristol under child protection arrangements.
- One child returned home to parents under child in need arrangements.
- One child returned to local authority care following an unsuccessful return home.
- Two children returned to their mother's care in Bristol.
- One child was made the subject of a child arrangement order to the private foster carers.

The majority of these cases remained open to children's social care in a capacity other than private fostering. The increase in notifications this year is an indication that the raising awareness work completed since 2016 is having some affect and this now needs to be improved upon and expanded.

Next steps
Continue to work with education safeguarding and schools leads to raise awareness of what private fostering is and the need to refer such arrangements to the local authority.

11.4 Communications

Website: An upgrade of the board's website has resulted in improvements; it is mobile friendly, better aligned with South West Child Protection Procedures and increasingly well used. The developments have been welcomed by practitioners.

The SSCB website utilises a word press platform which is accessible to practitioners and the public. It is accessible from mobile and tablet devices and has a much improved search function. This, alongside greater use of twitter and establishing a Facebook page has helped to increase the board's digital presence within the partnership.

The SSCB website http://sscb.safeguardingsomerset.org.uk/

- The most visited page on the website in 2016/17 was the Training page. This was followed by the Effective Support page, where the Effective Support for Children and Families Document (previously known as the Threshold Guidance) and associated guidance is housed. The 3rd most visited page is the designated lead page.
- The Child Sexual Exploitation page has been visited over 1100 times, likely to be as a result of the increased awareness raising and the Avon and Somerset Constabulary led poster campaign.
- Visits to the SSCB website were at their highest throughout February and March 2017, which can likely be attributed to an increased social media presence and publication of Somerset's Child Sexual Exploitation Quick Guide for practitioners.

Social media

Twitter @SomersetSCB

- March 2017 was the most successful month for the SSCB twitter account.
- 30 tweets, 179 profile visits and 11500 impressions.
- Top 2 Tweets earned 2359 tweets between them and were related to the SSCB's "Working together to tackle Child Sexual Exploitation in Somerset" conference.

Facebook https://www.facebook.com/somersetscb/

The SSCB's Facebook page was established in February 2017 and has proved to be a popular way to communicate informally with practitioners.

Top 3 posts had a cumulative reach of 8783:

- Launch of Child Sexual Exploitation Quick Guide for Practitioners 22nd February reached 3225.
- Working Together to Tackle Child Sexual Exploitation conference post on 23rd March reached 3666.
- Shared BBC article warning of "The disturbing YouTube videos that are tricking children" on 27th March reached 1892.

Newsletters and Learning bulletins

The SSCB started publishing quarterly newsletters in August 2016 and monthly learning bulletins in January 2017.

The board has seen a steady increase in downloads of these publications, with the most downloaded learning bulletin in March 2017 (1137 downloads) and newsletter in February 2017 (967 downloads).*

** These download figures count the number of times each publication has been downloaded from the SSCB website. The do not account for managers cascading the download within their own agencies.*

11.5 Developing policies and procedures

What was done?

During the previous year the SSCB was keen to improve and develop the quality of policies and guidance available to the SSCB through online procedures. New procedures in the South West Child Protection Procedures online (SWCPP) were commissioned as part of a regional 'consortium approach' in early 2016. The SSCB has worked with consortium colleagues and the provider to develop robust policies where there were some initial gaps.

Where specific local guidance has been required to supplement the overarching procedures and improve how practitioners are supported, task and finish groups were established to conduct this work. Practitioner guidance developed in the reporting year included:

- New updated Children Missing guidance;
- CSE practitioner guidance was developed and launched;
- Development work on Pre-Birth guidance;
- New and updated Effective Support for Interventions guidance;
- New Resolving Professional Differences protocol.

Task and finish groups were established to revise or develop a number of new strategies and guidance, including the development of a neglect strategy and revision of the pre-birth protocol. The SSCB is engaged with the Somerset Children Trust in development of a 'Think Family' strategy for Somerset.

A safeguarding leads page was also created on the SSCB website to help improve practitioner's access to safeguarding protocols and guidance.

How well it was done

Usage of the South West Child Protection Procedures website has incrementally increased throughout the year.

Impact

A survey mid-way through the reporting year was conducted which evidenced a need in Somerset to further raise awareness of the SWCPP resource. Quality feedback around usage evidenced that 19% of practitioners who responded

stated that the resource was not very easy to use (4.7% could not find what they were looking for). 81% of respondents stated that the resource easy or extremely easy to use.

Southwest procedures on line have since been routinely promoted through the SSCB monthly newsletters, social media feeds with usage data reported to the Board to promote compliance. The SSCB continues to work within a consortium arrangement.

Next steps

Policy and Procedures group will be established to:

- monitor effectiveness and compliance with SWCPP and SSCB guidance;
- report on how agencies put into practice updated/new policy guidance and documents;
- conduct timetabled procedures reviews to ensure to ensure that procedures are complaint with Working Together to Safeguard Children 2015 and national guidance;
- monitor the quality and impact of guidance implementation across agencies;
- further follow up targeted promotions of the SWCPP will take place in 2017/18.

11.6 Community members

The attendance of Community Members at Board meetings and a variety of other forums has been critical to offering a different perspective, enabling the Board to stay in touch with local realities and the issues of concern in Somerset's communities. The Community Members, Penny Quigley and Kevin O'Donnell have made a significant contribution to the functioning of the SSCB over 2016/17.

Both have been engaged in a variety of different forums and subgroups, and continue to offer their unique perspective to the Board based on their regular engagement with communities and in their own roles as volunteer mentors and children's advocates.

The community members operate as full members of the SSCB, participating as appropriate on the Board itself and in various SSCB work streams.

Community Members have continued to demonstrate steadfast commitment to the work of the Board in coordinating and ensuring the effectiveness of safeguarding arrangements.

The SSCB is hugely grateful to the Community Members for their dedication, time and effort. They have both regularly attended SSCB meetings, participated fully in Board discussions, adding value and facilitating partners where necessary, to reflect on the work they are doing and its impact.

Each of the Community Members has their own skill set and have been able to apply their specific talents in different areas of Board activity:

One community member has extensive experience in training and communications and has:

- Played a vital role in developing evidence of impact of the Boards commissioned programme of training, carrying out 'test and check' phone calls with individuals from agencies around how they have transferred learning into safeguarding practice.
- Researched safeguarding training developments in good and outstanding Boards and contributed good practice examples to training development within the SSCB.

The second community member has general management experience, with particular skills in data analysis and performance measurement, this member:

- has taken a key role within quality and performance and co-chair the work of this important subgroup on behalf of the Board;
- led the redefinition of the Board's Data Dashboard;
- performed a detailed audit of the website and subsequently was a member of the website design oversight team.

In 2016/17 Community members continued to:

- provide confident challenge and written reflection on all Board meetings throughout 2016/17;
- create & maintain the Board Charter;
- participate in the SSCB Development Day (in April 2017) to help the Board reflect on its Business Plan priorities going forward into 2017-18;
- help the SSCB to shape the new S11 QA process and have participated as chairs and challengers in the initial S11 Peer Review process;
- attend a variety of safeguarding training sessions including Working Together Level III (safeguarding leads);
- continue to campaign to ensure the child's voice is heard in Somerset at child protection conferences;
- answer queries from the general public regarding Safeguarding issues;
- meet with other LSCB's to share ideas and best practice.

Moving forward Community members plan to develop their knowledge and skills through participation in the 2017 national LSCBs conference, and are

making links with others to test if a good practice forum for community members in the South West would support the safeguarding children agenda.

11.7 Voice of the child

The Voice of the Child (VOC) scrutinised through SSCB Section 11
Section 11 scrutiny explored the quality of voice of the child work across members of the partnership selected for peer review. Members were asked for supplementary evidence of their VOC work, which highlighted the fact that there is a strong breadth of engagement with children and young people emerging across the Partnership. Systematic use of VOC data across the partnership still remains a development area by the Board.

Examples of VOC work undertaken by SSCB partner agencies were submitted to the SSCB as further evidence to support their S11 responses. (Appendix C S11, 'Voice of the Child')

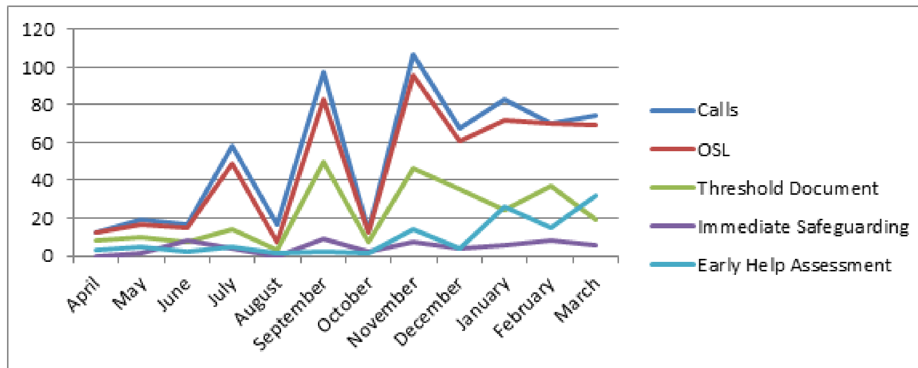
The Voice of the Child addressing CSE (SSCB Priority 4)
As part of the Fenestra SCR, children and young people contributed directly to the review to ensure key messages around Child Sexual Exploitation were fed back to the SSCB in order to inform future developments. Workshops and interviews were held with a variety of different groups and individual children and young people across the county, their messages (Appendix C) were significant in informing the Board work on Child Sexual Exploitation and the progress of the SCR.

11.8 Safeguarding Leads Consultation Line

The 2015 Ofsted report highlighted the following as a priority action for Somerset, "progress the early help strategy more swiftly, ensure that it is well embedded in practice across the partnership and that thresholds for services are better understood and implemented to reduce the number of inappropriate referrals and re-referrals to children's services"**.**

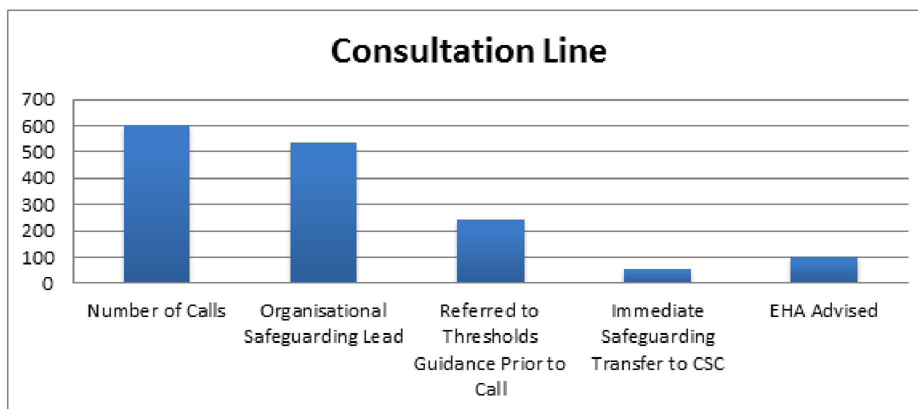
The consultation line was established in 2016, to provide safeguarding consultation and guidance to partner agencies to cultivate understanding of what level of intervention is appropriate to the presenting needs. From review of performance data and the feedback received, the consultation line proved to be of benefit to professionals when making decisions in relation to children's needs.

Table 9: Pattern of calls to consultation line 2016/17



The patterns of peaks and troughs in demand in the periods between July and November 2016 were likely to mirror the approach to and return from school holiday periods. Schools were the highest users of the consultation line.

Table 10: Summary of calls to the consultation line 2016/17



Between April 2016 and March 2017, 242 of the 604 callers referred to the 'Effective Support for Children and Families in Somerset Guidance; 9% of calls to the consultation line were transferred to Children's Social Care due to concerns for immediate safeguarding, 16% of callers were advised to initiate an Early Help Assessment. 88% of users were Organisational Safeguarding Leads (OSL's) for their agencies; this is a 33% increase in OSL's using the line when compared to the February– August 2016 consultation line first review report.

> "*The consultation line is extremely helpful and vital to the OSL role. I was advised on how to use the escalation policy. We all need to be more reflective in our roles and the consultation line allows us/enables us to build confidence*". (Sky College)
>
> "*Guidance is amazing and very clear*" (Bishop Fox's School)

Impact

Over the course of the year there was a noticeable tipping point as early help became more understood. It is reported however that there is still a high level of

dependence across the partnership. Education partners continue to be the most frequent users of this service.

Next steps
Action is being taken over the coming year to scrutinise workforce confidence and competence in their understanding and application of the Early Help and the Effective support for Children and Families.

11.9 Safeguarding Support to Schools

Education safeguarding advisory meetings continued to be well attended across 2016/17 with representation from, Secondary, Primary, Special, Independent schools as well as Further Education Colleges & early years providers. The group facilitate important communications across the Education, Early Help and Children's Services on their statutory safeguarding duties and compliance with SSCB Policies and procedures.

12. Key priorities for the SSCB for 2017/18

<table>
<tr><td colspan="2">Strategic priority 1: Early Help</td></tr>
<tr><td>Outcome</td><td>Children and families receive good quality and timely multi-agency help to keep children safe and promote their wellbeing.</td></tr>
<tr><td colspan="2">We will evaluate the effectiveness and impact of Early Help arrangements across Somerset by:
• evaluating the effectiveness of partners' delivery of their Early Help responsibilities
• assessing the impact of Effective Support Guidance and the threshold decisions on children and young people's outcomes (to include use of the EHA and step up and step down arrangements)
• understanding the views of children and parents/carers who receive early help support and services.</td></tr>
<tr><td colspan="2">Strategic priority 2: Multi-agency Safeguarding</td></tr>
<tr><td>Outcome</td><td>Children are safeguarded through multi-agency partnership working.</td></tr>
<tr><td colspan="2">We will evaluate the effectiveness and impact of safeguarding arrangements in Somerset by:
• scrutinising data and monitoring agency compliance with statutory child protection (CP) procedures and local guidance (effective support and resolving professional differences)
• assessing impact of the partnership's work around hidden harm through focused audit of identification and response to hidden harm and its impact on children
• understanding effectiveness of arrangements for practitioner engagement through audit and safeguarding conversations with practitioners
• understanding the views of children and parents/carers who experience Somerset's CP processes.</td></tr>
<tr><td colspan="2">Strategic priority 3: Neglect</td></tr>
<tr><td>Outcome</td><td>Children who are experiencing or at risk of neglect are identified and safeguarded</td></tr>
<tr><td colspan="2">We will raise the profile of neglect by:
• improving the awareness of professionals about neglect, the issues surrounding it and practical approaches for dealing with it
• developing, launching and implementing a multi-agency neglect strategy, practitioner guidance and the Somerset neglect action plan
• promoting early identification and responses
• assessing the effectiveness of agency responses
• understanding children's lived experience of neglect in order to improve practice</td></tr>
</table>

Strategic priority 4: Child Exploitation/ Children missing	
Outcome	*"Children who are at risk of, or subject to, all forms of exploitation and abuse (including children missing from home, care or education) are identified and safeguarded" (to include CSE, trafficking, county lines modern slavery)*

We will work with partners to:

- **improve** the effectiveness of the strategic approach to tackling CSE/CM in Somerset through implementation of the CSE/CM action plan and redesign of the CSE system
- **evaluate** the effectiveness of partners' arrangements for identifying, assessing and tackling CSE/CM
- **understand** the views and experiences of children and families vulnerable/ and or subject to exploitation in influence the work of the partnership

Strategic priority 5: Strong Leadership and Strong Partnership	
Outcome	*The SSCB leads the safeguarding agenda and develops robust arrangements to co-ordinate and ensure the effectiveness of how children and young people are safeguarded in Somerset.*

We will achieve this by:

- **working with partners** to deliver successfully against the Business Plan and associated work plans set for SSCB and its subgroups / working groups
- continuing to **strengthen the governance** interface between SSCB and other key strategic forums
- **communicating and raising awareness** about safeguarding to individuals, organisations and communities
- **maintaining** SSCB's Learning & Improvement Framework, facilitating, cascading and embedding learning from evidenced based practice and assessing impact of learning activity
- **scrutinising and challenging performance** of partner organisations around their safeguarding work
- **engaging** with children, young people and families to capture their views and experiences, influence the partnership's work and evaluate the impact of partner activity on their outcomes.

13. Commentary on effectiveness of the Safeguarding arrangements in Somerset

Overall, the way the SSCB and its partners have worked together to keep children safe in Somerset has improved over the past year. Many children and families are receiving more effective services, often at an earlier stage than previously. The Board is better sighted on the quality and effectiveness of safeguarding arrangements. However, there is still work to do across the partnership to improve the quality and consistency of services, to strengthen early help arrangements, and to promote improvement in key areas such as neglect and the exploitation of children.

A brief analysis of the effectiveness of local arrangements, with examples of work carried out by the partnership, is set out in the summary below.

There is regular and effective monitoring and evaluation of multi-agency frontline practice to safeguard children.

The Quality and Performance subgroup and its multi-agency audit groups have conducted audits into frontline practice which has resulted in identification of improvements required and outcome focused actions to be taken. Follow up work has been undertaken to assess progress. For example:

- an audit of pre-birth work with vulnerable parents has led to improved pre-birth guidance for practitioners and information sharing around family vulnerabilities;
- an audit of cases of children with a parent in prison led to improvements in how partners are expected to plan for release of offenders from prison;
- an audit of cases of children subject of a child protection plan resulted in enhanced guidance for practitioners around child protection planning and core groups.

Partners hold each other to account for their contribution to the safety of children.

Board meetings are held quarterly and include highlight reports which enable scrutiny of SSCB subgroup activity and progress against the Board's action plan. Issues and risks are monitored and recorded on a risk register and issues log and action taken to address them is agreed by the Board and its Governance Group.

For example, the risk was identified that *'the Early Help strategy is not purposefully driven, well understood or applied by all partners'.* This led to heightened engagement with partners, including a conference, targeted training, the development of targeted communications tools and an Early Help Champions 'train the trainer' programme. This has resulted in improved engagement across partners with early help arrangements.

The restructure of Board meetings has enabled increased partner participation and helped to increase challenge across the SSCB, with partners holding each other to account more purposefully. The Section 11 process and development of the peer challenge model has assisted with this process.

Safeguarding is a demonstrable priority for all the statutory members.

Engagement and commitment by SSCB members and other agencies to Board meetings, subgroups and Board activities (e.g. conferences, the annual development day) demonstrates the priority given to safeguarding children. Board development sessions focused upon culture and effectiveness and confirmed priorities for 2017/18 to include 'strong leadership' and 'strong partnership' as a 5th priority. In addition:

- board meetings have increased in challenge and have been highly participative throughout the year, with improvement in attendance;
- closer working arrangements with other Boards included Safeguarding Adults, Children's Trust, Safer Somerset Partnership, Health and Wellbeing Board and the development of the Joint Working Protocol;
- the development of the Governance Group has led to closer working arrangements within the three lead agencies - CCG, Police and the Local Authority and enhanced the ability to monitor risks and ensure adequate resources;
- resource issues are routinely addressed by governance leads.

There is a strong learning and improvement framework in place.

The SSCB undertakes a wide range of activity aimed at identifying and promoting learning, including engaging directly with practitioners, learning from feedback from children and families, and drawing on learning from local and national reviews and research. In addition:

- a good range of opportunities for learning is provided and receives consistently positive evaluation;
- a strong level of engagement from frontline practitioners in SSCB learning events, safeguarding conversations and multiagency training events, which receive positive feedback and are frequently reported as valued and impactful by practitioners;

- engagement in learning from reviews routinely includes partners from all agencies with particular increased participation by schools;
- developments to target and improve learning through the website, newsletter and social media have been welcomed and prompted positive feedback from practitioners.

The Board ensures high quality policies and procedures are in place.

SSCB works with other LSCBs across the southwest to provide a consistent framework of policies and procedures, which are regularly updated. To support this:

- audit activity has been planned for single agencies to monitor the use of thresholds and the effective support for children and families guidance;
- policies and protocols are reviewed by subgroups and updated;
- task and finish groups are established as required in order to work on specific issues, e.g. the pre-birth guidance.

The Board is working to understand the nature and extent of the local issues in relation to children missing and children at risk of sexual exploitation.

The Board has a subgroup which leads on this aspect of its work:

- the CSE subgroup monitors the action plan and reports to the SSCB on progress;
- the Board routinely poses challenge to ensure that risks are effectively identified and the safety of vulnerable children remains a priority;
- return home interviews increased over the last year, with plans to audit the quality of returns to better understand reasons for children going missing;
- the Strategy is regularly reviewed and updated to reflect increased knowledge and understanding of risks and information.

Case audits, including joint case file audits, are used to identify priorities.

Practitioners and managers working with families are routinely involved in quarterly multi-agency audits of casework practice, whereby strengths, key lessons, and impact are identified. Lessons are cascaded via agencies and through the SSCB's learning bulletin. SMART action plans are used to address recommendations and actions identified. Improvements are monitored by the quality and performance subgroup:

- Multi-agency audits result in outcome focused plans monitored by the quality and performance sub group.
- Quality of practice is discussed in Safeguarding conversations around CP/CIN cases, between Board members and practitioners

- The Quality and Performance subgroup has requested agencies to provide details of their audit schedules for previous 12 months and for 12 months ahead, to be monitored in 2017/18;
- Routine reports that include audit activity outcomes from quality and performance are provided to the Board at quarterly meetings for further scrutiny and challenge.

The LSCB is an active and influential participant in informing and planning services

The SSCB is influential through its strategic involvement with Somerset's partnership boards - the Health and Wellbeing Board (HWBB), Children's Trust (SCT) Safeguarding Adults Board (SSAB), Corporate Parenting Board (SCPB) and the Safer Somerset Partnership (SSP).

- Through the Joint Board Working Together Protocol the SSCB challenges other Boards and shares information to help influence planning for services for Children.
- Through sharing of annual reports (including the SSCB annual report) the SSCB challenges evidence and impact and influences the setting of priorities to support service planning for children.

The Board ensures sufficient, high quality multi-agency training is available and evaluates impact and effectiveness.

The Board provides and commissions a wide range of multi-agency training, which supports its priorities. In addition:

- the SSCB routinely evaluates impact of training output and outcomes upon practice;
- this information shared across the SSCB subgroups to monitor performance and improvement;
- assurance of single agency training activity is a key development area for 2017/18;
- SSCB members receive reports on opportunities and agency engagement is routinely monitored;
- training pathways have been agreed and are understood by agencies;
- the training strategy is closely aligned with the learning and improvement framework.

Appendices

A: SSCB membership

B: SSCB Structure chart

C: Voice of the Child in section 11 audits

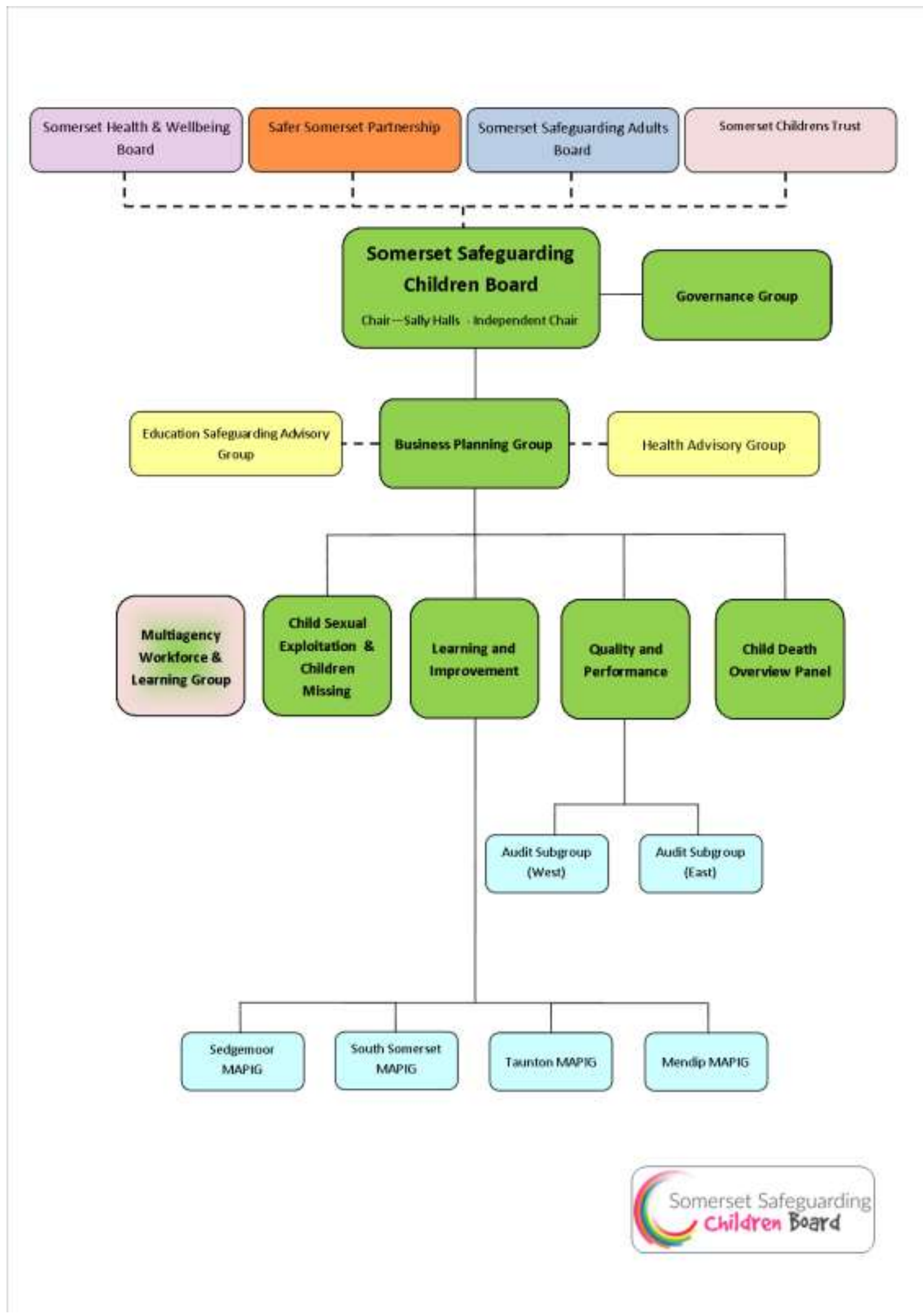
D: Single Agency Assurance reports

E: SSCB Multi-agency Training Attendance

Appendix A: SSCB membership

Name	Job title	Agency
Sue Balcombe	Director of Nursing and Patient Safety	Somerset Partnership NHS Foundation Trust
Trudi Grant	Director Public Health,	Somerset County Council
Peter Brandt	Assistant Chief Officer, (head of Somerset LDU)	Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company
Sandra Corry	Director of Quality and Safety	NHS Somerset Clinical Commissioning Group (CCG)
Nick Rudling	Deputy Safeguarding Lead	NHS England (South West)
Sally Halls	Independent Chair	
Simon Lewis	Assistant Director Housing, Representing Somerset District councils	Taunton Deane Borough Council
Shelagh Meldrum	Director of Nursing and Elective Care	Yeovil District Hospital NHS Foundation Trust
Pauline Newell	Service Manager, CAFCASS	CAFCASS (Cornwall, Devon and Somerset)
Hayley Peters	Executive Director of Patient Care	Taunton and Somerset NHS Foundation Trust
Kevin O'Donnell	Community Member	
Penny Quigley	Community Member	
Sue Rogers	Deputy Director – Education	Education, Learning and Schools, Somerset County Council
Liz Spencer	Assistant Chief Officer, Head of the National Probation Service – Somerset Local Delivery Unit Cluster	National Probation Service South West
Will White	Head of Public Protection Unit	Avon and Somerset Constabulary
Tom Whitworth	Youth Offending Team Manager (Strategic Manager, Vulnerable Young People)	Somerset County Council
Claire Winter	Deputy Director Children and Families	Somerset County Council
Julian Wooster	Director of Children's Services	Somerset County Council
In attendance		
Frances Nicholson	Cabinet Member for Children and Young People	Somerset County Council, (participant observer)

Appendix B: SSCB Structure Chart



Appendix C: Voice of the Child in section 11 Audits

The returns from the section 11 audit and subsequent quality assurance follow up sessions showed a range of activities across partners, focused on listening and responding to the voices of children.

The Voice of the Child within Education Commissioning in Somerset
Somerset's education commissioning continues to be a developing area of work particularly in relation to Special Educational Needs and Disabilities (SEND). The Somerset SEND Engagement and Participation Team continue to develop approaches to enable children and young people with SEND and their families to engage in discussions around policy development.
Education commissioning carried out consultation with children and young people to help develop the Somerset Emotional Wellbeing and Positive Behaviour Strategic action plan – this work involved the CAMHS Participation Group, and children from mainstream and special schools.

The Voice of the Child within Avon and Somerset Police
The Avon and Somerset Constabulary Children & Young People Lead helped develop the Force's activities to ensure that the wishes and feelings of children and young people are taken into account. The Force has adopted the four main strands of the National Strategy for the Policing of Children & Young People plan, one of which relates to youth engagement. There is explicit reference to children and young people in the Force Engagement Strategy. The Force Cadet programme ensures a voice for young people in the organisation.

The current Continuous Improvement Plan features four child focussed actions, across both local policing and specialist operations, including to "continue work to ensure that the views of victim and children are at the heart of Protect Investigations".

Children and young people have been involved in the design of interview suites where Achieving Best Evidence interviews are held. In relation to the design and planning of a brand-new facility, consultation included a young person with autism, and her support worker, visiting an existing facility to explain how things could be done better. A number of community engagement projects have been delivered with the intention of developing closer relationships with children, increasing their confidence in the police and their confidence to report crime.

The police state that "All investigators, or those supporting child victims or those at risk of abuse (e.g. witnessing domestic abuse and missing episodes), know

the importance of establishing and recording the voice of the child. Those attending child protection conferences review all the contact that has been had with the child and therefore any views that have been expressed and these can then be reflected at the child protection conference. The Constabulary has dip sampled Child Protection investigation records to establish how well officers and staff have listened to the child and understood their needs, how well this was recorded and whether the child's needs were appropriately taken into account when making any decisions. This was most recently done in May 2016 where amongst the findings six cases were identified where very young children were not spoken to and where the review considered that they were not too young that they could not have been spoken to. Whilst the dip samples identified a majority of cases where the child's views and needs had been taken into account during decision-making, in view of the number of cases where this was not evident it is considered prudent to grade this question Grade 2, rather than Grade 3. These findings are to be reported to the Constabulary Improvement Board of 30 June."

The Voice of the Child within the CCG
The voice of the child is included in the provider trust contribution to the annual CCG safeguarding report. Some GP practices and health providers have already achieved or are being encouraged to work towards achieving the Young People Friendly Services (YPFS) accreditation run by the Public Health department, which specifies a set of standards for services working with young people. Children and young people were involved in providing feedback to the integrated paediatric therapies service, CAMHS service and in the revised operating model for Wessex House inpatients CAMHS service when it reopened. In addition children and young people were involved in the development of the CAMHS transformation plan.

The Child Death Overview process which is overseen by the CCG Associate Nurse includes parents/families views and wishes where appropriate."

The Voice of the Child within Somerset Partnership NHS Foundation Trust
Young people continue to be heavily involved in Somerset Partnership's (Sompar) service developments including training, the development of referral pathways and design of the SOMPAR website. For example, a bespoke CSE training package for the Child and Adolescent Mental Health Service (CAMHS) featured an audio recording of a young person giving their experience of CSE.

All staff and volunteers are made aware of the Trust's safeguarding policies and procedures and advised of the importance of listening to children and young people. Regular feedback is sought from service users, e.g. attendees at young people's clinics, work with Children's Centres with young children

and antenatal and postnatal services. The Trust has a Children's Participation worker, and a Children's Participation strategic group to ensure this work is prioritised, coordinated across the Trust and that service user feedback is used to drive forward service improvement. All CAMHS patients use Routine Outcome Measures to evaluate the outcome of their treatment. These are used at least twice during their care. Young people have been involved with developing all of the CAMHS policies, such as the Standard Operating Policy and information for families. Young people are also part of the group working on the new Children and Young People website. Young people have been involved with the refurbishment of Wessex House, the inpatient CAMHS unit. They have also been involved in developing pathways and targets. Some young people have met with the Trust's Chief Executive Officer to discuss CAMHS and young people attend a number of the Clinical Governance Steering Groups. Any new literature is reviewed by young people.

Health assessments for children looked after are completed with the young people present and are recorded in their own words. Plans of care for identified health needs are also developed with the young person.

A Somerset wide Transitions Intervention Resource Panel has been set up to ensure young people make a robust transition to adult services and their needs continue to be met. Their voice is represented by the Leaving Care Worker who attends the group. This ensures a bespoke package of care is developed for each young person, unique to their needs

The Voice of the Child within Yeovil District Hospital

Data is routinely collected from children, young people and their families. On the children's ward there is a 'You said.... We did' board for patient feedback to be given and resultant actions publically documented. User data (feedback, demographics, etc.) is used to support and guide service development and communication with other agencies / organisations re service provision, for example, feedback from young people with neuro-behavioural disorders within South Somerset / Dorset is currently informing work with partner organisations and the CCG to further develop service provision for this group

The expressed views of children and parents / carers documented within medical records are included within reports submitted for case conferences (although in most cases reports are requested and written retrospectively after the discharge of the patient from the hospital)

The Voice of the child within the Devon and Somerset Fire and Rescue Service

Devon and Somerset Fire and Rescue Service (DSFRS) systematically obtain feedback from children and young people who have received an intervention.

DSFRS Education Service Delivery Plans are informed by the views and identified needs of children, particularly in relation to risk education. KS1/KS2/ KS3/KS4 lesson plans informed by rigorous pre and post lesson assessments, carried out across the whole service area with all results collated to inform/develop future lesson planning.

Firesetter Advisers are trained to elicit and understand the child/young person's voice throughout each firesetter intervention.

DSFRS Cadets provide a safeguarding contact point which is established and well-advertised at each Cadet unit. All concerns are immediately referred to the safeguarding team, which co-ordinates any required actions.

All external events and activities for young people which are conducted by DSFRS are carefully monitored and feed-back is sought from children and young people in order to inform future events.

The Voice of the Child within Somerset's 'getset' services.

Somerset's 'getset' services continued to develop their feedback mechanisms through a new QA framework which includes audits of learning from feedback from children, young people and members of their families that are fed into service reviews. The 'getset' service uses the 'Outcome Star' to enable children to contribute to needs assessment and develop an action plan.

Moving forward into 2017/18 'Getset' services plan to develop effective service user feedback mechanisms further, to include 'spot checks' as part of the case work audit process; early help officers will contact families direct to obtain their feedback on the service and this will provide impact evidence for service developments which will be monitored by both the Early Help and SSCB Boards.

The Voice of the Child within district councils

The district councils acknowledged as part of the Section 11 audit process that that across all of the council services in Somerset, it is a challenge to embed the voice of the child across ALL services.

> "We have not directly consulted with families and children as part of our service planning however our Transformation Design is based around consultation with all of the TDBC and WSC councillors and this will be reflected in our new service. Our Housing Service uses a range of forums (Tenants forums and Boards) and surveys to shape the service - however this is only targeted at the tenants who are adults."

The SSCB section 11 audit of one council found examples of good practice as a result of consultation with local families and children including the development of the Alcombe play park and Halcon young people's shelter.

A survey carried out within the communities of Taunton district took place to enable tailoring of services for young people in areas regarding as 'high need'. The results of the consultation and survey were fed into the One Team. As a result of a number of young people expressing an interest in gaining employment through working on community projects 'Inspire To Achieve' is now working in the Halcon area. This is proving successful with active participation from young people in community projects.

APPENDIX D: Single Agency Assurance Reports

The Board uses assurance reports and other sources of information (such as independent inspection reports) to seek assurance about the effectiveness of single agencies' work in safeguarding children.

Police effectiveness in Somerset

The PEEL (Policing Effectiveness, Efficiency and Legitimacy inspection by Her Majesty's Inspectorate of Constabulary (HMIC) (published March 2017), found that Avon and Somerset Constabulary had improved to 'Good' at keeping people safe and reducing crime. This was an improvement on the previous year's finding when the Force was judged to require improvement.

The force was judged as 'Good' in its *effectiveness at preventing crime, tackling anti-social behaviour and keeping people safe.* The inspection highlighted that police cannot prevent crime on their own and that effectiveness depends on their ability to work closely with other policing organisations and partner agencies to understand local problems and use a range of evidence based interventions to resolve them.

The Force was judged as 'Good' in its effectiveness at *investigating crime and reducing re-offending,* this was an improvement on the 2015 inspection. The force was deemed to have effective measures in place to monitor sex offenders and violent offenders working closely in partnership with specialist officers to manage risk, however it was highlighted that the management of the risks posed by registered sex offenders was an area for improvement.

The Force was judged as 'Good' in its effectiveness in *protecting those who are vulnerable from harm, and supporting victims. In 2015 this was an area judged as* requiring improvement, with particular reference made to the response to missing and absent children and the response to victims of domestic abuse. Concerns in 2015 included that the 'absent' classification was used inappropriately in some cases which exposed children to risk, and that some frontline staff did not understand the risk factors associated with missing children and the link with child sexual exploitation.

The inspection report highlighted that these areas of concern were addressed, with changes to the categorisation and assessment options on Niche, the police database, and changes to processes ensuring that there is clear daily high level oversight of missing children. The report also referred to improvements made

in the sharing of information with partner organisations about children who are reported regularly missing.

Areas for improvement included:

- The management of the risks posed by registered sex offenders
- the way the force tackled serious and organised crime
- the role of neighbourhood officers
- closer working the with south west regional organised crime unit

CCG effectiveness

The CCG produces an annual report on Safeguarding Children and Children Looked After, which is publically available.

The CCG reported work with the local medical committee and with Children's Social Care to improve the provision of GP reports to child protection conferences. The importance of engaging in the child protection process and providing information on children and families is highlighted in safeguarding training to GPs delivered by the safeguarding team. Named professionals have been requested to escalate concerns to the designated professionals when GP reports are found to absent or insufficient in content.

The CCG also provided updates to the Board on actions, progress and improvements at October 2016 meeting in relation to the following:

Improvements within the CCG were updated at the October 2016 SSCB. Additional updates provided in 2017 demonstrate progress across the following themes

Leadership and governance

- The Associate Children's Safeguarding Nurse provided interim cover for the vacant Designated Nurse Safeguarding Children and Children Looked After post.
- Interim cover arrangements for the vacant Designated Doctor Safeguarding Children post were put into place.
- Active recruitment to the vacant Designated Doctor Safeguarding Children post (to be continued into 2017/18).
- Appointment to the vacant Executive Lead for Safeguarding / Director of Quality, Safety and Engagement post in December 2016.
- Appointment to the vacant Designated Nurse Safeguarding Children and Children Looked After post in January 2017.
- Increase in funding and additional sessions for the vacant Designated Doctor Safeguarding Children post.
- Reviewed and strengthened safeguarding quality schedules in contracts with NHS Trusts.

The Quality Assurance of Safeguarding in NHS Trusts

- Quality assurance of all safeguarding referrals and audits is in place to provide assurance. Audits undertaken by health care providers demonstrated improvements in the quality and appropriateness of referrals to Children's Social Care
- Visit to Somerset Direct and multi-agency audit of referrals to provide assurance of referral quality and application of thresholds
- Child protection supervision is in place for midwives
- Improvements are evident in information sharing and pre-birth planning
- Training needs analyses are in place for all staff within Health Care settings that require mandatory safeguarding children training, in line with the Intercollegiate Document.

Systematically Identifying Children most at risk across all agencies

- The joint appointment of a Child Sexual Exploitation project worker for six months, funded by NHS England to develop a care pathway for CSE.
- Review undertaken of care pathways and timely access to services for young people at risk of CSE
- Awareness raising about risk of CSE and indicators provided for relevant staff groups
- A specific CSE model is now included within training delivered to primary care and pharmacists.
- Investment in acute psychiatric CAMHS liaison posts for timely response to young people presenting with risk taking behaviour

Embedding Early Help

- All NHS Trusts participated in the Early Help Workshops in 2016
- All NHS Trusts have identified an Early Help lead
- An audit of referrals demonstrated good progress in embedding Early Help in the Health Visiting service.
- Some evidence of Early Help assessments / participation in team around the child meetings in primary care

Health Advisory Group

- The Somerset CCG Designated nurse safeguarding children chairs the SSCB health advisory group, which has membership from agencies across the Somerset health economy and provides leadership and an oversight of safeguarding across the county.
- The work of the group in 2016/17 included:-
  - Ongoing developments in supporting children and young people who are at risk or who have been sexually exploited, and

contributing to the work of the partnership in relation to child sexual exploitation (CSE).
    - Improvement of health outcomes for looked after children (LAC) through strengthened partnerships and pathways led by CLA health professionals and commissioners.
    - Development of a skilled workforce through training and learning opportunities.
    - Contribution to and learning from serious case reviews.
    - Reviewing the efficacy of early help and safeguarding referral processes, and how this has impacted on safeguarding and promoting the welfare of unborn babies, children and young people.

Next steps for the CCG

- The work plan of the Health Advisory group is to be more clearly aligned to that of the SSCB ensuring that the development of safeguarding arrangements across the partnership is progressed.
- Reviewing and strengthening quality assurance processes to achieve a clear streamlined process which will include quarterly and annual reporting arrangements, based on dashboards for Children Looked After and safeguarding children.
- Undertake further work to robustly evidence that health care providers have embedded early help into practice.
- Training needs analysis of all staff within Health care settings that require mandatory safeguarding children training in line with the Intercollegiate Document.
- Working with the partnership in the ongoing development of multi-agency early help and safeguarding referral processes.

Assurance report from Early Help Commissioning Board

In February 2017 the Board Business Planning group received a report on 'Programme 5' of the Children and Young People's Plan about *Providing help early and effectively* (Universal and Early Help Commissioning Board).

The report outlined progress on the Early Help tools and systems designed to help practitioners in their roles. These were launched in 2016 and developed throughout the reporting year.

Progress across 2016/17 included:

- Launch of **'Professional Choices' website** in September 2016, a multi-agency website aimed to enable efficient and secure, multi-agency document and information sharing

- Launch of the **Early Help Assessment (EHA)** process through Professional Choices in September 2016; this reduced 43 referral forms down to one, the EHA focused more on the needs of vulnerable groups
- Development of an **Early Help performance scorecard**
- Development and implementation of the **Somerset Early Help Strategy**
- Development of a **Somerset Choices website**, (a public facing web directory of local care and services available for families)

Impact

Targeted support and guidance around thresholds for intervention was provided to agencies making a high number of inappropriate contacts/referrals.

The **Team Around the School (TAS)** project progressed well, with new clusters joining; a handbook and tools were made available to support activity; a TAS Co-ordinator post was established; funding for TAS was identified and allocation formula finalised.

The **Early Help Dashboard** evidenced that referrals to Children's Social Care had decreased throughout the year, whilst Early Help Assessments increased. Initial analysis of these trends indicated developing confidence in practitioner's ability to effectively apply thresholds.

Challenges

Robust impact and outcomes data for Early Help requires further development. Sustained support for the workforce that enables them to continue to purposefully embed Early Help will need to continue as a priority into 2017/18

Next Steps

The Early Help Strategic Commissioning Programme Board and the SSCB will continue to evaluate and monitor performance and impact data in the forthcoming year.

Somerset District Councils effectiveness

The Children Act (2004) places duties on District Councils to ensure their functions and services are discharged having regard to the need to safeguard and promote the welfare of children. The Act also requires District Councils to promote inter-agency co-operation. Somerset's district councils fulfil their responsibilities in a number of ways.

The Assistant Director - Housing and Community Development of Taunton Deane Borough Council and West Somerset Council represents Somerset's five District Councils on the SSCB. This role includes a responsibility to

disseminate information; best practice and guidance from the SSCB to the Councils. This is done through:

- Email briefings and feedback from SSCB meetings and other events. This included sharing new guidance, learning from serious case reviews and update information.
- Attendance at quarterly District Safeguarding Lead meeting which covered both Children and Adult Safeguarding.
- Training – District Safeguarding Leads received SSCB 'Working Together training as well as bespoke training on early help and CSE.
- A safeguarding annual report to the Chief Executives of the District Councils and County Council as well as SSCB.

Taunton Deane and West Somerset Council also provided a representative on the Child Sexual Exploitation (CSE) subgroup and led the District Council response on compliance with and expectations in relation to this priority.

District Councils are a member of the 'Universal and Early Help Strategic Commissioning Board'.

The main test of district council's compliance was through the 2016/17 Section 11 audit co-ordinated by the SSCB. This was completed by all five Somerset District Councils and showed good compliance across all key areas, with overall scores of 'Green' on the RAG status. The audit provided assurance that District Councils have made progress and strengthened their approach to safeguarding. This was particularly so in the following areas:

- Leadership and championing in organisations
- Policy and processes
- Accountability in organisation
- Staff training
- Recruitment
- Interagency working

Areas with lower scores were:

- Service Development informed by children and families
- Case decisions informed by children and families

Impact

Housing Providers: There was increased engagement of Housing Providers across 2016/17 in multi-agency safeguarding developments in Somerset. This had previously been an area for improvement and has been addressed through the developing Somerset Housing Providers Safeguarding meetings, coordinated by the District Councils which included 14 Housing Providers which provide most of the 31,000 units of social housing in Somerset. Group membership includes representatives from both adult and children safeguarding

boards in Somerset, with endorsement from the respective independent chairs. During 2016/17, four meetings took place and covered developments across the safeguarding agenda, including CSE and Early Help. Learning from SSCB serious case reviews was also shared at these meetings.

Licensing and Safeguarding / CSE: It was also reported in 2016/17 that the District Council Licensing Teams across Somerset were taking an active role in helping to ensure Somerset communities were aware of CSE, the signs and how to report their concerns. This work was led through their engagement with the CSE subgroup and included:

The District Councils played a role in promoting awareness and preventing CSE through the following:

- Assisting the wider community awareness campaign, rolled out in 2017, by raising awareness with their contacts in Parish and Town Councils and the Voluntary and Community Sector.
- Development of training and materials for the taxi trade in Somerset to raise awareness of CSE and 'what to do' if they identify possible CSE.
- Work with the police to develop awareness raising materials for the night time economy, particularly the fast food establishments, hotels and B&Bs in Somerset.

Radicalisation and extremism

The SSCB received a report from the Safer Somerset Partnership (SSP) on 'Embedding Prevent in Somerset: Progress Report 2017 which outlined progress made since 2015 in co-ordinating action to prevent radicalisation and extremism.

Impact

The SSP reported that the results demonstrated that key agencies had done well to embed the duties within their own organisations. The main areas for individual agency improvement concerned policy development, with regards to adapting safeguarding policies and ICT policy; and ensuring that Prevent featured on corporate risk registers.

In 2016/17, 1,012 multi-agency practitioners completed the government workshop to raise awareness of Prevent (WRAP) training, with 605 safeguarding leads in Somerset education, trained as trainers. Overall, 98% positive responses were reported in relation to the training in Somerset.

The SSP concluded that overall, agencies across Somerset responded very well to the requirement to implement the Prevent duties. The work achieved within Somerset was praised by Home Office leads and the Prevent Board

continued to work with Police, receiving referrals and utilising intelligence to tackle counter terrorism.

Challenges

Challenges noted by the partnership included reference to future resilience with pressures in capacity and resource to embed and maintain the quality of the response to the Prevent duty in Somerset.

APPENDIX E: SSCB Multi-Agency Training Attendance

Course title	Number of courses	Central Ed	Charities	CSC	Children's centres	District councils	EY providers	Health	Independent schools	Other	Police	Probation	Schools	All
Courageous conversations	1	1	1	0	0	0	1	1	0	0	0	0	0	4
CSE Train the trainer	1	0	0	0	0	0	0	0	1	0	0	0	3	4
CSE half day	5	3	0	39	2	0	7	2	0	0	0	0	16	69
CSE and CWD	1	1	0	4	0	0	0	0	0	0	0	0	7	12
CSE working with parents/ skills and practice	3	0	14	22	5	0	0	6	3	0	0	0	6	56
Parental MH	2	1	2	2	0	0	2	8	0	2	0	0	1	18
Safer Recruitment	1	2	3	1	0	0	0	1	0	0	0	0	21	28
Signs of safety	1	1	0	12	1	0	1	0	0	0	0	0	1	16
Thresholds	1	1	0	1	0	0	1	2	0	0	0	0	4	9
Update	17	39	6	22	24	1	77	25	22	1	5	0	201	423
Working Together	17	27	13	43	6	0	126	9	22	0	2	0	206	454
Total	50	76	39	146	38	1	215	54	48	3	7	0	466	1093