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Somerset Health and Wellbeing Board

Thursday 17 January 2019
11.00 am Taunton Library Meeting Room, Taunton Library, Paul Street, Taunton, TA1 3XZ

To: The Members of the Somerset Health and Wellbeing Board

Councillor Christine Lawrence, Somerset County Council (Chairman)
Councillor Frances Nicholson, Somerset County Council (Vice-Chair)
Councillor David Huxtable, Somerset County Council
Councillor Linda Vijeh, Somerset County Council
Councillor Amanda Broom, Somerset County Council
Councillor Sylvia Seal, South Somerset District Council
Councillor Gill Slocombe, Sedgemoor District Council
Councillor Jane Warmington, Taunton Deane Borough Council
Councillor Keith Turner, West Somerset District Council
Councillor Nigel Woollcombe-Adams, Mendip District Council
Nick Robinson, Clinical Commissioning Group
Dr Ed Ford, Clinical Commissioning Group (Vice-Chair)
Rosie Benneyworth, Clinical Commissioning Group
Mr Mark Cooke, NHS England
Judith Goodchild, HealthWatch
Stephen Chandler, Somerset County Council
Trudi Grant, Somerset County Council
Julian Wooster, Somerset County Council

Issued by Scott Wooldridge, Strategic Manager - Governance and Risk - 9 January 2019

For further information about the meeting, please contact Jennie Murphy on 01823 357628 or email jzmurphy@somerset.gov.uk or or Julia Jones on 01823 359027 or email jjones@somerset.gov.uk

Guidance about procedures at the meeting follows the printed agenda.

This meeting will be open to the public and press, subject to the passing of any resolution under Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

This agenda and the attached reports and background papers are available on request prior to the meeting in large print, Braille, audio tape & disc and can be translated into different languages. They can also be accessed via the council's website on www.somerset.gov.uk/agendasandpapers

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AGENDA

Item Somerset Health and Wellbeing Board - 11.00 am Thursday 17 January 2019

*** Public Guidance notes contained in agenda annexe ***

1 **Apologies for absence**

To receive Board Members' apologies

2 **Declarations of Interest**

3 **Minutes from the meeting held on 15 November 2018** (Pages 7 - 10)

The Board is asked to confirm the minutes are accurate**.**

4 **Public Question Time**

The Chairman will allow members of the public to ask a question or make a statement about any matter on the agenda for this meeting.

5 **Health and Care Integration** (Pages 11 - 16)

To consider the report.

6 **Safeguarding Children Annual Report** (Pages 17 - 100)

To consider the report.

7 **Children and Young People's Plan 2016-2019** (Pages 101 - 114)

To consider the report

8 **Health Protection Annual Report** (Pages 115 - 138)

To consider the report.

9 **Director of Public Health Annual Report** (Pages 139 - 180)

To consider the report

10 **Somerset Health and Wellbeing Forward Work Plan** (Pages 181 - 182)

To discuss any items for the work programme. To assist the discussion, attached is the Board's current work programme.

11 **Any other urgent items of business**

The Chairman may raise any items of urgent business.

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Guidance notes for the meeting

1. **Inspection of Papers**

Any person wishing to inspect Minutes, reports, or the background papers for any item on the Agenda should contact Jennie Murphy on Tel: 01823 357628 or Email: jzmurphy@somerset.gov.uk. They can also be accessed via the council's website on **www.somerset.gov.uk/agendasandpapers**

2. **Minutes of the Meeting**

Details of the issues discussed and recommendations made at the meeting will be set out in the Minutes, which the Board will be asked to approve as a correct record at its next meeting. In the meantime, information about each meeting can be obtained from Jennie Murphy on Tel: (01823) 3550628 or email jzmurphy@somerset.gov.uk

3. **Public Question Time**

If you wish to speak, please tell Jennie Murphy, the Board's Clerk, by 5pm 3 clear working days before the meeting - (01823) 355628 or email **jzmurphy@somerset.gov.uk**

At the Chairman's invitation you may ask questions and/or make statements or comments about any matter on the Board's agenda – providing you have given the required notice. You may also present a petition on any matter within the Board's remit. The length of public question time will be no more than 30 minutes in total.

A slot for Public Question Time is set aside near the beginning of the meeting, after the minutes of the previous meeting have been signed. However, questions or statements about any matter on the Agenda for this meeting may be taken at the time when each matter is considered.

You must direct your questions and comments through the Chairman. You may not take direct part in the debate. The Chairman will decide when public participation is to finish.

If there are many people present at the meeting for one particular item, the Chairman may adjourn the meeting to allow views to be expressed more freely. If an item on the Agenda is contentious, with a large number of people attending the meeting, a representative should be nominated to present the views of a group.

An issue will not be deferred just because you cannot be present for the meeting. Remember that the amount of time you speak will be restricted, normally to two minutes only.

4. **Exclusion of Press & Public**

If when considering an item on the Agenda, the Board may consider it appropriate to pass a resolution under Section 100A (4) Schedule 12A of the Local Government Act 1972 that the press and public be excluded from the meeting on the basis that if they were present during the business to be transacted there would be a likelihood of disclosure of exempt information, as defined under the terms of the Act.

5. **Committee Rooms & Council Chamber and hearing aid users**

To assist hearing aid users the following Committee meeting rooms have infra-red audio transmission systems (Luttrell room, Wyndham room, Hobhouse room). To use this facility we need to provide a small personal receiver that will work with a hearing aid set to the T position. Please request a personal receiver from the Board's Administrator and return it at the end of the meeting.

6. **Recording of Meetings**

The Council supports the principles of openness and transparency, it allows filming, recording and taking photographs at its meetings that are open to the public providing it is done in a non-disruptive manner. Members of the public may use Facebook and Twitter or other forms of social media to report on proceedings and a designated area will be provided for anyone who wishing to film part or all of the proceedings. No filming or recording will take place when the press and public are excluded for that part of the meeting. As a matter of courtesy to the public, anyone wishing to film or record proceedings is asked to provide reasonable notice to the Council's Monitoring Officer (Scott Wooldridge on 01823 355628) so that the Chairman of the meeting can inform those present.

We would ask that, as far as possible, members of the public aren't filmed unless they are playing an active role such as speaking within a meeting and there may be occasions when speaking members of the public request not to be filmed.

The Council will be undertaking audio recording of some of its meetings in County Hall as part of its investigation into a business case for the recording and potential webcasting of meetings in the future.

A copy of the Council's Recording of Meetings Protocol should be on display at the meeting for inspection, alternatively contact the Committee Administrator for the meeting in advance.

SOMERSET HEALTH AND WELLBEING BOARD

Minutes of a Meeting of the Somerset Health and Wellbeing Board held in the Taunton Library Meeting Room, Taunton Library, on Thursday 15 November 2018 at 11.00 am

Present: Cllr C Lawrence (Chairman), Cllr D Huxtable, Cllr L Vijeh, Cllr A Broom, Cllr S Seal, Cllr G Slocombe, Cllr Wool, Robinson, Ed Ford (Vice-Chair), Judith Goodchild, T Grant and J Wooster

Other Members present:

Apologies for absence: Cllr F Nicholson, Cllr J Warmington, Cllr K Turner, Benneyworth, Mark Cooke and S Chandler

353 **Declarations of Interest** - Agenda Item 2

There were no declarations of interest.

354 **Minutes from the meeting held on 27th September 2018** - Agenda Item 3

The minutes of the meeting were accepted as being accurate by the Board.

355 **Public Question Time** - Agenda Item 4

There were no public questions.

356 **Improving Lives Strategy** - Agenda Item 5

The Board received this report which had been subject to extensive public consultation. Feedback from the consultation helped guide the strategy and two key issues have been strengthened as a result. The report will be presented to Cabinet next week then to the CCG and a launch event on 13 December.

The board welcomed the final strategy and agreed to adopt the Improving Lives Strategy 2019-2020.

It was agreed that an updated version of the strategy would be sent to all members.

The Board congratulated Catherine Falconer on her new role with the Chief Medical Officer and wished her well.

357 **Safeguarding Adults Board Annual Report** - Agenda Item 6

The Board considered this report and a presentation outlining the key points. The report summarised the key events in 2017 and 2018 under the overall responsibility to review safeguarding issues as they arise and strengthen policies in the light of findings. The report also provides an assurance that safeguarding is kept under review.

The Board were informed that the Safeguarding Adults Board had reviewed the Peer Review process and introduced a robust audit that introduced greater challenge. The Mendip House Review had raised some concerns in relation to 'out of county' placements and the need for more stringent process for statutory commissioning framework. There is one in place for children but not adults. The Department of Health has been lobbied to introduce a statutory process, but the proposed Green Paper had yet to be published.
The Somerset Health and Wellbeing Board were invited to be co-signatories to a letter to the Department of Health to support the introduction of a Statutory Framework.

The Somerset Health and Wellbeing Board agreed to support this approach and to co-sign a letter.

Further discussion included:

- Mechanisms to assess new providers and discovered this is limited to those who register with the CQC.
- The number of 'out of county' placements and the tracking of these and well as an understanding of the cost to other local services.
- Target timescales for responding to safeguarding issues when they are reported.
- Private facilities and mechanisms for ensuring they register with the CQC.

The Somerset Health and Wellbeing Board:

- **Reviewed and considered the Somerset Safeguarding Adults Board's 2017/18 Annual Report,**
- **Noted progress and highlights and**
- **Agreed to continue to promote adult safeguarding across the County Council and in the services that are commissioned.**

358 **Health & Wellbeing Board Mid-Year Performance Report** - Agenda Item 7

The Board considered this report and welcomed the clarity of the reporting method. The Board noted that the report now covered six workstreams. The board noted that there had been progress in the early months in relation to delayed transfer of care, but latterly this has stalled. There was concern that without robust plans in place the pressure winter would inevitably bring could have an adverse impact on targets.

The Somerset Health and Wellbeing Board:

- **Noted the updated plan and the updated Plan on a Page 2018-19 (Appendix A)**
- **Considered and noted the HWB Board Scorecard (Appendix B)**

359 **Safer Somerset Report** - Agenda Item 8

The Board received the report and were informed that the Strategic Partnership had been in place since 2012. It fulfils statutory functions and aligns its activities to Health and Wellbeing strategies. The priorities are agreed with the Police and Crime Commissioner and will be in place until 2021.
The Board were informed that a new model has been developed for MARAC (Multi Agency Risk Assessment Conferences) which co-ordinate and assure multi agency response for high risk cases of domestic abuse. This approach has reduced the number of cases that need to be discussed face to face and will lead to action being taken more quickly.
The Board were informed that in relation to Serious and Organised Crime the improved sharing of intelligence has ensured that Central Intelligence and Local Services are aware of what is going on nationally and locally and this has been positive.
Taunton Town Centre Rough Sleepers Initiative was started last Christmas in response to the deaths of local rough sleepers. Multi agency response and audit has informed work. There will be a week of action in the first week of December to reduce the risks to rough sleepers in Taunton leading up to Christmas.
Further Discussion included: -

- Information sharing and the impact of GDPR. Concluding that in fact GDPR had put information sharing on a stronger and more secure footing
- County Line criminal activities and the use of weapons brought from outside the County. Research is being undertaken to understand the motivations of young people engaging in these criminal activities.
- Somerset Prevent is working to stop radicalisation and criminality.
- Rough Sleepers in other parts of the County and the support being offered.
- Further strengthening of the Partnership between the Health and Wellbeing Board and Police.

The Somerset Health and Wellbeing Board endorsed the Safer Somerset Partnerships Annual report and proposed that Superintendent Mike Prior should be co-opted as a non-voting member of this Board with immediate effect.

360 **Somerset Health and Wellbeing Board Forward Plan** - Agenda Item 9

The Somerset Health and Wellbeing Board agreed that some items should be moved from the January meeting until later in the year as that agenda was very full.
The Board requested a change in the electronic invitation to the meeting as they were currently booked for 10am until 15:00 and this length of

time was not needed. It was agreed that the meeting invitation would be altered with a revised end time of 13:00

361 **Any other urgent items of business** - Agenda Item 10

There were no other items of business.

The Chair highlighted that the Drugs and Alcohol Service has received good results from a recent Care Quality Commission inspection. It was agreed a letter of congratulations should be sent to the team.

(The meeting ended at 12.38 pm)

Somerset Health and Wellbeing Board

17 January 2019
Report for information

Somerset Health & Care Integration

Lead Officer: Rosie Benneyworth/ Director of Strategic Clinical Services Transformation
Author: Ruth Smith/ Programme Manager, Somerset Health & Care Strategy
Contact Details: 01935 385021

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Rosie Benneyworth	12/12/2018
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	17/12/2018
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	17/12/2018

Summary:	In September the Fit for my Future programme produced a case for change which set out a number of emerging proposals to address its findings. This paper outlines each proposal and categorises them into two groups: • Group A – proposals which will require public consultation and proposals which require further work to determine whether or not they are likely to involve significant change and therefore require public consultation. • Group B – proposals which can be taken forward more quickly; they would not require a formal consultation process as they would not have a significant impact on the configuration and location of services. These proposals would be taken forward through system level delivery groups.
Recommendations:	**That the Somerset Health and Wellbeing Board receives the proposals as part of the overarching strategy and provides a view on appropriate engagement.**
Reasons for recommendations:	To provide the Health and Wellbeing Board with opportunity to help shape emerging outcomes and decisions.
Links to Somerset Health and Wellbeing Strategy	The Health and Care Strategy supports the vision of the Somerset Health and Wellbeing Strategy, by encompassing its underlying principles and priorities in the development of the proposals (where applicable).

Financial, Legal and HR Implications:	No financial, legal and HR implications to note at this stage
Equalities Implications:	An equality impact assessment will be undertaken as options are developed.

1. Background

1.1. In September the Somerset Health and Care Strategy 'Fit for my Future' programme produced the document "Why do we need to change and what are our change ideas so far?" As well as setting out the case for changing health and care services in Somerset the document sets out a number of emerging proposals to address the case for change.

1.2. Further work has been carried out on these proposals and how they could be taken forward. As a result, they have been divided into two key groups as follows.

- ***Group A. Proposals potentially involving significant service change.*** This group includes all proposals which will require the consideration of options that would involve significant service change in the configuration and location of services. These proposals would require a formal public engagement and consultation process in line with legislation and NHS guidance on service reconfiguration. Decision making on the implementation of these proposals could only take place after feedback from a public consultation (which it is planned will be carried out between October and December in 2019).

  This group also includes a number of proposals which require more work to determine whether or not they are likely to involve significant change. A work programme has been developed for these which will provide the necessary information by the end of January 2019 to allow the decision making on whether they will form part of Group A or B. Those forming part of Group A will work to the same October to December 2019 public consultation timetable. Those forming part of Group B will be taken forward as quickly as practicable.

  The Group A proposals will continue to be driven by the "Fit for my future" programme.

- ***Group B. Proposals that can be taken forward without formal public consultation.*** These proposals can be taken forward more quickly, through system wide delivery groups. While they would still require significant engagement with relevant patients and local people, they would not require a formal consultation process because they would not have a significant impact on the configuration and location of services

1.3. Recommended Group A proposals

The proposals have been divided up into three "settings of care" areas; these are acute care, community based care, and mental health care. It is anticipated that a future public consultation will address each of these areas separately.

Acute setting of care

The proposals in this area include the following elements:

Reviewing the configuration of Stroke Services in Somerset
This proposal will identify the optimal configuration for stroke services (including diagnosis, treatment and rehabilitation) in Somerset, to further improve the quality of care for stroke patients in the South West. It is likely that at least one of the options which will need to be considered would involve reducing the number of sites from which acute stroke services are provided, and would therefore involve significant service change.

Reviewing obstetric and acute paediatric services
Both of the two Somerset acute providers have concerns over the long term viability of maintaining two obstetric and acute paediatric services in the county, primarily related to critical mass and staffing. Work undertaken so far by the Maternity and Children's group has identified some pressure for change but has not demonstrated clearly whether it is likely or not that services can continue to be provided to high quality in the future under the current configuration.

It is proposed that the group be asked to progress this work to confirm whether there is a clear case for change for these specific specialties. If there is a case for change, a detailed option appraisal will need to be carried out. The appraisal would need to consider options which could result in services no longer being provided in both the current locations. This would clearly involve a major service change.

Review of other potentially vulnerable acute specialties (including oncology) and potential to separate emergency and elective services to improve patient flow
Since the development of the case for change document the CCG has been working with our two local acute providers to identify where there may be areas where our acute specialities will not be sustainable in the future. A recent meeting with medical directors and a number of lead clinicians from both Trusts has confirmed the need for a more detailed piece of work reporting back by the end of January and covering a range of acute specialties and areas to enable the Governing Body to determine whether there is a need to contemplate significant service change in these areas.

Community setting of care

Two proposals from the initial work of the strategy could have a significant impact on the future configuration and service profile of our community hospitals and are therefore likely to be subject to public consultation. These are described below.

Develop a network of Urgent Treatment Centres in Somerset
This proposal develops a network of Urgent Treatment Centres across Somerset with a consistent and clear service offer which meets national standards and maximises our ability to address urgent treatment needs without attendance at Emergency Departments. These will replace the existing Minor Injuries Units and provide a wider range of services than they currently offer, including being led by GPs. As Urgent Treatment Centres provide a wider range of services than Minor Injuries Units and will require a different staffing and skill mix and critical mass of patients, we will need to consider options which involve having fewer Urgent

Treatment Centres than we have minor injuries units.

Ensuring patients are cared for as close to their home as possible, minimising all unnecessary use of inpatient care

This proposal has emerged from the work of the urgent and emergency care pathway group and the long term conditions/proactive care group. The case for change covering these areas identifies that:

- Patients can have worse outcomes if they stay in hospital inpatient beds longer than they need.
- There are significant numbers of patients currently within inpatient beds who could be cared for at a lower setting of care.

Work is ongoing to review all the relevant evidence, including a recent clinical utilisation audit, to agreed identification of:

- How many patients could be treated at a lower setting of care.
- What this would require in terms of enhanced community based provision and changed clinical models.
- What the impact would be on the number of acute and community hospital beds the system will require in the long term.

Initial indications are that this is a major opportunity to improve quality of care and reduce overall costs of care delivery; it could mean that in the future there will be a need for significantly fewer acute and community hospital beds.

If this is the case it is likely that we will need to consider the impact of a reduced requirement for beds on the configuration of our acute and community hospitals. The development of enhanced community services, and a resulting reduced need for hospitals beds would not in itself constitute a significant service change; however, if this impacts on the viability of specific services at specific sites (or the sites themselves) it is likely that this would be considered to be a major service change, and therefore requiring consultation.

Mental health setting of care

Adult mental health inpatient services

This proposal sets out a review to identify our future needs for mental health inpatient beds for adults of working age and older people. This could have an implication for the number of sites from which we provide mental health inpatient beds, and on whether or not the temporary closure of the older people's mental health unit at Yeovil is continued.

Work is underway to explore the requirements for both adults of a working age and older age adults so that there is a clear understanding of what options will need to be considered and whether these may involve significant service change.

1.4. Recommended Group B proposals

The following proposals should not require formal public consultation as they should not involve a significant change in the location where patients can access existing services (except in some cases ensuring this is closer to their homes than now). Implement a neighbourhood health and wellbeing and team model (incorporating the development of neighbourhood teams, proactive care, frailty and end of life care.)

- Roll out of the integrated diabetes model of care: embedding a replicable coordinated pathway for long term conditions.

- Developing a single, integrated system to access urgent and emergency care in Somerset, addressing every element of urgent and emergency care including primary care, Integrated Urgent Care Service, ambulance services, urgent treatment centres and Emergency Departments.

- Review and transform outpatient services / access to a specialist opinion, in all specialities, to deliver services very differently. This would reduce the need for both first outpatient appointments and follow-ups, streamline and speed up the process and develop a range of new approaches to replace the traditional outpatients' model.

- Implement a business case for tackling tobacco dependence (smoking), through ensuring that the smoking status of all patients admitted to hospital will have smoking status identified and be offered nicotine replacement therapy and support while in hospital and after discharge.

- Commission a single non-surgical oncology service for Somerset, bringing together services, staff and pathways which can connect or operate at a Somerset rather than organisational level.

- Review of diagnostic provision within Somerset to ensure it can address current and future need (elective and cancer) with a specific focus on MRI, CT and endoscopy.

- Develop all components of mental health provision to address service gaps including in the areas of:

    ~ Common mental health needs – primary and community mental health care

    ~ Complex mental health needs

    ~ Mental health crisis services

    ~ Psychosis services

    ~ Dementia Care

- Learning disabilities; moving to a population based approach, increasing the take up of annual health checks, improving crisis support and improving provision of specialist placements

- Enhancing access to midwife led services (the nature of this proposal may change dependent on the outcome of the obstetric/paediatric review detailed above).

- Reconfiguration of the management of high-risk and complex maternity cases to ensure safer birthing outcomes, through staff specialisation and locality-

based expertise. (This primarily involves some patients who would have travelled to Bristol for specialist care going to Taunton instead).

- Integrated children's service focussed on children and families health and wellbeing. The integrated services will cover health and social care, public health and will have effective links with education services. The proposal will focus on supporting and empowering parents, teachers and health care staff alike to promote the emotional and physical health and wellbeing of our future generation and to avoid/prevent ill health and the need for hospital admission.

2. Options Considered and reasons for rejecting them

2.1. Not applicable at this stage

3. Consultations undertaken

3.1. Not applicable at this stage

4. Implications

4.1. Not applicable at this stage

5. Background papers

5.1. None

Somerset Safeguarding Children Board

Annual Report 2017/18

1. Foreword by the Independent Chair

I am pleased to introduce this annual report for Somerset Safeguarding Children Board covering the year 2017-18. This is a public report which sets out the work of the Board and gives a 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.

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. Some have also faced significant workforce challenges at both leadership and practitioner levels, which at times has had an impact on their ability to maintain consistency and quality of services. 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. This is to be welcomed, and will be of continued interest to the Board in the coming year.

As previously, agencies have continued to work together 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. As understanding increases, so efforts can be made those areas still in need of improvement. This will include, in the coming year, attention being paid to other areas of exploitation which are now becoming more evident, as well as a particular focus on children with disabilities, who can be particularly vulnerable.

The coming year will require key partners –the Council, Avon and Somerset Police and Somerset Clinical Commissioning Group – to review their arrangements for safeguarding children in response to the changed legislative context that has been introduced by the Children and Social Work Act 2017. This gives greater flexibility locally whilst increasing accountability for NHS and police partners alongside the local authority, and is an opportunity to think differently about how best to safeguard children in Somerset. Plans will be published and consulted upon by summer 2019, in readiness for implementation by October 2019.

The children's workforce – professionals, volunteers and others – are the bedrock of safeguarding arrangements, whatever the legislative context. Every day they work to support families and keep children safe. I have been inspired by the dedication and commitment of all those I have met during the course of the year and thank them all for their hard work and dedication.

Sally Halls

2. Executive Summary

This report sets out how Somerset Safeguarding Children Board (SSCB) has worked during 2017/2018 to meet its statutory objectives, which are to co-ordinate local work to safeguard and promote the welfare of children and young people, and to ensure the effectiveness of that work.

Overall, SSCB partners have continued to work together improve their safeguarding arrangements amidst a changing national context for safeguarding, reduced leadership capacity and shrinking resources. The response to challenges within individual agencies has had sometimes had an impact across the partnership, resulting in – at times – challenging conversations between partners and at the Board.

Partners have strengthened their response to children and young people, including providing help and support earlier, but more needs to be done to ensure that service responses are consistent in quality and timeliness, and effective in their impact on the safety and wellbeing of children. Key to this will be listening and responding more systematically to what children and their families are saying works for them.

Midway through the year, Ofsted also reported as follows:

Since the last inspection in 2015, when Somerset children's services were judged as inadequate overall, the local authority has made steady progress in improving the quality of services that children and young people receive. Senior leaders have worked effectively with an improvement partner, and they have created a culture of openness and willingness to learn that supports further improvement.

By way of context, the report gives information about children and families in Somerset which shows that, despite the relative affluence of the county, too many children are living in poverty. It also gives a snapshot of the levels of child protection and other activities aimed at helping families at the right time and promoting the wellbeing of their children.
During the year, SSCB has focused on five priority areas:

1) Early Help
2) Multi-agency Safeguarding
3) Neglect
4) Child Exploitation (CE) / Children Missing
5) Strong Leadership and Strong Partnership

The report gives details about what was done in relation to these, and what impact there has been to date. It also describes and evaluates other aspects of the Board's work, in relation to such activities as the provision of multi-agency training, private fostering, and managing allegations against people in positions of trust.
In relation to **early help**, SSCB has focused on the importance of children and families receiving good quality and timely multi-agency help to keep children safe and promote their wellbeing. Good progress has been made, and there is

a good level of engagement across many partners. However, there is still much to do to achieve a timely, consistent, good quality response to families in need of help, informed by the views of children and families, supported by a clear understanding and application of thresholds for services by professionals, and with demonstrable impact. The Board will continue with its focus on this priority in the forthcoming year.

The partnership closely monitored the effectiveness of **multi-agency work to safeguard children**. While practice has improved significantly, audits and scrutiny of performance has indicated areas where more needs to be done to improve the quality and consistency of partners' contribution to multi-agency plans that safeguard children and reduce risks to their safety and wellbeing.

Neglect was identified as a priority because of the serious impact it can have on the long-term chances for children. Although is commonly occurs in the context of poverty and other aspects of social disadvantage, neglect can affect children in any social context. 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, so understanding its repercussions and the potential for both prevention and intervention is vital. SSCB accordingly wanted to be sure that children who are experiencing or at risk of neglect are identified and safeguarded. Whilst good progress has been made, further work is required to ensure that neglect is promptly and effectively identified, understood and addressed. The publication of a serious case review (SCR) during 2018-19 about the impact of long term neglect on a number of children will provide additional impetus to the Board's continuing focus in this area.

Child exploitation and children missing was SSCB's fourth priority area during the year, with the Board seeking assurance that 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). Since the publication of the SCR 'Fenestra', the Board has worked on improvements aimed at getting the system right for children at risk of or experiencing CSE. Pleasingly, Ofsted reported (January 2018) seeing effective multi-agency action to safeguard children at high risk of CSE, but noted that more needed to be done by the partnership to improve responses to children who go missing.

An important function of LSCBs is to undertake case reviews. SSCB published two serious case reviews (SCRs) in 2017/18. A third was initiated, which will be published later in 2018.

Details of these and other types of reviews undertaken by the Board during the year are included.

The SSCB is responsible for **leading the multi-agency safeguarding agenda** and developing robust arrangements to co-ordinate and ensure the effectiveness of how children and young people are safeguarded in Somerset. It has

continued as a partnership to improve its effectiveness, against a backdrop of reduced capacity across the partnership. Pleasingly, when Ofsted re-inspected the Local Authority's children's services in November 2017, it noted improvements in how children are safeguarded, particularly with regard to child sexual exploitation and the provision of Early Help services, which were judged as becoming more embedded across Somerset.

Looking to the future, as well as continuing work to improve the quality and
effectiveness of multi-agency working to safeguard children, 2018-19 will also see preparations being made to design and implement the new safeguarding arrangements heralded by the Children and Social Work Act 2017. Somerset County Council, Avon and Somerset Police and Somerset Clinical Commissioning Group have responsibility for leading this, working with partners across and beyond Somerset. Details will be reported in the next Annual Report, which will be the final report from SSCB in its current form.

3. About this report

This report sets out how Somerset Safeguarding Children Board SSCB) has worked during 2017/2018 to meet its statutory objectives, which are to co-ordinate local work to safeguard and promote the welfare of children and young people, and to ensure the effectiveness of that work.

The report provides an assessment of the performance and effectiveness of local services. It identifies areas for improvement, and the actions being taken to address them. It also gives detail on the priority areas addressed by the Board during this period, as well as the data and reporting provided by partner agencies regarding their performance in working together to safeguard children and young people in Somerset.

The report includes:

- Lessons learned from reviews undertaken during the year and how SSCB has used the learning to improve practice;
- The financial contribution of each partner agency and how that money is spent;
- The Board's planned priority areas for 2018-19.

The SSCB Annual Report for 2017/18 has been sent to:

- The Leader and Chief Executive of Somerset County Council;
- The Police and Crime Commissioner for Avon and Somerset;
- The Chair of Somerset's Health and Wellbeing Board;
- The Chair of the Safer Somerset Partnership.

4. Children in Somerset

In Somerset there are an estimated 109,657 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 *(ONS 2016 mid-year population estimates).*

4.1 Levels of Poverty

Somerset remains a relatively affluent county and experiences lower overall levels of deprivation than both the South West and national averages. In 2015, it was considered that 12,150 children aged under 16 were living in poverty, equating to 13.1% of all children. This was the lowest proportion experienced in the previous decade. The national average for England was 16.8%. (Children in Low-Income Families Local Measure, HMRC).

10.6% of primary school children, 8.9% of secondary school children and 10.1% of middle school children are in receipt of free school meals (School census, January 2017).

However, this masks significant variations between geographical areas.

The Somerset Joint Strategic Needs Assessment (JSNA) 2015-16 gives the following information

19 Somerset neighbourhoods (LSOAs) are classified as being within the **20%** most deprived in England (IDACI). All are in urban areas. Sedgemoor accounts for nearly half of areas (9), followed by South Somerset and Taunton Deane (4 each), and Mendip (2).

- 10 Somerset LSOAs are classified within the **10%** most deprived in England.
- 6 Somerset LSOAs are classified within the **5%** most deprived in England.
- The most deprived area is in Bridgwater Sydenham, in which >50% of children live in income deprived families.
- Young people in poor households show a strong concentration in urban housing estates: 50% of income-deprived children live in 5% of the county's geographical area and 10% live in less than 0.1% of the area, all within Taunton, Bridgwater and Yeovil.

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 the lowest out of 324 local authorities for social mobility.

Somerset Safeguarding Snapshot 2017-18

Early Help	1,420 open early help assessments (EHA) as at 31/3/18 – this is 27% lower than last year and reflects a policy of not keeping EHAs open for more than one year. 1,955 referrals EHA's to the Early Help hub. 829 Team Around the Child (TAC) meetings were held during the academic year, a notable increase from 92 in 2016/17, demonstrating increasing confidence in multi-agency Early Help approaches.
Contact and referral information	26,457 contacts to Somerset Direct 5,355 referrals made to Children's Social Care (CSC) 5,561 C&F assessments started in 2017/18, of which 3,344 were completed within the timescales set. 5,585 statutory child and family (C&F) social work assessments completed 1,762 CIN cases open as at end of March 2018.
Child protection	37.7 per 10,000 children were subject of child protection plans compared to 43.3 per 10,000 for England and 37.4 for statistical neighbours 428 children from 237 families were subject of child protection plans at 31st March 2018 Over 80% of child protection plans ended within 12 months 1.6% of child protection plans ended after more than two years
Children looked after	43.8 per 10,000 children were looked after during the year (average) 516 children were looked after on 31st March 2018, an increase of 37 over the figure at the end of March 2017 31 children secured permanence as a result of adoption (compared with 34 in the previous year) 25 children left care under Special Guardianship orders (30 in the previous year) 229 children looked after by other local authorities were placed in Somerset at 31st March 2018 (199 in 2017) 52 residential providers were operating in Somerset, comprising 38 children's homes and 14 other residential settings.

Child exploitation	65 children identified as being at risk of CSE (with CSE banner) as at 31/3/18 (almost 50% higher than last year). There were 446 reports of a child going missing from a foster or residential placement during the year. 466 reports of a child going missing from their own family. 743 Return Home Interviews were conducted - an increase of 275 reviews conducted in previous reporting year.
Children with additional needs	9,389 children were in receipt of SEN Support as at 31/3/2018, which was 13% less than last year. 1,805 children were in receipt of Education Health and Care Plans [EHCP] as at 31/3/2018, with 33 children with a Statement of Special Educational Needs (SEN) as at 31/3/2018. *(SEND Code of Practice required all Statements of Special Education Needs to be converted to EHCP. At that time SCC held 1,072 Statements of SEN (January 2014 figure). This figure increased slightly from 2014 – 2018 with move-ins from other LAs. The DFE deadline for conversions from Statements to EHCPs was March 2018. The majority of Statements were converted during 2017 – 2018 in order that SCC met the DFE deadline.)*
Domestic abuse	665 MARAC domestic abuse cases discussed * 891 children were associated with these cases* 25% repeat domestic abuse cases discussed at MARAC* * *Data for 2017/18 data was not available at the time of publishing, therefore this data is from January to December 2017*
Allegations against staff working with children	487 notifications of allegations of abuse made against staff working with children in 2017/18, compared to 478 in 2016/17.
Private fostering	Thirteen private fostering notifications were made in 2017/18 with 6 private fostering arrangements in place as of March 2018.

5. About SSCB

The Somerset Safeguarding Children Board (SSCB) 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. SSCB draws its membership from a range of local and regional organisations. It is funded by a small number of key partners (see Appendix A for information about partner contributions and budget).

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

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. Leadership within the health and education/ schools sectors is provided through the Health Advisory Group and the Education Safeguarding Group respectively.

The SSCB structure, membership and various subgroups are detailed in Appendix B.
More information about safeguarding in education is detailed in Appendix C.

The SSCB Constitution (https://sscb.safeguardingsomerset.org.uk/wp-content/uploads/SSCB-Constitution-updated-December-2016.pdf) sets out how the partnership works, its governance arrangements, and the roles and requirements of its members.

The Working Together Protocol for Strategic Partnership Boards in Somerset (https://sscb.safeguardingsomerset.org.uk/wp-content/uploads/2016/02/Working-Together-Partnership-Protocol-2016-17.pdf) sets out how SSCB works with and relates to a number of other partnerships in Somerset, which focus on children in care, adults in need of safeguarding, community safety, and health and wellbeing.

5.1 The SSCB Independent Chair

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 and is accountable to the Chief Executive of Somerset County Council (SCC). She meets regularly with the County Council's Cabinet Member for Children's Services and Director of Children's Services and with senior leaders from partner agencies. She also attends and contributes to the regular performance review meetings held with the Department for Education and the Council's Improvement Partner, Essex County Council. The Independent Chair also conducts meets annually with all partnership members to discuss the performance and contribution of their agency to safeguarding children.

5.2 The SSCB Business Unit

SSCB is supported by the Safeguarding Business Unit, which comprises three full time staff (Business Manager, Senior Business Unit Officer, Training Manager) and three part-time staff (Training Administrator, Child Death Overview Panel Administrator and Quality Assurance and Audit Officer. The Business Unit was also supported during the year by part time resource for Service Improvement from Children's Social Care.

5.3 SSCB membership and attendance 2017/18

The SSCB met four times in 2017/18. Board attendance suffered a notable decline from 82% in 2016/17 to 71.05% in the reporting year. Partner attendance was challenged during the latter part of the year. The attendance rates by agency are set out in appendix D.

5.4 Community members

The Board benefits from two long-standing community members who play a significant role in providing a community perspective to inform the Board's activities. They regularly attend task and finish groups as well as a number of subgroups including Child Exploitation, Training and Development and Quality and Performance, and provide invaluable insight and consistent challenge to the Board. The community members also regularly presented the 'child's voices' and have helped to establish a meetings culture which puts children and young people's experience at the heart of Board discussion and decision making.

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

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. It uses a range of methods to do this. Key elements include:

- Scrutiny of data and performance information
- Multi-agency audits of frontline case work
- Case reviews
- Section 11 audit (comprising self-assessment and peer challenge by Board partners)
- Section 175/157 audit (of education settings)
- Assurance reporting
- Monitoring risks and issues (through the risk register and challenge log)
- Capturing feedback from children and users of services
- Engagement with practitioners through 'safeguarding conversations' about cases
- Inspection reports

Appendix E gives more information about s11 and s175/57; Appendix F gives more information about the multi-agency audit programme.

Based upon information from these activities, together with consideration of other information such as:

- findings from inspections and through quality and performance reviews;
- national and local priorities;

- issues emerging from practice, identified by those working with children;
- issues raised by Somerset children, young people.

SSCB partners identified a number of areas that it wished to prioritise in order to improve the effectiveness of Somerset's safeguarding arrangements. The priorities were agreed as follows:

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

Priority 2 - Multi-agency Safeguarding: *Children are safeguarded through multi-agency partnership working.*

Priority 3 - Neglect: *Children who are experiencing or at risk of neglect are identified and safeguarded*

Priority 4 - Child Exploitation (CE) / Children Missing: *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).*

Priority 5 - Strong Leadership and Strong Partnership: *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.*

These were set out in the Board's business plan for 2017-19 which can be found on the SSCB website: https://sscb.safeguardingsomerset.org.uk/wp-content/uploads/Somerset-Safeguarding-Children-Board-Business-Plan-2017-2019.pdf .

These in turn informed the Board's programme of multi-agency audits, details of which are given in Appendix F.

6.Progress against SSCB Priorities in 2017/18

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

What we said we'd do

During 2017-18, the Board wanted to 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.

What we did:

- **Refreshed** the Early Help Effective Support document;
- **Developed** an Early Help scorecard to tell us the number of EHA contacts by source, those EHAs open/closed with getset services, the number of contacts to getset by area, the number of EHA episodes resulting in no further action (NFAs), escalation, repeat referrals, cases closed with needs met/ or most needs met, or those escalated to CSC;
- **Promoted** the consultation line to practitioners;
- **Conducted** a multi-agency audit of Early Help application at tier 2 (Child Sam audit);
- **Commissioned** an assurance report about the delivery and effectiveness of Early Help.

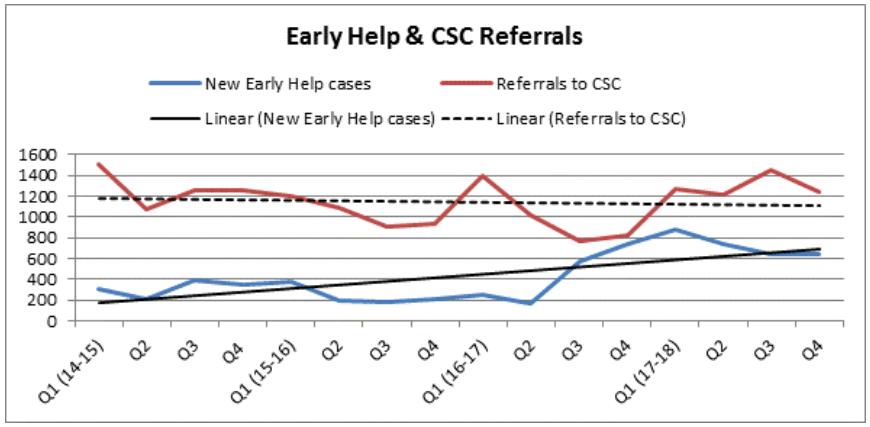
What we are pleased about

- The **Professional Choices** one-stop-shop website for all Early Help professionals continued to embed well, with uptake that grew rapidly across the year:
    - Registered users increased by 50% from 1,571 in April 2017 to 2,357 at the end of March 2018.
    - Entries in the 'Who's who' directory of professionals increased to 1,441 at the end of March 2018.
    - The Early Help Assessment (EHA) form was downloaded 16,171 times in the year ending 31 March 2018, compared with 7,418 at the end of March 2017.

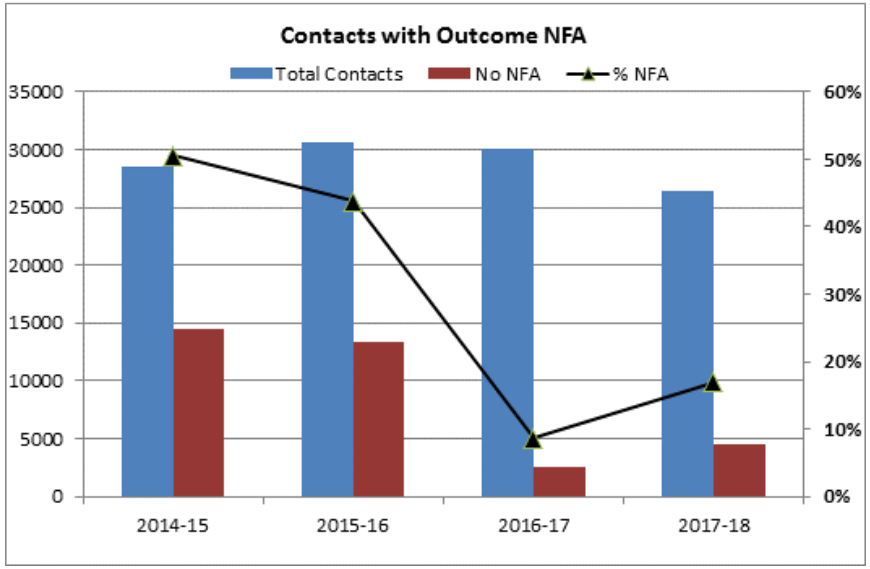
- The multi-agency audit highlighted some **positive practice;**
- 2017 saw a **sharp rise** in the use of EHAs, linked with conversion rates that went on to become referrals, which generally demonstrated improved understanding of thresholds;
- Across the year there was **positive use of the consultation line**, mainly by schools;
- Some partners conducted a **single agency workforce survey** of Early Help application at Level 2 (to baseline knowledge and confidence of the workforce);
- **Team around the School** (TAS) multi-agency meetings were put in place across the year, with some evidence of effective partnership delivery of Early Help;
- **One teams** are beginning to develop in consistency of approach;
- Progress is being made with **integration** of the new Family Support Service, (Public Health nursing) with the getset, Early Help and Children's services.

What we are concerned about

- **Early Help and referrals:** There was a decreasing trend in new Early Help referrals in Q3 and Q4 of the reporting year, coupled with a significant increase in referrals to Children's Social Care (CSC) in comparison to the same time the previous year. It is possible that the Ofsted inspection in Q3 and some local workforce issues with reduction in Early Help services resource may have impacted at that particular phase in the reporting year.

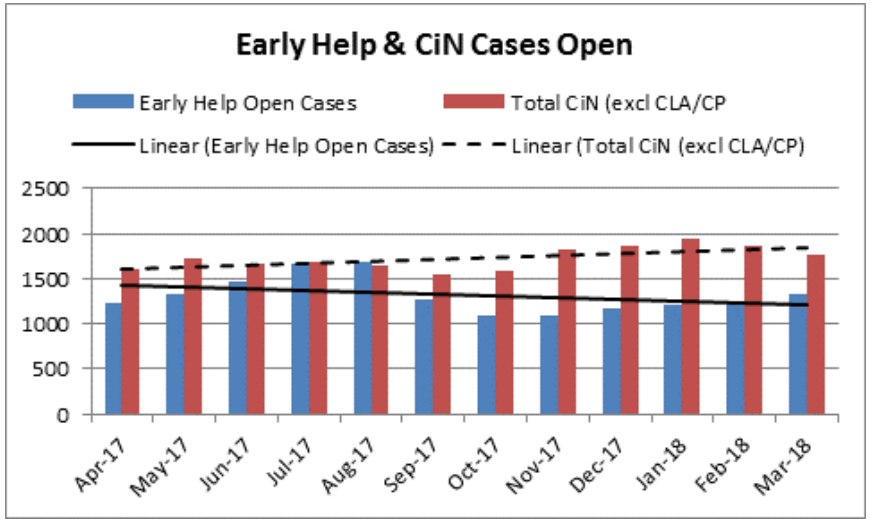


- A rise in the percentage of **re-referrals** to Children's Social Care over Q3 and Q4 following a period of stability.
- **Lack of impact** - over 50% of cases with EHAs with 'needs not reduced at closure', could explain why re-referrals to CSC peaked in 2017/18.
- A significant **data gap** has emerged regarding the Early Help Advice Hub, which helps reinforced the EH process by providing advice, logging assessments and triaging EHAs. However, only cases assigned to getset were being recorded, which means that similar activity across services is not recorded.
- **Missed opportunities** to identify risk and a variable understanding of thresholds was evident in the findings of a SSCB multi-agency audit in Q3 (see appendix F); the assurance report considered by the Board similarly highlighted issues with the 'conversion' of contacts to referrals, the number of redirected referrals to getset, the potential that a number of referrals were made without consent, which also suggested that thresholds were not sufficiently understood.
- **The percentage of contacts to Somerset Direct with outcomes as no further action (NFA):** these almost doubled in comparison to the previous reporting year, giving further evidence of the instability and variability in use of Early Help.



Year	Total Contacts	No NFA	% NFA
2014-15	28,540	14,428	50.6%
2015-16	30,649	13,412	43.8%
2016-17	30,103	2,616	8.7%
2017-18	26,457	4,474	16.9%

- Data on **Early Help and Level 3 children in need** (CIN) suggests a need for the partnership to work towards greater consistency and more common understanding of the thresholds for social care intervention at levels 3 and 4.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Early Help Open Cases	1224	1319	1466	1656	1688	1278	1099	1093	1174	1213	1247	1320
Total CiN (excl CLA/CP	1605	1728	1666	1681	1648	1552	1580	1817	1854	1934	1865	1760

- The SSCB multi-agency audit highlighted some practice gaps including:
  - **confusion** around use EHA as a holistic multi-agency tool and referral for Level 3/4 services
  - **negative perception** of the Lead Professional role (as overly time consuming)
  - **lack of professional curiosity** in casework

- GPs and Midwifery/Health Visiting sometimes **working in isolation** to one another
- **lack of awareness** and use of Pre-Birth Guidance.

- **Identification of SEND** issues, at the Early Help stage, needs to be strengthened;
- Concern around the number of referrals going to assessment teams suggested that **thresholds for intervention** by CSC may be too low.

Ofsted (2018) found a similarly mixed picture, concluding that "*Early help services in Somerset have improved, yet are not fully established across the partnership*" and that the 'Effective Support for Children and Families in Somerset' (thresholds guidance) has embedded well but requires further integration with partners to increase capacity of Early Help across the partnership.

What we will do next

SSCB has decided to keep 'early help' as a priority area of focus in 2018-19. Attention will shift from developing and assessing process to evaluating impact on outcomes for families through:

- **evaluating the consistency and effectiveness** of partners' delivery of their Early Help responsibilities;
- **assessing the impact** of the Effective Support Guidance and the threshold decisions on children and young people's outcomes (including use of the EHA, 'step up' and 'step down' arrangements and Resolving Professional Differences);
- **understanding the views of children and parents/carers** who receive early help support and services;
- **seeking assurance** that Early Help arrangements are embedding and are effective.

Further information about the EHSCB can be found at **appendix H.**

Priority 2: Multi-agency safeguarding
Children are safeguarded through effective multi-agency working

What we said we'd do

During 2017/18 SSCB wanted to 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 **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.

What we did

- **Developed and regularly scrutinised a 'priority 2' scorecard** comprising key performance information;
- **Reviewed multi-agency child protection case examples** against themes from audit and learning reviews to inform learning and where improvements needed to be made;
- **Undertook 'safeguarding conversations'** with practitioners regarding cases which had had successful outcomes.

What we found

At the end of March 2018, in Somerset, 238 children from 237 families were subject of a child protection plan. The categories of abuse that the plans related to were as follow:

Categories of abuse for CP Plans at 31st March 2016, 2017 and 2018

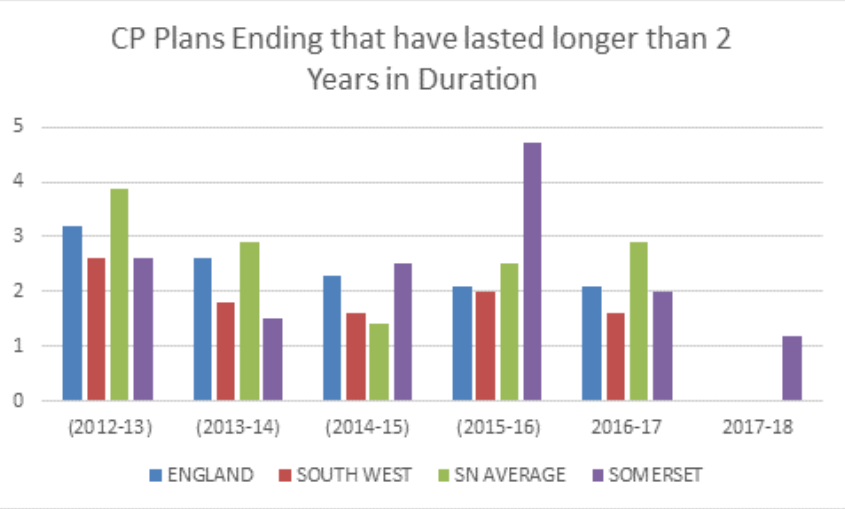
Type of abuse	No. at 31/3/18	% at 31/3/18	% at 31/3/17	% at 31/3/16
Emotional abuse	181	41.6	21.5	31.2
Neglect	224	51.5	69.7	57.7
Physical abuse	11	2.5	1.7	4.7
Sexual abuse	16	3.7	1.4	0.4
Multiple factors	3	0.7	5.6	6.1

This table shows an increase over the past 3 years in the percentage of plans for emotional abuse. Some fluctuation in percentage of rates has occurred historically. The figures for

the reporting year show a reduced percentage of cases categorised as neglect. This may be the result of work with child protection chairs and multi-agency partners around the use of the category of emotional abuse rather than neglect in cases where the primary concern is domestic violence and other presenting issues are not at a level that would otherwise have met the threshold for child protection. This will need continued monitoring.

What we are pleased about

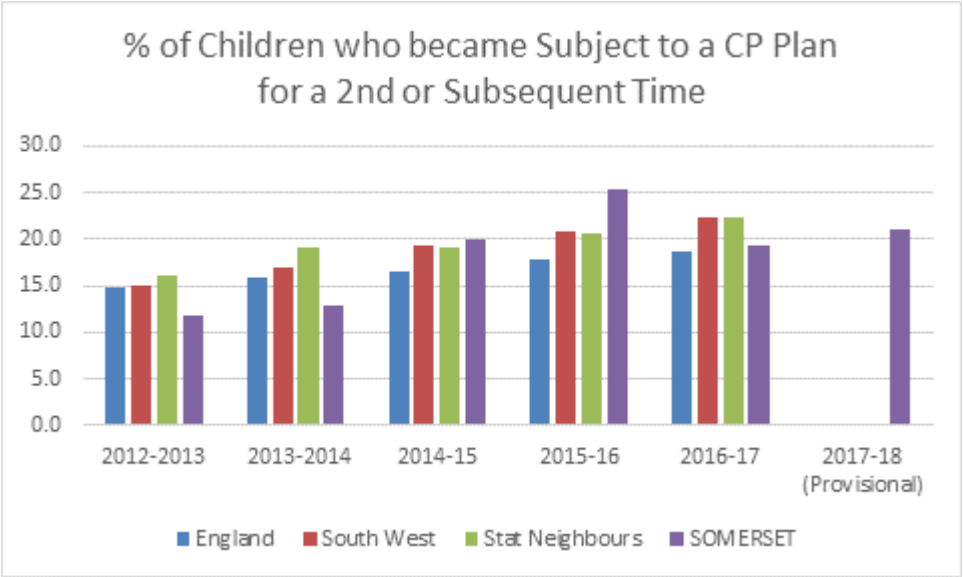
- The proportion of long term CP plans has steadily continued to reduce across the year.
- Safeguarding conversations - The Board reviewed three multi-agency practice examples of CP/CIN cases. These highlighted evidence of positive multi-agency practice and a number of learning themes for the Board including:
    - the need to improve the multi-agency system for communication to relevant partners of significant events in a child's life;
    - the availability of accessible low level primary mental health services;
    - consistent application of the resolving professional differences; practitioners understanding each other's roles.
- S11 peer challenge QA workshops and S175/157 schools audits were well received and arrangements for the QA of schools' self-assessments made good progress across the year.
- **A reduction in the duration of child protection plans** to 1.2%; this was a further reduction from 2% in the previous reporting year and the 2016/17 national average of 3.4%.



	(2012-13)	(2013-14)	(2014-15)	(2015-16)	2016-17	2017-18
ENGLAND	3.2	2.6	2.3	2.1	2.1	
SOUTH WEST	2.6	1.8	1.6	2	1.6	
SN AVERAGE	3.9	2.9	1.4	2.5	2.9	
SOMERSET	2.6	1.5	2.5	4.7	2	1.2

What we are concerned about

- The **quality of multi-agency input** at child protection meetings. These included a lack of focus on risk reduction, agency attendance at RCPCs and strategy meetings and the need to improve aspects of S47 investigations. Challenge by CP chairs was also noted by Ofsted as an area for improvement, together with access to advocacy services.
- Quality of '**strategy discussions'** including action planning, interim safety plans, contingency planning also attendance by relevant agencies, dissemination of records, and the need to embed police guidance.
- The **unavailability of police officers** to conduct joint investigations, meaning that children had to repeat their story.
- The **needs of children kept overnight** in police custody are not effectively ascertained.
- The number **of children subject of a child protection (CP) plan** increased slightly across the year; and the percentage of children who are subject of a CP plan for a second or subsequent time increased notably in Q2, although reduced to a more stable position by the end of Q4. Whilst still below the 21.9% held by statistical neighbouring authorities, the national average of 18.7% indicates a concerning performance trend, possibly reflecting the variable understanding of thresholds for intervention which is evidenced in performance data across the year.



	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-18 (Provisional)
England	**14.9**	**15.8**	16.6	17.9	18.7	
South West	**15.1**	**17.0**	19.4	20.9	22.4	
Stat Neighbours	**16.0**	**19.0**	19.1	20.7	22.3	
SOMERSET	**11.8**	12.9	19.9	25.3	19.3	21.1

Under this priority the Board also undertook to review children in specific circumstances including:

- Unaccompanied asylum-seeking children: the SSCB now receives six-monthly reports on progress;

- Children impacted by domestic abuse: the SSCB scrutinised the domestic abuse Board annual report;
- Planning for children in emergency situations following the Grenfell tower disaster: The SSCB commissioned a baseline report from civil contingencies which will be delivered in Q2 2018/19.

What we will do next

SSCB will keep 'multi-agency safeguarding' as a priority area of focus in 2018-19 and will evaluate the effectiveness and impact of safeguarding arrangements in Somerset by:

- **scrutinising** data and **monitoring** the quality of agency engagement and compliance with statutory child protection (CP) procedures and local guidance (effective support and resolving professional differences)
- **assessing** impact of the partnership's work with children with additional needs and assure ourselves that the system performs effectively on their behalf
- **engaging with practitioners** through audit, safeguarding conversations and other means.
- **strengthening learning** from both Adults and Children Board reviews
- **assessing impact** of Think Family approaches to safeguarding vulnerable children
- **understanding the views of children and parents/carers** who experience Somerset's CP processes

The SSCB will also seek assurance that:

- there is effective oversight and needs assessment of children kept overnight in police stations;
- housing partners are sufficiently aware of and respond effectively to issues for vulnerable families;
- actions are taken to improve joint enquiries and joint investigations between Police and Children's Social Care.

The Board is also interested to assure itself that children with additional needs are being safeguarded, and will be seeking information about this in the coming year.

Priority 3: Neglect

Children who are experiencing or at risk of neglect are identified and safeguarded

What we said we'd do

During 2017-2018 we wanted to 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.

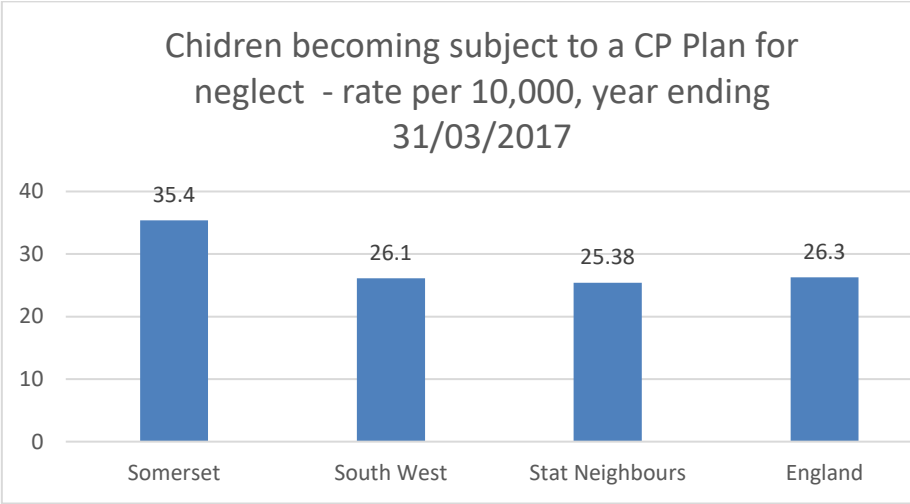
What we did

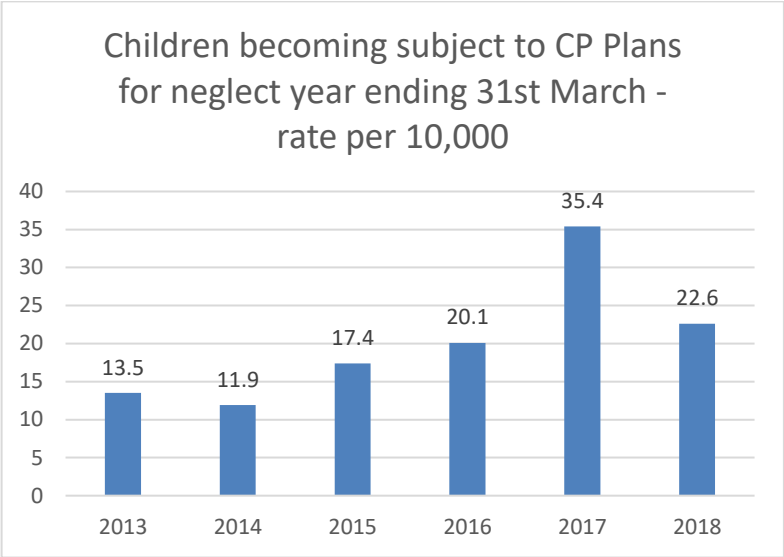
- Developed a **performance scorecard** comprising key performance information;
- Developed and implemented a **multi-agency neglect strategy and action plan;**
- Developed and piloted **guidance for practitioners**;
- Delivered a multi-agency **practitioner conference on neglect**;
- Carried out a **multi-agency audit** in Q1 (see appendix F) of a sample of cases of children subject of child protection plans under the category of neglect;
- Commissioned a learning review into a case of long term neglect which led to a Serious Case Review; learning will be published later in 2018.

What we found

Neglect is the most common reason for children to become the subject of a Child Protection Plan. On 31st March 2018, a total of 224 children were the subject of Child Protection Plans with the category of neglect. This represented 51.5% of all children on Child Protection Plans.

At the end of 2017, the Somerset rate per 10,000 children becoming subject to Child Protection Plans for neglect was higher that the rates for the South West, our statistical neighbours and for England.





However, this figure appears to have been anomalous, and may have been related to categorisation issues, as the rate per 10,000 for the year ending 31st March 2018 fell to 22.6. Nonetheless there has been an increasing trend over the past five years as shown in the table below.

Despite the high level of child protection plans in relation to neglect, the percentage of early help assessments with neglect identified as a factor was low at 5.9%.

What we are pleased about

- The task and finish group working on the neglect strategy and associated activities has had significant support from across agencies;
- The **practitioner conference** was very well received by the 120+ practitioners who attended. The conference increased awareness of neglect and its impact on children and helped pilot the toolkit;
- The practitioner guidance and toolkit has been well received.

What we are concerned about

- The multi-agency audit found that concerns about neglect were initially reported at a higher level than early help; there was little evidence of Team around the Child (TAC) meetings being used and there were issues of consistency in the identification and categorisation of neglect. Learning points from the audit included the need for:
    - CP chairs to provide consistent advice to conferences about categorisation of neglect
    - further practitioner training and guidance on impact of neglect
    - advocacy to be routinely offered to children in CP conferences
    - plans and reports to be appropriately shared with families in advance of meetings.
- Identification of neglect is not happening early enough. The differentiation in the % of open EHAs with neglect identified as a factor (5.9%) compared with EHAs with one or more hidden harm factors (59.4%) and the increase in children becoming subject of a repeat CP plan due to neglect indicates that further work is required on how effectively neglect is identified, understood and addressed;
- Ofsted found that some children experiencing neglect waited too long before action was taken to improve their circumstances and child protection conferences were timely but did not always address delay for children who had experienced long term neglect.

What we will do next

During 2018-19 SSCB will continue to raise the profile of and tackle neglect by:

- **Improving** practitioners' knowledge and skill base in responding to neglect, the issues surrounding it and practical approaches for dealing with it;
- **Promoting and embedding** the multi-agency neglect strategy, practitioner guidance and the Somerset neglect action plan and assuring ourselves of its impact in improving children's lives;
- **Assessing the effectiveness** of current practice, including early identification and intervention in response to neglect, based on understanding gained from SCR and other reviews;
- **Understanding children's lived experience** of neglect in order to improve practice;
- **Sharing learning** from reviews and practice audits.

Board partners will also contribute to and share learning from the local authority peer review (2018/19) on neglect, which will take place in summer 2018; also share and promote the findings of the serious case review.

Priority 4: Child Exploitation (CE) / Children Missing

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).

What we said we'd do

During 2017-2018 we aimed to 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

What we did

- Significant **awareness raising** about child exploitation and particularly sexual exploitation, including:
  - Twitter and Facebook campaigns;
  - the learning bulletin (TUSK);
  - through delivery of targeted training;
  - the development of the CE champions role;
  - Police communications unit led CSE national events which generated practitioner and public engagement in Q4;
  - District councils led work with awareness raising training with taxi drivers and others in the night time economy;
- **Published the 'Fenestra' SCR** into CSE and achieved positive support from local radio to highlight the risks to young people associated with the lack of regulation of tattoo parlours;
- **Shared learning** across the county through a series of four multi-agency roadshows attended by 120 practitioners. The roadshows built upon the two multi-agency practitioner conferences in 2016/17, attended by 183 practitioners, where emerging learning from Fenestra was shared;
- **Briefed partners** about the emerging risks associated with 'county lines' activity in Somerset,
- Progressed work **on harmful sexual behaviour** and peer abuse by children, in response to an increase in concerns. New practice guidance is anticipated in 2018/19;
- **Commissioned an audit** of a small sample of children identified as being at risk of or experiencing child sexual exploitation

- Developed a **multi-agency performance dataset** for child exploitation.
- Held a multi-agency workshop to develop the **CSE strategy and action plans**
- Held further multi-disciplinary workshops to develop a CSE pathway and revise the assessment and screening tools
- Wrote to the Minister about the lack of regulation of **tattoo parlours and piercing studios** and national arrangements which do not adequately address safeguarding risks for children.

What we are pleased about

- **Leadership**: a Board member now chairs the CE subgroup
- **Improved awareness and understanding** of CSE and CE through communications activity and practitioner events
- To **increase capacity and improve** the identification of and response to CSE, Avon and Somerset Police has confirmed plans to roll out 'Operation 'Topaz' across Somerset in 2018/19
- Ofsted found evidence of **effective multi-agency actions** to safeguard children at high risk of sexual exploitation
- **Additional time limited capacity** was allocated by Somerset County Council which provided additional capacity to provide leadership across the partnership, and following a systems review resulted in a revised strategy and action plan, and the revision of pathways, strategy and assessment and screening tools;
- The **multi-agency strategic action plan** was developed following publication of the SCR 'Fenestra' findings.

What we are worried about

- **Leadership resource and capacity** to accelerate progress with this priority remains a concern for the SSCB. A bid for additional resource to the Home Office Trusted Relationships Fund was unsuccessful This challenge will need to be resolved in 2018/19
- Audit found that some **plans were not effective** in reducing risks, and there was a need to ensure links were made across the various child planning processes e.g. child protection planning, planning for child in need and children looked after (see appendix F).
- Ofsted reported that they found **responses to children who go missing are variable**. Use of tools to inform safety planning, trend and risk analysis was a key area for development, including return home interviews (RHIs) and how the data they capture are used. Ofsted also cited that the strategic response to children who go missing from home or care and those at risk of child sexual exploitation, needs to be accelerated.
- The Fenestra SCR found that **further work** was needed to ensure practitioners understood national policy around adolescent sexual activity to differentiate

between ‘inappropriate relationships’ and permitted consensual activity; the need to:

- address the tendency to focus on short term interventions with families
- improvement with multi-agency response to supporting children with their emotional health needs
- reinforced multi-agency collaboration
- safeguarding arrangements and education around CSE within tattoo parlours.

- There are **issues with data integrity** and the dataset does not yet give a clear overview of child exploitation in Somerset.

What we will do next

SSCB will work with partners to:

- **strengthen leadership** across the partnership and seek assurances that children vulnerable to exploitation receive an effective response to protect them
- **seek assurance** that the quality of response to children who go missing is consistently good
- **assess the impact** of the strategy and action plans for responding to child exploitation
- **evaluate the effectiveness** of partners’ arrangements for identifying, assessing and tackling child exploitation, (including training and use of the Champion role)
- **understand** the views and experiences of children and families vulnerable to / experiencing exploitation, particularly those with multiple vulnerabilities, such as home educated children

Activities will include:

- improving the collection and quality of data;
- improving the quality of return home interviews so they inform planning for children and help to reduce risk.

Priority 5: Strong Leadership and Strong Partnership

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

What we said we'd do

During 2017-2018 we aimed to achieve strong leadership and strong partnership 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 the 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.

What we did

The SSCB Business Plan 17-19 states that the SSCB commits to an approach that keeps safeguarding and the welfare needs of children and young people as central to its core business, and that lessons are learnt, and good practice is embedded. The Board operates a constructive challenge and assurance function for both Board partner's members and external organisations. There are sound governance and leadership arrangements in place, Board meetings are well attended and increasingly challenging. Preparations for new safeguarding arrangements are at an early stage.

- **Published two SCRs** and received regular progress reports on progress of multi-agency action plans and outcomes achieved
- **Cascaded learning** through practitioner learning events and roadshows, agencies' own training and briefing sessions, newsletters, monthly bulletins and 'Working Together' training. A third SCR focusing upon neglect was initiated in Q2 which will report in Q3 2018/19

What we are pleased about

- Having established '**Safeguarding Conversations'** as a positive method of engaging with practitioners and learning from successful multi-agency safeguarding practice
- Good levels of **involvement and attendance** by agencies across the majority of work streams

- Two of the three NHS providers are developing **joint safeguarding arrangements,** enabling improved consistency and engagement
- Ofsted found that **partnership working is improving**, with clear senior commitment to addressing issues which affect children
- The **Resolving Professional Differences Protocol** was widely promoted, and challenges were noted as being more appropriate by the end of the year
- Practitioners have systematically received important **guidance and learning** through use of social media, improved website and the implementation of incrementally increasing downloads of monthly learning (TUSK) bulletins and quarterly newsletters
- A broad range of data about the **child's voice** is now available to the Board
- There was **strong engagement** from across the partnership in the Section 11 peer QA workshops which was welcomed by partners.

What we are concerned about

- Some partners experienced particular **resource and capacity challenges** which impacted upon progress of SCRs
- Changing **leadership arrangements** affected responsive engagement with some SSCB activity and particularly priority 4 (CSE)
- **Attendance** by relevant staff at some multi-agency training events impacted upon 'Working Together' practice development across the partnership
- There have been particular challenges in **progressing the CE champion's role** across the partnership due to inconsistent and insufficient multi-agency engagement throughout the year
- **Reduced support to CDOP** from the CCG
- **Thresholds for intervention** at level 4 (CSC) remain a consistent theme for agency challenge.
- The time taken to meet the emotional health needs of children looked after
- Delays in police investigations.

Ofsted found similarly, reporting that partnership working is not yet consistent.

What we will do next

Whilst no longer a priority for SSCB in 2018/19, partners will be working together to develop new multi-agency arrangements for safeguarding for Somerset, following the Children and Social Work Act 2017 and the publication of the revised statutory guidance, *Working Together to Safeguard Children* (2018).

7.Case Reviews

An important function of LSCBs is to undertake reviews. Working Together (2015) states that:

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

The different types of review include:

- Serious case reviews
- Child death reviews
- A review of a child protection incident which falls below the threshold for an SCR (in Somerset, these are called learning reviews;
- Thematic reviews, and
- Review or audit of practice in one or more agencies

7.1 Serious Case Reviews

A serious case review (SCR) is undertaken for every case where abuse or neglect is known or suspected and either a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

SSCB published two SCRs in 2017/18. A third was initiated, which will be published later in 2018.

1) SCR 'Fenestra'

This SCR focuses upon the exploitation and sexual abuse of the two child victims, Child C and Child Q. The review also recognises learning from the experiences of the other seven young women who were identified during Operation Fenestra, who were also sexually abused by the perpetrators when they were children. Whilst no child died as a result of the abuse they suffered, they have nevertheless been severely affected by what has happened to them.

SSCB was extremely grateful for the consent of three of the young women and the parents of one to help us with this review, to contribute their thoughts and reflections, and help us fully understand what happened in order that we might be better informed in preventing such exploitation in the future. A number of other young people, some victims themselves of exploitation and abuse by others, also contributed valuable insights.

The scope of the serious case review aimed to identify the strengths and gaps in multi-agency responses to child sexual exploitation (CSE). The 'inappropriate relationship' model of CSE was the focus of this case and should provide additional learning to previous high profile CSE case reviews.

This model is defined as:

'Usually involving one perpetrator who has inappropriate power or control over a young person (physical, emotional or financial). One indicator may be a significant age gap. The young person may believe they are in a loving relationship'.
(*Puppet on a string: The urgent need to cut children free from sexual exploitation*
Barnardo's, 2011).

This particular model of abuse is distinct from the models described in other high profile serious case reviews, which have focused on victims either being coerced into having sexual relationships with the boyfriend's associates (known as the 'boyfriend' model) or where they may be forced/ coerced into sexual activity with multiple men (known as organised/networked sexual exploitation or trafficking).

What we learned

There were eight key findings:
1. There can be difficulty distinguishing between informed consent for adolescent sexual activity and coercion/inappropriate relationships - because of difficulties reconciling national guidance and the law relating to sexual activity.
2. There is a tendency to focus on short-term intervention for perceived parenting deficits, without taking time to hear parents' worries about risks outside the family.
3. The need for CSE investigations to be able to develop consistent relationships with alleged victims over a long period.
4. Linking information within and between agencies is integral to protecting children from harm – improvements have been made but there is scope for further development.
5. Children who are at risk of, or who have experienced CSE need accessible, timely and skilled support for their emotional and mental health problems.
6. There is a need for early multi-agency collaboration and consistent, persistent relationship-based intervention.
7. Current arrangements in relation to piercing and tattoo salons do not adequately address safeguarding risks.
8. The practice of some primary care medical services (as advised by medical indemnity insurers) is contrary to statutory requirements in relation to their involvement in serious case reviews; this risks undermining the ability to learn lessons and improve safeguarding of children in the future.

What we did

The Board considered the findings carefully, and developed a multi-agency action plan in response. A number of agencies also developed their own action plans. These are monitored by the SSCB Child Exploitation subgroup with oversight from the Learning and Improvement subgroup. A number of roadshows took place across the county to share the learning from the review; the findings in the report have been incorporated into training for designated safeguarding leads.

What has changed?

The SSCB has noted significant improvements in the way partners have responded to children at risk of sexual exploitation, whilst acknowledging that further work is needed

to safeguard children at risk from or experiencing this type of abuse. This continues to be progressed through the work of individual agencies and also the Board's Child Exploitation subgroup.

The SCR Fenestra and the SSCB response can be found on the SSCB website.

2) SCR 'Child Sam'

The SSCB published the full report of the SCR Child Sam in September 2017.

Child Sam was a very young infant who 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 him with significant brain damage and life-long impairments. Child Sam's stepfather was subsequently convicted of grievous bodily harm and received a custodial sentence.

What we learned

Findings related to effective pre-birth planning, the need to understand the significance of family history, the identification of risk and vulnerability in families where domestic violence is a feature and the importance of sharing information and working together to provide children and young people with the help they need.

The review made several recommendations relating to:

1. Use of the pre-birth protocol;
2. Identification of and response to the risks and responsibilities within families;
3. Training for health services staff regarding measuring, recording and plotting growth measurements for infants, and the presenting signs and symptom of brain injury in young babies;
4. The need for full and formal recorded handover arrangements where there are unavoidable changes in staff;
5. Understanding and application of 'thresholds' for intervention at level 2;
6. Identifying and assessing risks within the wider family context and sharing the information within and across agencies appropriately.

What we did

Learning from the review has been cascaded through the TUSK learning bulletin and covered in training for designated safeguarding leads. A multi-agency action plan in response to the recommendations made by the review team was developed and implemented, alongside action plans within individual agencies.

What has changed?

Practitioner guidance including a 'pre-birth toolkit' has been developed; improvements have been made in how agencies identify, assess and respond to the risks and vulnerabilities within families where domestic abuse is a concern.

The full SCR can be found on the SSCB website.

SCR 'Neglect'

In the summer of 2017 a learning review was commissioned to consider the case of children who had experienced neglect over a period of years. During the course of the review, information was shared that indicated that the criteria for a serious case review had been met. The resulting SCR will be published in 2018/19.

Emerging themes include recognising and taking effective action to tackle neglect, agency engagement with CP/CIN processes, understanding and application of Early Help and the lead professional role, understanding the impact of adolescent neglect, recognising the additional vulnerabilities of disabled children, record keeping, leadership and oversight, supervision and quality assurance of practice.

7.2 Child Death Reviews

The SSCB is responsible for ensuring that a review of each death of a child normally resident in the SSCB's area is undertaken by a multi-agency Child Death Overview Panel (CDOP). The CDOP has a fixed core membership drawn from organisations represented on the SSCB, with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. Through the year, Somerset's CDOP was chaired by a Consultant in Public Health.

CDOP publishes an annual report, which is obtainable via the SSCB website.

7.3 Learning reviews

1) "Taylor" family

A learning review was held in May 2017 concerning the Taylor family, whose children were referred to CSC as their mother had been a victim of serious domestic abuse incidents. There were delays in the process and a failure to share information about the incidents in a timely way. The learning review took the form of a case discussion with key professionals.

What we learned

The review found that:

- In common with other clients at high risk of domestic abuse, Mrs Taylor consistently minimised what had happened.
- The health visitor demonstrated consistency and tenacity in working with the family.
- The social worker's direct work with one of the children demonstrated good practice.
- There was a failure to link the children in the household to the domestic abuse incidents on the police system—attributed to the new police system. This led to delays. The system has subsequently been revised.

- There was a delay between the first incident and discussion at the One Team meeting, and another delay before the health visitor was emailed.
- The One Team and/or the health visitor could have completed a 'DASH' assessment which would have supported escalation and prevented drift.
- There was difficulty in gaining information from other police forces; in this case information about Mr Taylor's previous convictions was provided by children's services in another area.

What we did

SSCB reiterated through its learning bulletin and through the Board that any agency can complete a 'DASH' risk assessment for domestic abuse and clarified the process for escalating concerns to the police. The Safer Somerset Partnership undertook to review the DASH to ensure it is effective.

2) Child F and Child G

Siblings, both aged under 2, were found to have unexplained injuries including bruising to the face and evidence of fractures. Practitioners also had concerns related to domestic abuse, neglect of the children, parental cannabis use.

A learning review was carried out in spring 2017 because although the case did not meet the criteria for either a SCR, it was felt that lessons could still be learned and examples of good practice highlighted. The review took the form of a 'desktop' analysis of learning from agency reports and reflection sheets.

What we learned

The review noted the need for improvements in a number of areas:

- Missed opportunities to safeguard the children—it is vital to share concerns with other agencies;
- Record keeping – it is important for work to be written up in a timely fashion, decisions recorded, and management advice recorded appropriately;
- Third party information—third party information should be acted on, and/or followed up to ensure a referral has been made;
- Inter-agency working — when multiple agencies are involved, identifying a lead professional and holding a TAC will ensure that a shared plan is created. This will also help ensure that financial and/or personal crises do not overshadow the needs of the children;
- Assessments — the need to consider the family composition and ensure that information is brought forward from one assessment to the next;
- Lack of engagement — this should heighten concern and not be part of the rationale for no further action in a case.

What we did

Findings were shared through the SSCB Things You Should Know (TUSK) learning bulletin.

3) Child H

A multi-agency practice review was held in December 2017 after child H was referred to the Learning and Improvement Subgroup by the Child Death Overview Panel. Child H was a child with severe disabilities who died from natural causes but there were concerns that, prior to death, the child was living in unsuitable housing and did not have a school place.

What we learned

- While Child H was in hospital referrals were made to various health teams and social care. As the concerns referred required early help and medical support. H had been in the UK for about four months at that point. No formal discharge planning meeting was held before H left hospital.
- The first referral to Children's Social Care was not accepted. A second referral to Children's Social Care was accepted, and the social worker visited the family, with an interpreter. Child H's mother gave more details about the domestic abuse she had experienced in her home country. This was verified with authorities in the previous country.
- Child H was not identified by any agency as a child missing education.

What we did

Following a learning event, recommendations in response to findings were accepted by the Board. Actions to address the recommendations are monitored through the Learning and Improvement subgroup. Learning was disseminated through the SSCB TUSK learning bulletin and professionals reminded of the significance and their responsibility towards children missing from education; also, the importance of having information available in common languages and interpretation services.

7.4 Thematic reviews

Two thematic learning reviews were initiated in 2017/18 and will report in 2018/19.

1) Review of child deaths through suicide or 'probable' suicide.

A number of children have died in Somerset between 2009 and 2018 as the result of suicide or in circumstances deemed as 'probable' suicide. A thematic learning review was initiated in the reporting year to ascertain any common themes arising from the deaths of children by suicide or probable suicide in Somerset and identify anything unusual or different from the published national evidence. The review also aims to identify actions that the SSCB and its partners could take in order to support young people and reduce the likelihood of further suicides or attempted suicides among children.

The review will conclude in 2018/19 and findings will be shared across the partnership.

2) Review of cases where sex offenders have access to children

Following consideration of a small number of serious incident notifications together with information from local and national inspections, the Board initiated a thematic review to examine practice in relation to the assessment and management of risks posed by registered sex offenders to children, in order to identify and address any practice improvements that may need to be made.

This review will also conclude in 2018/19 and findings will be shared across the partnership.

8. Other activities and functions of the SSCB

LSCBs have a number of statutory functions. These are:

(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Where they have not been covered in other areas of this report, they are recorded in this section.

8.1 Allegations Management – Designated Officer (LADO)

The role of the Designated Officer is to be involved in the management and oversight of allegations of abuse made against people who work with children. This includes those in either a paid or voluntary role where it is alleged that they have:

- 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 487 (478 in 2016/17) notifications of allegations during 2017/18 consisting of:

- 194 allegations of physical abuse (40% of all allegations)
- 123 allegations of sexual abuse (25% of all allegations)
- 118 allegations of neglect / inappropriate behaviour (24% of all allegations)
- 52 allegations of emotional abuse (11% of all allegations).

What was done?

A review of allegations of physical abuse, the largest category, has led to regular meetings and scheduled forums with safeguarding colleagues, in both SCC and partner agencies e.g. District Councils, to share quality assurance information relating to providers. This in turn has led to a specific action to work with providers to improve safer recruitment practises and the employment of suitable staff.

Work has also been undertaken with Avon & Somerset Police, in particular its Professional Standards Dept., to ensure allegations against officers that meet the criteria to trigger the managing allegations procedure are being reported.

The statutory timescale of one working day to report concerns around inappropriate behaviour is being monitored to ensure compliance by agencies / organisations. There is appropriate challenge where the timescale is not met.

There are quarterly quality assurance meetings to evaluate the consistency and standard of actions and decision making taken by the Designated Officer in managing individual cases.

The managing allegations business process is being developed as part of a contingency plan that ensures established processes are preserved and systems maintained when there are changes in the workforce.

How well was it done?

The re-inspection of the LA Children's Services (Nov.17) by Ofsted found that the local authority '*identifies and investigates allegations of abuse against professionals effectively*' commenting that action plans and case recording are comprehensive. It acknowledged that on-going cases are tracked well and that this ensures that investigations are well coordinated and responsive to children's needs.

The continuing promotion of the role of the managing allegations procedure with agencies / organisations has seen the total number of notifications rise year on year with an increase of 2% from the previous reporting period.

However, over a 1/3rd of notifications received did not meet any of the criteria to trigger the managing allegations procedure. This is an 11% increase from last year. This indicates a need for further training for managers / headteachers in applying the criteria to reported incidences and reflects the pressure on regulated settings to have evidence of consultation with the Designated Officer.

There is a steady improvement in meeting target timescales to resolve individual cases as demonstrated by the month on month % increase in the closure of cases reducing the anxiety

for children, their families, carers, and the employee / volunteer.

The embedding of a quality assurance process has enabled a closer scrutiny of individual cases managed by the Designated Officer, including the assessment of risk, decisions taken and the rationale to close cases. The audit process evidences consistency in action and decision making by the Designated Officer. The independent quality assurance group has endorsed the decision making by the Designated Officer in all cases audited.

What difference has been made?

All notifications are sent to Somerset Direct, the initial point of contact to report child protection and welfare concerns. This ensures that allegations against people who work with children are not dealt with in isolation from Children's Social Care and / or the Police and the safety and welfare needs of children are prioritised and co-ordinated.

The active oversight of cases by the Designated Officer ensures that when a child is identified as being at risk immediate actions are taken to safeguard and manage the risk to other children.

Regular auditing of a sample of cases ensures that decisions taken by the Designated Officer are child centred, are based on a clear rationale, demonstrate best practice, are clearly recorded and applied consistently.

What next?

The LADO will be working on the following areas in the coming year:

a) *Promotion*

- Work with partners to reduce the number of inappropriate notifications whilst increasing the reporting of allegations that are appropriate as they meet the threshold.

- Increase the number of notifications received within one working day.
- Continue to raise awareness of the managing allegations procedure particularly with faith based groups.
- Improve the % of closure rates of notifications.
- Further delivery of the nationally accredited safer recruitment course.

b) Issues to highlight

- The high number of inappropriate notifications that do not meet the threshold for reporting.
- The need to examine the numbers of notifications from the Police & NHS trusts.
- The number of notifications not reported within the statutory timeframe of one working day.
- The lengthy time that certain cases remain on-going e.g. those cases subject to criminal investigations and court proceedings.

8.2 Multi-Agency Training

Multi-agency training, led and coordinated by the SSCB training manager, continues to be valued and evaluated as highly positive across all sectors of the partnership. The SSCB partner organisations support the training in kind with key speakers and free venues to keep the cost to agencies as low as possible. The training became fully self-financing in the reporting year.

What was done?

This year, a total of 53 courses were delivered across 2017/18

A total of 1,224 training places were provided, in addition to 92 attendees at four Multi-agency Practitioner Information Groups (MAPIG) sessions, 126 multi-agency practitioners attendees at the Serious Case Review, Operation Fenestra, MAPIG sessions and 123 attendees at the annual Multi-agency Practitioners conferences, 'Working Together to Tackle Neglect'.

Participation by agencies can be found in **Appendix G** SSCB multi-agency training attendance.

Introduction to Child Protection and the refresher courses 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. The training also drew attention

to areas of concern identified from the Operation Fenestra SCR such as ‘cuckooing’ and ‘county lines’

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.

Arrangements with partner agencies ensured appropriate multi-agency expertise was available to contribute to the multi-agency safeguarding training.

The Working Together modules continued to 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 who are 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 ‘Confident & Competent Multi-Agency Working with Children in Need’ approaches and joint working between the agencies. These sessions were repeated in each of the four areas of the county. The sessions were delivered by the Consultant Social Worker who led the Child in Need Plan.

The aims of the session were to explore an example of good multi-agency practice from pre-birth and to have a reflective opportunity to consider all aspects of practice. Safeguarding conversations are a new initiative, launched last year by the SSCB, and following a successful pilot there is now a programme of meetings to be held quarterly around the county.

Safeguarding conversations provide an opportunity for members of the Board to sit down with a group of professionals involved in one case with the aim of identifying areas of good practice that can be shared and lessons that can be learned. They can also reflect on how well policies and

procedures are understood and used in practice and on the effectiveness of multi-agency working.

Summary of messages

Practitioners told us

- Excellent evidence of good practice - would be good to know how CSC intends to replicate this.
- Very interesting as I sit on the L and I subgroup to follow this case through.
- It's nice to see how multi-agency working really supports families.
- Very informative session highlighting successful inter-agency working and working with families using a doing with approach as opposed to a doing to.

The response to the session suggested that attendees left feeling motivated and identified that the approach professionals should be taking towards multi-agency working with children in need should be under-pinned with the aspiration to encourage communication and open and transparent approach.

Further details can be found in the Training Annual Report which is available on the SSCB website.
https://sscb.safeguardingsomerset.org.uk/wp-content/uploads/Training-Annual-report-17-18-for-annual-report.pdf

8.3 Safety and welfare of children who are privately fostered

What has been done?

Historically the numbers of privately fostered children in Somerset have been low; in 2017/18 thirteen notifications were received; this is the same number as the previous year. Only one of the children in the 2017/8 cohort was also privately fostered in the previous year.

The sustained number of notifications in 2017/8 represents an incremental rise from the ten notifications in 2015/16 and 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 social care teams.

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

Who are our privately fostered children?

Of the thirteen children privately fostered during 2017/8, seven were male and six female.

All but one of the children were aged 14 or 15 when they became privately fostered. The youngest child is now 3 and has been privately fostered by the same person from a very young age.

None of the privately fostered children had any identified disability or additional educational needs.

Five of the boys became privately fostered due to a breakdown in family relationships and one was an international student, whereas five out of the six girls were international students from western Europe, placed with host families for up to nine months, in order to improve their English. The girls were all placed by a single student exchange agency. One girl was privately fostered due to family breakdown.

A family member notified the Local Authority for all children who were privately fostered due to family breakdown.

For those children who were international students, the student exchange agency notified the Local Authority for all the children they placed. For the one male international student, not placed by this agency, the college they attended in Somerset, notified the Local Authority.

Of the eight private fostering arrangements that ended during 2017/8 all had lasted less than twelve months, as the child either became sixteen or returned home. Two of the international students returned home earlier than planned due to homesickness.

Communication and Impact

During 2017 the private fostering factsheet was sent to boarding/independent schools, host families and other organisations to remind them of their statutory responsibility to notify the Local Authority about any private fostering arrangements.

The sustained numbers of notifications this year is an indication that the raising awareness work completed continues to be effective in supporting the identification of children who are privately fostered.

Next steps

Continue to work with safeguarding leads, particularly in schools and in health settings, to sustain improved awareness of what private fostering is and the need to refer such arrangements to the local authority.

8.4 SSCB Communications

The SSCB business unit have continued to build on the work from last year, to make the SSCB website the “go-to” hub for all information relating to child safeguarding in Somerset.

Greater use of twitter and Facebook have also contributed to the Board’s increased digital presence across the partnership, with notable success in publicising serious case review publications and directing practitioners to the website.

Downloads of newsletters and TUSK (Things You Should Know – the SSCB learning bulletin) continue to be good, averaging 1100 downloads per edition*. Practitioners tell us that these publications are invaluable in keeping them up to date with latest policy, learning from SCRs and other reviews and understanding the work of the partnership.

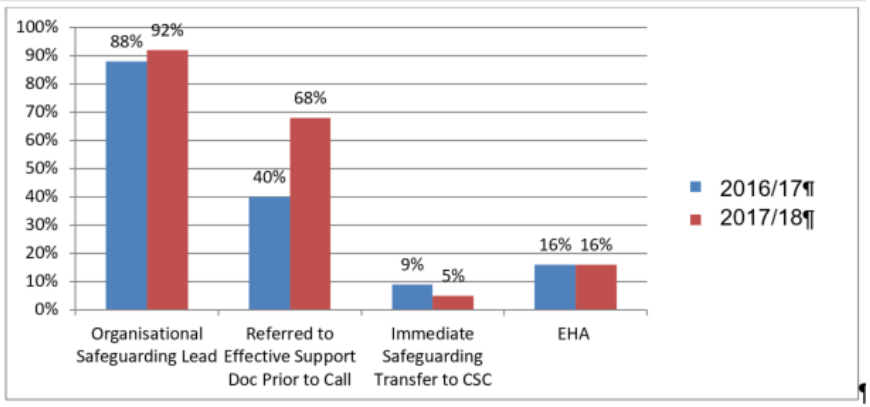
**These download figures count the number of times each publication has been downloaded from the SSCB website. They do not account for managers cascading the download within their own agencies.*

8.5 Safeguarding Leads Consultation Line

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.

There has been a **60% increase in calls** to the consultation line since the last financial year (604 calls during 2016/17, compared to 967 during 2017/18), with 92% of calls coming from Organisational Safeguarding Leads (OSLs), compared to 88% last year.

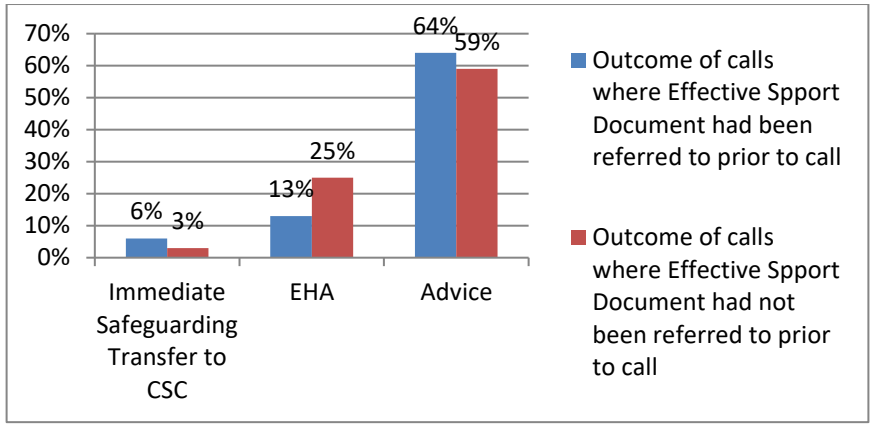
Comparison summary of calls to consultation line 2016/17 and 2017/18



Whilst the volumes of calls to the consultation line have increased from last year, there is not a remarkable difference in terms of the outcomes of these calls; there has been a 4% decrease in calls requiring an immediate safeguarding transfer to Children's Social Care. This could be indicative of practitioners being more comfortable with thresholds, and therefore not requiring the reassurance from the consultation line regarding these urgent referrals. However, the numbers are so small it is difficult to definitively draw this conclusion.

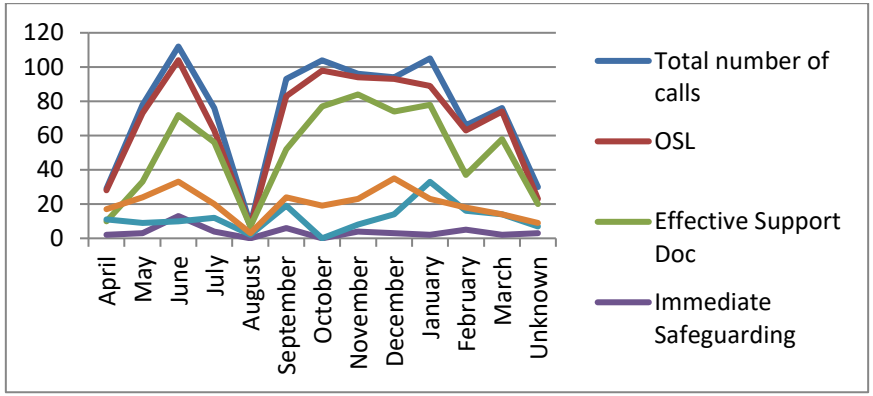
There has been a decrease of 28% in callers referring to the Effective Support Document prior to calling the consultation line, which could further indicate that practitioners are more aware of and comfortable with thresholds. Conversely, it could also suggest that practitioners are not using the Effective Support Document due to lack awareness/time/using the consultation line instead of utilising the document.

Outcomes where Effective Support Document had/had not been used prior to call



The data indicates that whilst there is not a significant detriment to practitioners not using the Effective Support Document prior to making a call to the consultation line in terms of immediate safeguarding referrals, it does seem to indicate an issue around practitioners completing EHAs, with 25% of callers being advised to complete an EHA.

Pattern of calls to consultation line 2017/18



Calls to the consultation line have remained consistently high, the obvious exception being August, which coincides with the school summer holidays. Figures for April are very low, which is not consistent with the rising trend from the end of last year, but could be due to data collection issues at the start of the new financial year (it is also possible that missing calls are accounted for within the "unknown category"). June was the busiest month for the consultation line, with 112 calls, closely followed by October and January with 104 and 105 calls respectively.

8.6 Voluntary and community/faith sectors

The SSCB built on links developed with the Voluntary, Community and Social Enterprise (VCSE) strategic forum through delivery of a consultation workshop in Quarter three. The workshop aimed to raise awareness of children's safeguarding across the network and to consult with VCSE partners about how they wish to engage with the children's safeguarding agenda and the SSCB. Particular emphasis was placed around the SSCB's commitment to drive Think Family practice forward and the important role of the VCSE and the duties placed upon them in safeguarding children. The workshop enabled the network to consider how the SSCB might help them in developing and building upon their own practice in safeguarding children and how blocks and inhibitors might be overcome.

8.7 Listening to children

SSCB encourages its partners to listen and respond to the views and wishes of children and their families, both in their daily work and in service planning and development.

Whilst there are clearly a number of areas of good practice, there are also improvements needed, for example in the context of child protection activity.

In its '***Reinspection of services for children in need of help and protection, children looked after and care leavers' (January 2018)***, Ofsted noted that:

Too few children benefit from access to advocacy for child protection conferences, and this is a missed opportunity to maximise their voice and understand the experiences of children in need of protection. (Recommendation)

In Somerset, advocacy for children who are in need of protecting and Independent Visitors for children looked after is provided by a charity called ***Route 1 Advocacy***. When this service was initially commissioned, a requirement for 70 independent visitors and provision of advocates to represent children ***550 times*** in Child Protection Conferences was envisaged. Since then, referrals for this service have been embraced by social workers who recognise the paramountcy of enabling children to access this type of support which ensures their voices are heard. As a result, ***Route 1 Advocacy*** has reached and surpassed these figures.

This level of provision translates into 30.7% of children over the age of 4 years who are the subject of a child protection conference receiving support from an advocate. In addition, 76 children have been matched with an Independent Visitor over the last year and a number of further referrals (circa 37) were pending matches at the end of the reporting year.

These figures suggest that the initial commissioning was not aspirational enough. Whilst a business case will be submitted in the new financial year to request expansion of this service, alternative ways of ensuring independent representation will be considered. This includes further promotion of the children and young people's application ***'Mind of My Own'*** (MOMO), so that the success of the impact of MOMO for Children Looked after can be replicated for children in need of protection.

The Board was informed that further voice of the child work is planned for 2018/19 in capturing children's views and experiences relating to safeguarding, through school pupil surveys – this has been agreed as a new standard expectation within the governor safeguarding self-assessment audit process to ensure children's voice and influence is used to improve services that support them.

9. Priorities for the SSCB 2018/19

Strategic priority 1: Early Help	
Outcome	*Children and families receive good quality and timely multi-agency help to keep children safe and promote their wellbeing.*

We will move from '*process*' to *'impact' and* continue to embed Early Help arrangements 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 (including use of the EHA, step up and step down arrangements and resolving professional differences);
- **understanding the views of children and parents/carers** who receive early help support and services;
- **assuring ourselves** that Early Help arrangements are embedding and are effective.

Strategic priority 2: Multi-agency Safeguarding	
Outcome	*Children are safeguarded through multi-agency partnership working.*

We will evaluate the effectiveness and impact of safeguarding arrangements in Somerset by:

- **scrutinising** data and **monitoring** the quality of agency engagement and compliance with statutory child protection (CP) procedures and local guidance (effective support and resolving professional differences);
- **assessing** impact of the partnership's work with children with additional needs and assure ourselves that the system performs effectively on their behalf;
- **engaging with practitioners** through audit, safeguarding conversations and other means;
- **strengthening learning** from both Adults and Children Board reviews;
- **assessing impact** of Think Family approaches to safeguarding vulnerable children;
- **understanding the views of children and parents/carers** who experience Somerset's CP processes.

Strategic priority 3: Neglect	
Outcome	*Children who are experiencing or at risk of neglect are identified and safeguarded*

We will continue to raise the profile of and tackle neglect by:

- **improving** practitioners' knowledge and skill base in responding to neglect, the issues surrounding it and practical approaches for dealing with it;
- **promoting and embedding** the multi-agency neglect strategy, practitioner guidance and the Somerset neglect action plan and assuring ourselves of its impact in improving children's lives;
- **assessing the effectiveness** of current practice, including early identification and intervention in response to neglect, based on understanding gained from SCR and other reviews;
- **understanding** children's lived experience of neglect in order to improve practice;
- **sharing learning** from reviews and practice audits.

Strategic priority 4: Child Exploitation	
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*

We will work with partners to:

- **strengthen leadership** across the partnership and seek assurances that children vulnerable to exploitation receive an effective response to protect them (home educated);
- **assure ourselves** that the quality of response to children who go missing is consistently good;
- **assess impact** of the strategy and action plans for responding to child exploitation;
- **evaluate** the effectiveness of partners' arrangements for identifying, assessing and tackling child exploitation, (including training and use of the Champion role);
- **understand** the views and experiences of children and families vulnerable to / experiencing exploitation, particularly those with multiple vulnerabilities, such as home educated children.

10. Assessment of the effectiveness of the safeguarding arrangements in Somerset

Overall, the Somerset Safeguarding Children Board (SSCB) partners have continued to work together improve their safeguarding arrangements amidst a changing national context for safeguarding, reduced leadership capacity and shrinking resources. The response to challenges within individual agencies has sometimes had an impact across the partnership, resulting in – at times – challenging conversations between partners and at the Board.

Partners have strengthened their response to children and young people, including providing help and support earlier, but more needs to be done to ensure that service responses are consistent in quality and timeliness, and effective in their impact on the safety and wellbeing of children. Key to this will be listening and responding more systematically to what children and their families are saying works for them.

Midway through the year, Ofsted also reported as follows:

'Since the last inspection in 2015, when Somerset children's services were judged as inadequate overall, the local authority has made steady progress in improving the quality of services that children and young people receive. Senior leaders have worked effectively with an improvement partner, and they have created a culture of openness and willingness to learn that supports further improvement.'

A brief analysis of the effectiveness of local arrangements with examples of work carried out by the partnership is set out 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 continued to scrutinise practice on behalf of the Board, providing both learning and appropriate challenge. Safeguarding conversations around multi-agency case work and Board member observations of child protection processes have provided an insight into practice issues, what works well and where gaps might exist.

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

Single agency assurance reports were received throughout the year and scrutinised by the Board. Full Board meetings continued to be held quarterly, and the work of all multi-agency subgroups was scrutinised and monitored by the

partnership. Progress against the SSCB business plan was reported at Board meetings with risks and exceptions flagged to partners, prompting agency challenge where necessary. The SSCB Governance Group monitored actions taken to address issues and risk.

Safeguarding is a demonstrable priority for all the statutory members.

SSCB partners have continued to demonstrate a commitment and drive to improve children's safeguarding through their attendance and engagement in the Board itself, and with its subgroups and task groups. When attendance and contributions have been poor, partners have been appropriately challenged by peers and the Independent Chair and relevant challenges made to senior executives.

There is a strong learning and improvement framework in place.

The Partnership has facilitated and resourced a wealth of opportunities for learning which are effective, highly valued by practitioners and have a demonstrable impact on improvement. Practitioner engagement in SSCB training, roadshows and learning reviews of cases where agencies did not work well together remains high. Practitioners value the face to face learning opportunities provided and also the learning communications such as the learning bulletins and SSCB newsletters and messages through social media. Download statistics for learning review reports, learning bulletins and newsletter continue to incrementally increase demonstrating practitioners' commitment to learn from practice and improve it. Two serious case reviews were published and one initiated. Serious incidents were scrutinised by the learning and improvement subgroup, to tease out opportunities for learning and improvement. Safeguarding conversations – a form of appreciative enquiry developed by the Board – are well supported and provide a valued opportunity for the Board members to consider good and successful practice

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

Policies and procedures are shared across most of south west England, and were monitored, evaluated and updated by the Board. The quality and impact of policies upon practice were routinely considered as part of learning reviews and audits. Where weakness were identified, polices were reiterated in order to embed them further throughout the year. Particularly, effective support for children and families guidance, resolving professional differences guidance and pre-birth guidance were strengthened throughout the year. Where gaps were identified in guidance for practitioners, the subgroups worked together with practitioners to develop guidance and help strengthen their responses to safeguarding concerns; guidance was developed around neglect and also child exploitation across the reporting year.

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 SSCB Child Exploitation subgroup continued to address this as a high priority because of the identified nee for significant improvement. The subgroup has actively reshaped and expedited action plans to address strategic and operational deficits in the multi-agency response to child exploitation. There has been ongoing scrutiny and challenge to partners to ensure the progress against the action plans maintains momentum and child exploitation remains a multi-agency priority.

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

Board members, practitioners and managers have continued to be involved in multi-agency audits of case work. Audit findings along with outcome focused action plans are monitored by the SSCB and exceptions routinely reported to the Board to highlight where action or intervention by partners may be required. Findings inform priority setting by the Board, as well as the more detailed actions that need addressing within individual agencies.

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

.

Through strategic involvement with other partnership boards in Somerset and through analysis of SSCB led self-assessment (S11 and S175/157) the SSCB has continued to challenge and inform partners and providers of where actions need to be taken to improve service planning and provision. The SSCB uses its statutory powers to influence where action needs to be taken by other partnerships to improve children's safeguarding and promote their wellbeing. The annual report and serious case reviews are presented to individual agency leadership groups and to other multi-agency partnerships, leading to constructive responses in a number of areas.

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

The SSCB has maintained oversight and responsibility for multi-agency safeguarding children training for designated safeguarding leads. The SSCB training and development subgroup routinely evaluates impact of training output across the partnership, which supports the Business Plan priorities. The SSCB training and development strategy is closely aligned to the learning and improvement framework and associated activity. This is a key strength of the Board

Appendix A: SSCB Partner Contributions and Budget

The overall SSCB budget included two components including a **core budget**, which includes business unit salaries (excluding training) and Board running costs, and the SSCB **training budget** which included training manager and administrative salaries and training related running costs, expenditure and income.

Partner agencies continued to contribute to the SSCB's budget for 2017/18, in addition to providing "in kind" resource including staff time and the provision of 'free' training venues.

At the outset of 2017/18 agency contributions reduced in quarter two following reduction in resource allocation of the CCG's child death review manager.

Agency contributions 2017/18

Agency	Actual contribution 2017 / 2018 (£)
Avon and Somerset Constabulary	19,600
Somerset Clinical Commissioning Group	30,350
National Probation Service (South West)	1,440
Community Rehabilitation Company (Somerset Local delivery unit)	1,010
Somerset County Council	140,210
CAFCASS	550
Taunton Deane and West Somerset District Council	1,600
South Somerset District Council	1,600
Mendip District Council	1,600
Sedgemoor District Council	1,600
Total Income	**199,560**

This financial year's overall combined training and core budget, had an outturn of **£5,145 surplus**. This was due in part to a 50% reduction in costs to the Section 11 audit tool negotiated by the Business Manager and the delivery of additional training courses in response to demand, which resulted in excess of planned generated income.

SSCB Expenditure 217/18

SSCB Core budget	Expenditure 2017/18 £	Under/ overspend (variance) £
Salaries	203,230	13,980
Running costs	13,135	(1,565)
Serious case reviews	14,853	(8,147)
Total running expenses	27,988	(9,712)
Total core expenditure	231,218	4,268
Core Income	209,210	17,740
Core SSCB overspend (underspend)		22,008

The outturn of the SSCB, partner funded **core budget** was a planned overspend of £22,008.

SSCB Training Budget

This financial year saw for the first time the 100% transition of training salaries (for the 1.0 FTE SSCB training manager and the 0.8 FTE training administrator and 0.2 FTE apportioned time from SCC finance admin support), into the £0 'standalone' SSCB training budget.

The fully traded training budget continued to work extremely well throughout the year and exceeded income targets. The surplus generated was recycled back into the Board's core budget to support priority areas and to enable the partnership to deliver further flexible multi-agency safeguarding training events in response to Board priorities and learning from the serious case review, 'Fenestra'.

The income achieved from training continued to enable the partnership to deliver a responsive programme of multi-agency safeguarding training and fully subsidise a number of multi-agency practitioner learning events to broaden the reach of learning from reviews. Income from multi-agency training also offset 100% of SSCB training related salaries and associated costs. The net surplus of **£27,153** was recycled back into the Boards work and used to off-set the core SSCB planned budget pressure.

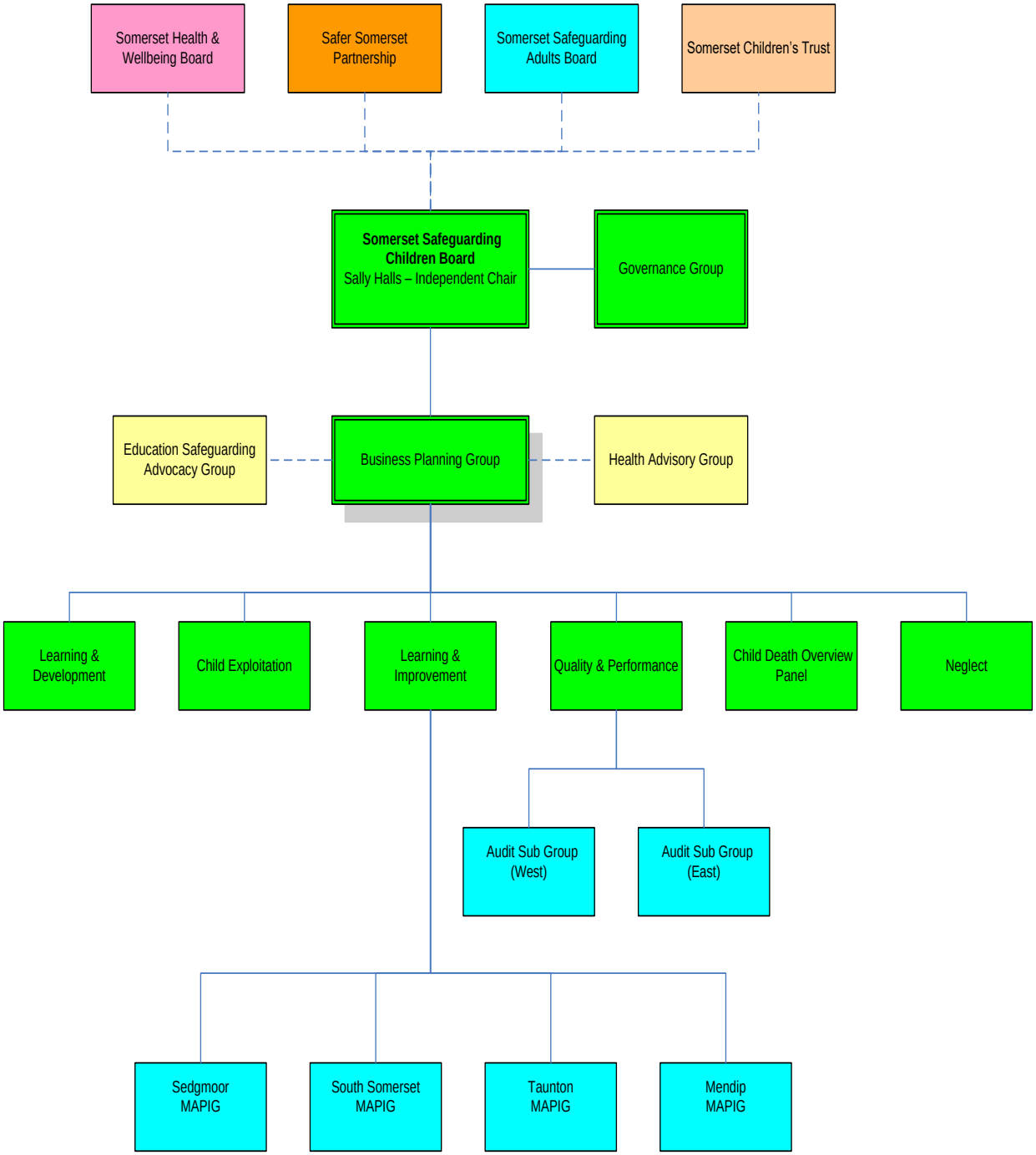
Training expenditure 2017/18

Training budget	Expenditure 2017/18 £	Under/ overspend (variance) £
Training Salaries (training manager 1.0FTE, admin/finance 1.0 FTE)	71,470	4,470
Training & conference costs	28,897	(10,203)
Training income	(127.520)	(21,420)
Training overspend (underspend)	(27,153)	(27,153)
Overall SSCB overspend (underspend)	(5,145)	

The outturn figure for the SSCB budget overall in 2017/18 was **£5,145** underspent. This figure was carried forward to support the Board's ongoing SCR and Learning review work.

Appendix B: SSCB Structure, Membership and Subgroups

SSCB Structure



SSCB Membership 2017/18

Name	Role and agency
Mark Barratt	Assistant Director – Safeguarding, Care and Quality Assurance
Alison Bell	Consultant in Public Health, Public Health
Peter Brandt	Assistant Chief Officer, Community Rehabilitation Company
Sandra Corry	Director of Quality, Safety and Engagement, Somerset Clinical Commissioning Group
Maria Davis	Designated Nurse for Safeguarding Children and Children Looked After, Somerset Clinical Commissioning Group
Dave Farrow	Head of Outcomes and Sufficiency, Somerset County Council
Trudi Grant	Director of Public Health, Somerset County Council
Sally Halls	Independent Chair, Somerset Safeguarding Children Board
Simon Lewis	Assistant Director, Taunton Deane Borough Council
Shelagh Meldrum	Director of Nursing and Elective Care, Yeovil District Hospital NHS Trust
Pauline Newell	Service Manager, CAFCASS
Frances Nicholson	Cabinet Member for Children and Young People, Somerset County Council
Kevin O'Donnell	Community Member, Somerset Safeguarding Children Board
Richard Painter	Head of Safeguarding, Somerset Partnership NHS Foundation Trust
Hayley Peters	Executive Director of Patient Care, Taunton and Somerset NHS Foundation Trust
Mike Prior	Superintendent, Avon and Somerset Constabulary
Penny Quigley	Community Member, Somerset Safeguarding Children Board
Nick Rudling	Deputy Safeguarding Lead, NHS England South (South West)
Liz Spencer	Assistant Chief Officer, National Probation Service
Tom Whitworth	Strategic Manager, Vulnerable Young People
Claire Winter	Deputy Director Children and Families. Somerset County Council
Julian Wooster	Director of Children's Services, Somerset County Council

Appendix C: Safeguarding in Education

Support Services for Education ran a successful conference in the reporting year, on dealing with on-line issues for providers. A second conference is expected in the new financial year to consider harmful sexual behaviour, recognising the changes being brought in through Keeping Children Safe In Education 2018 and Working Together.

South West Grid for Learning (SWGfL) are important members of our work with providers and with partners ensure we have the most recent on-line safety advice available for our education providers. Each year SWGfL present to the SSCB Education Advisory Group on current issues.

The Team Around the School (TAS) model of working was rolled out across Somerset and continued to evolve in the reporting year. It is anticipated that this model will play a key role in ensuring that children and young people at risk of missing out on education through exclusions, the use of part time timetables etc, with the attendant safeguarding risks that that brings, are identified early and appropriate support put in place.

There was very high movement of staff and Head teacher turnover in the primary sector holding the Designated Safeguarding Lead (DSL) role were noted during the reporting year; some schools were susceptible to non-compliance operating without a DSL. Interim arrangements were put in place with support from other local schools and the Education Safeguarding Advisor (ESA).

Single Central Registers 'drop-ins' were initiated and will be developed further in the forthcoming year by the ESA. Demand for this support remained high and additional capacity to support this work will be sought in the new financial year.

A significant number of telephone queries to the ESA related to safer recruitment, the 175/157 self-assessment audit or Single Central Record queries. An emerging theme throughout the year was requests for advice on issues around peer on peer allegations, this has been reported to the wider partnership through the SSCB to augment a multi-agency approach to respond to these themes.

From Quarter three in the new financial year in 2018, the new requirements from government and Ofsted will expect to see clear programmes of statutory and proactive in-house safeguarding training, evidencing that all education providers and staff are aware of local Somerset polices and guidance for safeguarding. ESA will work closely with the SSCB training manager to respond to these demands.

The ESA developed a twitter account and reached 200 followers. The impact has resulted in improved reach to DSLs and sharing of good practice and useful relationships with ESAs in other areas.

Work was undertaken in the reporting year to purposefully capture children's voice and views on the safeguarding issues affecting them - the ESA provided schools with quizzes and surveys for this purpose, this will be developed further in the forthcoming s175 audit, this will now be a requirement on

schools to do one pupil survey a year purely around safeguarding issues.

Schools reported that many of their recorded concerns related to children and young people with SEND and disability. Other areas of vulnerability are children missing education, elective home education, 16-18 year olds on private apprenticeships and 19 year olds still on school rolls. These are recognised risks and have prompted further focus for development in the forthcoming year.

An analysis of education referrals to the Early Help Hub and First Response shows that despite access to a range of advice and support available to schools and settings as detailed in this section of the report, practitioner confidence around early help decision making remained relatively low and requires further impetus. This is an area of work that we will be focusing on through the Education and Early Years Safeguarding Advisers, TAS and other support mechanisms in the forthcoming year.

The coordination and delivery of safeguarding advice, guidance and support to early years settings and schools is delivered through the Commissioning Manager for Safeguarding and Children Missing Education who is part of Children's Services. This is also supported by the Education and Early Years Safeguarding Advisers (ESA and EYSA) who are part of Support Services for Education (SSE), the traded unit for education services, for Somerset County Council.

The Commissioning Manager chairs the Education Safeguarding Advisory Group which met on a regular basis across 2017/18 and is well attended with representation from:

- Local Authority Education Safeguarding Officers
- Somerset Association of Secondary Heads (SASH)
- Somerset Association of Primary Headteacher Officers (SAPHTO)
- Special Education Needs – Somerset Expertise (SENSE)
- Independent Schools
- Further Education Colleges
- Early Years
- getset
- Police
- Health
- South West Grid for Learning (SWGfL)

The group facilitated important communications across education providers on all statutory safeguarding duties and compliance with SSCB Policies and procedures. This included ensuring that learning from serious case reviews, domestic homicide reviews are embedded and that education continued to be an integral part of the SSCB.

The Education Safeguarding Advisor and Early Years Safeguarding Advisor met regularly with groups within the sectors and relevant DSLs across Somerset. The advisors established several communications methods to keep providers updated, ensuring they have the fullest and most

recent updates and are consistently clear on their safeguarding duties and responsibilities.

All safeguarding complaints made direct to Ofsted were addressed by education staff and recorded on the i-casework recording system. This ensured that the LA both challenged and supported providers about whom concerns were raised and that issues were dealt with swiftly. Since September 2017 there were circa 80 contacts from Ofsted covering a range of issues including bullying and health and safety concerns. This aligned with the national trend of increasing numbers of complaints being sent directly to Ofsted, which they in turn passed to LAs where it was felt appropriate.

SCC highlighted concerns to Ofsted about the triage process to communications they receive, following cases where complainants circumvented local arrangements for resolving concerns, which were not subsequently referred back to them.

Appendix D: SSCB Attendance by agency 2017/18

Agency		Quarter 1	Quarter 2	Quarter 3	Quarter 4
SSCB	Chair	Yes	Yes	Yes	Yes
	Business manager	Yes	Yes	Yes	Yes
SCC	Children's Services	Yes	Yes	No	Yes
	Children's Social Care	Yes	No	No	Yes
	Public Health	Yes	Yes	No	No
	Education	No	Yes	No	Yes
Youth Offending Team		Yes	Yes	Yes	No
Avon and Somerset Police		Yes	Yes	Yes	Yes
Health	Clinical commissioning group	Yes	Yes	Yes	Yes
	Somerset Partnership NHS Foundation Trust	Yes	Yes	Yes	Yes
	Yeovil District Hospitals Foundation Trust	Yes	Yes	No	No
	Taunton and Somerset NHS Foundation Trust	No	Yes	Yes	Yes
National Probation Service		Yes	Yes	Yes	Yes
CRC		No	No	No	No
CAFCASS		No	No	Yes	No
NHS England		No	No	No	No
Community members		Yes	Yes	Yes	Yes
		Yes	Yes	Yes	Yes
District Councils		Yes	Yes	Yes	Yes
Number of attendees		14	15	12	13
Percentage attendance		73.7	78.9	63.2	68.4

Appendix E: Assessing the effectiveness of child safeguarding and promoting the welfare of children in Somerset

Section 11 audit

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The focus of this audit is to establish the degree of compliance with and understanding by each individual agency of these responsibilities. It takes the form of an annual self-assessment, supplemented in 2017-18 for the first time by a number of 'peer challenge' workshops to assess the quality of each agency's self-assessment. 10 agencies took part in these workshops.

A multi-agency task and finish group is planned for August 2018 to review and revise the section 11 audit for 2018-19, which will be issued for completion across the partnership in October/November 2018. Peer Challenge workshops will then take place early 2019.

Section 11 standards

5.1 Service development plans are informed by the views of children and families
6.1 Individual case decisions are informed by the views of children and families
8.3 Appropriate staff and volunteers are trained to recognise signs of abuse and neglect
8.4 Outcomes and findings from reviews and inspections are disseminated to appropriate staff and volunteers
9.1 The organisation has a recruitment policy in effect which ensures professional and character references are always taken up
9.2 Any anomalies are resolved
9.3 Identity and qualifications are verified
9.4 Where appropriate enhanced or standard DBS checks are completed on all those staff and volunteers who work primarily or directly with children and young people and their managers
9.5 Face-to-face interviews are carried out

9.6 Previous employment history and experience is checked
9.7 Employees involved in the recruitment of staff to work with children have received training as part of the "safer recruitment training" programme
10.1 The organisation has identified principles of working with children and their families for all staff to work within
10.2 Staff understand when to discuss a concern about a child's welfare with a manager
10.3 Staff understand the threshold for making a referral to Children's Services or raising an Early Help Assessment
10.4 Staff have access to inter-agency guidance and procedures
10.5 Staff participate in multi-agency meetings and forums to consider individual children
10.6 Contractors to the organisation who work with Children and are delivering statutory services are Section 11 compliant and have been audited. Other contracts require the organisation to achieve Safeguarding Standards
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

Section 11 peer challenge workshops

In order to quality assure the section 11 returns, the Quality and Performance subgroup devised a process in the form of peer challenge workshops.

10 agencies underwent a peer challenge workshop:

- Somerset Partnership NHS Foundation Trust (pilot workshop)
- Avon and Somerset Constabulary
- Somerset Clinical Commissioning Group
- Devon and Somerset Fire and Rescue Service
- Somerset County Council Education Commissioning
- Somerset County Council getset services
- National Probation Service
- Taunton Deane and West Somerset District Council

- Somerset County Council Targeted Youth Support and Youth Offending Team
- Yeovil District Hospitals NHS Foundation Trust

The peer challenge workshops focussed on the standards within the audit that relate directly to SSCB Business priorities.

Many agencies from across the partnership provided "peer challengers" in order to make these workshops truly multi-agency.

The feedback from these workshops was overwhelmingly positive (from both "challenged" and "challenging" agencies), and did result in the moderation of grading for several standards across agencies, as seen in figure 1 below:

Figure 1: Result of Section 11 moderation (peer challenge) workshops

Agency	Result of moderation			
	Grade unchanged	Grade lowered	Grade increased	Not applicable/ not scored
Totals	**79**	**24**	**5**	**2**
Percentage	**72%**	**22%**	**5%**	**1%**

Section 175/157 audit

The equivalent to the section 11 standards in the education sector is set out in section 175 of the Education Act 2002, and for independent schools, under standards issued under 157 of the same Act,

The Section **157/175** Governor Safeguarding Audit ran its second year of self-assessment returns during the year, using the online self-assessment tool, ***'enable'***. The reporting year saw a 100% completion rate for the self-assessments, which was extremely positive. Actions identified from the self-assessment included the need to improve consistency of Early Help application across the education system, and improvements needed in the quality of schools' responses to keeping children safe, with emphasis on safeguarding leadership within settings.

Appendix F: Multi-agency audit programme

Practitioners and managers working with families are routinely involved in multi- agency practice audits. In 2017/18 four multi-

agency case work audits took place.

The audits resulted in outcome-focused action plans, written and 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. The topics and findings are summarized in table X below.

Q1 – June 2017	**Neglect** 7 case files audited, children subject to a child protection plan for the category of neglect, focusing on work prior to the Initial Child Protection Conference
STRENGTHS: • The parents' capacity to change their parenting was assessed, and the length of time the child had experienced neglect, and the cumulative effect of that neglect was taken into account at strategy discussions and Initial Child Protection Conferences (ICPC). • At the point of strategy discussion and ICPC the information sharing was appropriate, and the impact of neglect was considered.	
KEY LESSONS: • The voice of the child was not represented by advocacy in any of the ICPCs in the sample. • In 4/7 cases there was no evidence that child protection plans had been shared with children, and reports were not consistently shared with parents prior to conferences.	
IMPACT: • Promotion of advocacy has resulted in a steady rise in the percentage of referrals for an advocate. In April 2018 45% of children received a referral for an advocate for an ICPC compared to 32% the previous year. • There is an expectation that Social Workers will feedback to children about the outcome of the conference as part of their direct work with them. Chairs include a question in Conference to establish how and when this feedback will be given to the child.	

Q2 September 2017	**Child Sexual Exploitation** 8 cases audited, where the child was known to be at risk of, or exposed to, child sexual exploitation

STRENGTHS:

- A mixed picture overall but the audit identified that risks were correctly identified and plans put in place to address the risks.

KEY LESSONS:

- Some plans were not effective at reducing the risks to the child, particularly for vulnerable children who had high levels of need and complex family circumstances.
- Professionals working with children or their families were not always clear about developments because they were not included in planning. Sharing of information across the partnership was inadequate, for example, it was not shared with CAMHS that a young person was at risk of CSE, and the date of a court case was not shared with BASE.
- In one case the language used to describe a vulnerable young person's behaviours implied that s/he was to blame for the CSE.

IMPACT:

- The learning bulletin, TUSK, highlighted to all agencies of the importance of using non-blaming language. TUSK also reminded staff that if they were working with a child they should expect to be involved in planning, and that if they did not receive invitations to meetings, or notes from meetings, these should be requested and the 'Resolving Professional Differences' protocol could be used if there were difficulties.
- The importance of using non-blaming language is embedded in the child exploitation of Working Together training, and work is in progress to update the CSE training to include all the findings from Fenestra and recent national cases.

Q3 December 2017	**Multi-agency Early Help** 8 cases were audited which examined multi-agency practice with families prior to a contact being made with Children's Social Care. Four of these cases were assessed to be level 4 and further work followed, four were deemed not to meet the threshold.
STRENGTHS: • There was escalation in one case, when a delay in referring was discussed with a manager. Otherwise the Resolving Professional Differences Protocol was not needed or used. • Seven of the referrals were appropriate. • In seven of the cases First Response had communicated the outcome to the referring agency.	
KEY LESSONS: • There were missed opportunities to identify the risks to the children and complete Early Help Assessments (EHA). • For the eight referrals, only 4 EHAs were submitted. • All the EHAs had missing sections, with no reason given for the missing sections	
IMPACT: • Learning points were communicated through the SSCB learning bulletin. • An Early Help Workshop has been planned. This will address professionals' understanding of early help, and the EHA form. • Revision of EHA may follow the EHA workshop. It is planned to release updated guidance to reflect the points made.	

Q4 March 2018	**Multi-agency work on child protection plans** 8 cases were audited, considering the work leading up to a Review Child Protection Conference, including Core Groups, looking at the multi-agency engagement with the Plans and the progress made.

STRENGTHS:

- The voice of the child was represented at two of the conferences, with a report and the attendance of the advocate.
- The original risks to the child were clearly outlined in five of the RCPCs.
- With the exception of one RCPC where the CP Plan had been completed and the plan discontinued, all of the meetings focused on risk reduction.
- The police provided reports to all of the RCPCs, but did not attend any of them. A Joint working protocol is being agreed between police and children's social care to clarify when Police will attend RCPCs.

KEY LESSONS:

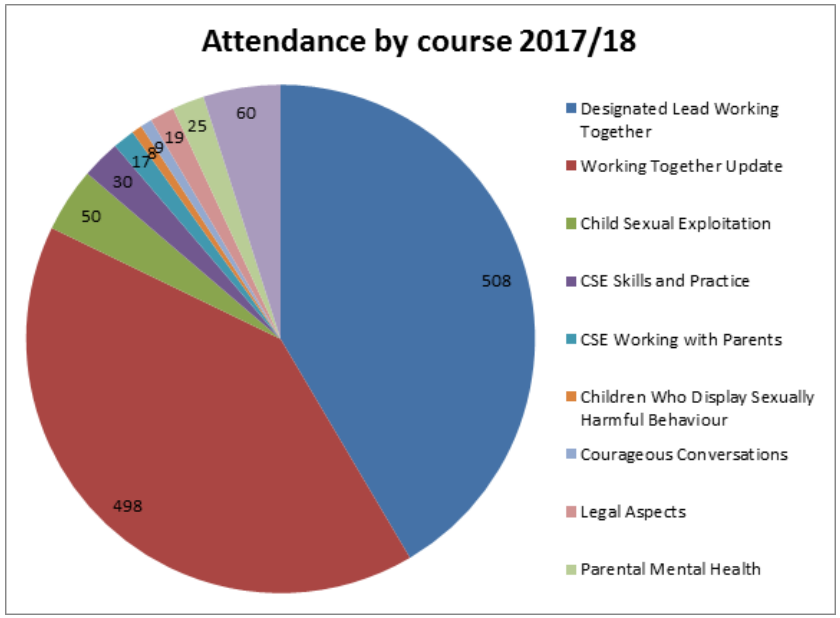
- Only 2 GPs sent information to the RCPC. One sent a letter rather than completing what was described as an "unwieldy conference report template", and the other information was handwritten. No GPs attended an RCPC. For one child there was no school nurse or hospital involvement so there was no input from any of the health agencies.
- In one meeting, the school was represented by the PFSA. It is more appropriate for the Head or Designated Safeguarding Lead to attend.

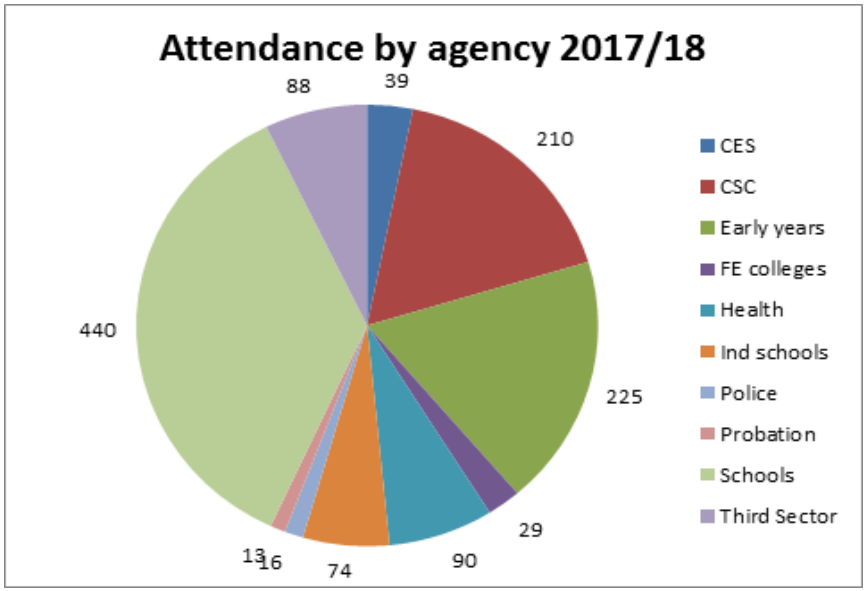
IMPACT:

- Work is planned to ensure that core groups routinely discuss and record scaling at meetings, to reflect the current level of safety for the child.
- Work is planned to improve the level of GP engagement with child protection conferences, and to promote the attendance at conference of the class teacher or Designated Safeguarding Lead

Appendix G: Multi-agency training attendance 2017/18

Attendance by course and by agency 2017/18												
	CES	CSC	Early years	FE colleges	Health	Indep schools	Police	Probation	Schools	Third Sector	Totals	%
Designated Lead Working Together	10	99	121	12	14	36	8	1	174	33	508	**41.5**
Working Together Update	17	92	87	13	47	33	0	1	194	14	498	**40.7**
Child Sexual Exploitation	2	2	3	0	4	0	2	11	13	13	50	**4.1**
CSE Skills and Practice	1	2	0	0	2	1	3	0	9	12	30	**2.5**
CSE Working with Parents	0	6	3	0	2	0	2	0	0	4	17	**1.4**
Children Who Display Sexually Harmful Behaviour	0	1	0	0	0	1	1	0	3	2	8	**0.7**
Courageous Conversations	2	0	0	0	5	0	0	0	2	0	9	**0.7**
Legal Aspects	2	0	1	1	9	2	0	0	2	2	19	**1.6**
Parental Mental Health	2	4	6	0	7	0	0	0	6	0	25	**2.0**
Safer Recruitment	3	4	4	3	0	1	0	0	37	8	60	**4.9**
	39	210	225	29	90	74	16	13	440	88	1224	**100.0**
Percentages	**3.2**	**17.2**	**18.4**	**2.4**	**7.4**	**6.0**	**1.3**	**1.1**	**35.9**	**7.2**	**100.0**	


Attendance by course 2017/18
508
498
50
30
17
9
19
25
60
Designated Lead Working Together
Working Together Update
Child Sexual Exploitation
CSE Skills and Practice
CSE Working with Parents
Children Who Display Sexually Harmful Behaviour
Courageous Conversations
Legal Aspects
Parental Mental Health


Attendance by agency 2017/18
39
210
225
29
90
74
16
13
440
88
CES
CSC
Early years
FE colleges
Health
Ind schools
Police
Probation
Schools
Third Sector

Appendix H: Early Help evaluation from EHSCB

The Ofsted inspection that took place during November 2017 found that early help services in Somerset have improved and required further integration with partners to increase its capacity. The local authority had also not systematically evaluated the impact of the early help offer on meeting the needs of children and their families.

What was done?

- The **'Effective Support for Children and Families in Somerset'** (thresholds guidance) was refreshed and continued to become embedded and part of professionals' daily toolkit.
- The Early Help Advice Hub has been established and co-located with the Children's Social Care First Response Team, continuing to reinforce the early help process by providing advice, logging Early Help Assessments (EHA) and triaging EHA's for the getset service.

Team around the school (TAS)

TAS multi-agency meetings were put in place across the whole of Somerset. The principles of information sharing and identifying needs early are becoming more adhered to and feedback from partners is that the multi-agency approach to early help is beneficial.

Multi-agency attendance has been closely monitored and the table shows average attendance over the period Sept 2016 to May 2017.

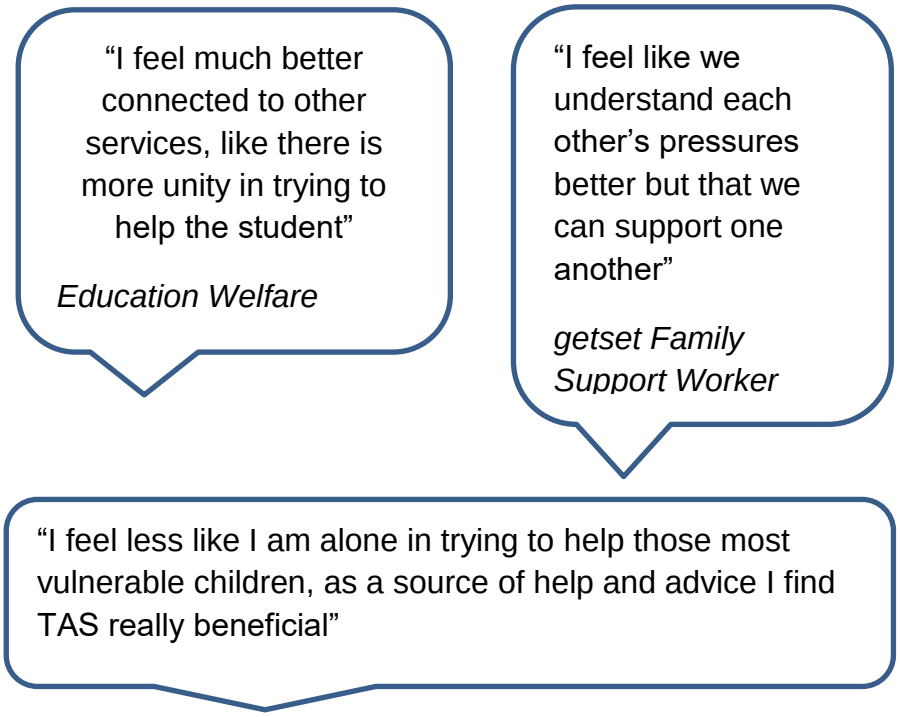
Organisation	Average attendance at TAS (Countywide)
School staff Designated safeguarding lead SENCO Parent & Family Support Adviser (PFSA) Other pastoral support Representation from feeder primary/infant schools	 98.2% 86.7% 97.7% 69.2% 83.1%
Police PCSO One/Inclusion team lead	 69.1% 21.0%
Children's Social Care	35.6%
Support Services for Education Educational Psychology Education Welfare Officer	 12.9% 75.5%
getset Early help officer Family support worker	 89.4% 96.6%
Housing association/provider	70.4%
School nurse/Health visitor	79.2%
Primary Mental Health Link Worker (CAMHS)	17.4%
Targeted Youth Service (TYS)	10.2%
Youth Offending Team (YOT)	12.6%
Pathways to Independence (P2i)	9.3%
Voluntary Sector Organisations	5.9%

So what?

In the spring term 2017 an evaluation was undertaken of TAS in 19 of the 29 schools (65.5%). The following findings were made:

Multi-Agency Working

- 95% of partner agencies are starting to see the benefits of regular multi-agency meetings.



- 85% of schools are reporting that actions are being taken more swiftly by other agencies.
- 87.5% report good spirit in holding partners to account.
- 97% felt it was a good way of keeping up to date with changes in other agencies and networking.
- 80% of TAS chairs have oversight of children from other schools when those school heads are not in attendance. (Issues sometimes occur where TAS is run in conjunction with One team operations where the focus and criteria may be split between school/community).
- 96.5% report strengthened relationships between partners – discussions help to understand thresholds, roles, responsibilities and accountabilities.
- 100% of those that have adopted it found it helpful to use the Behaviour and Vulnerability Profiling Tool (BVPT) though it should be noted that this is an extremely small sample as only 6 of the 29 schools are using the BVPT.
- 100% of TAS coordinators agreed that the meeting helped to reinforce the need to complete Early Help Assessments to start building evidence early on.
- 54.8% agreed that the TAS process generated significant time savings for other agencies - School Nursing Team, Education attendance, Police
- 100% said that they struggled to get attendance from some agencies due to stretched resources most notably Children's Social Care & CAMHS although this has improved.
- 100% reported that it highlighted high caseloads on PFSAs (average 25-30 caseload).

- 63% agreed it was difficult to show impact on academic progress at this stage as the approach is not yet fully embedded over a school year
- The majority of pupils supported through strategies put in place by the TAS had increased attendance, reduced exclusions and reduced use of reduced timetables according to 69.2% of TAS coordinators asked.

One teams (Known as One Teams / Together Teams / Mendip Shape One Teams)

Further work took place by partners to embed One teams across Somerset. These teams essentially operate a Think Family approach and play a role in coordinating multi-agency Early Help provision within their locality whose aim is to reduce demand and achieve positive outcomes.

Membership typically includes professionals from; getset, Police, Social Landlords, Health Visitors, Schools, MIND/Mental Health providers.

Impact of One Teams

Quantitative information around the impact of One Teams remains an area for development, partly due to the developmental nature of the approach.

The Bath Spa University conducted an evaluation of three 'One Team' Initiatives in September 2017. The report cited that local, dynamic, non-partisan, coordination of operational staff from across a range of services (where the richest picture of concerns is seen by all attending) ensures opportunities for intervention and support are identified and acted upon as early as possible. Performance data which corroborates this at this stage is not sufficiently developed, this this was acknowledged in the evaluation report. Measurement is very much an unresolved area and one which has been identified as needing a solution especially if One Team working and the financial commitment this requires is to be truly sustainable and become 'business as usual'.

Professional Choices

The original intention of Professional Choices was a one-stop-shop for all early help professionals. The site is embedding well and uptake is growing rapidly. The use of the virtual meeting rooms is variable. This particular tool underpins both the early help and child protection process in terms of TAS meetings and team around the child meetings and provides the functionality to share information securely with partner agencies. Some targeted work needs to be done with partner agencies such as GPs to help them see the benefits.

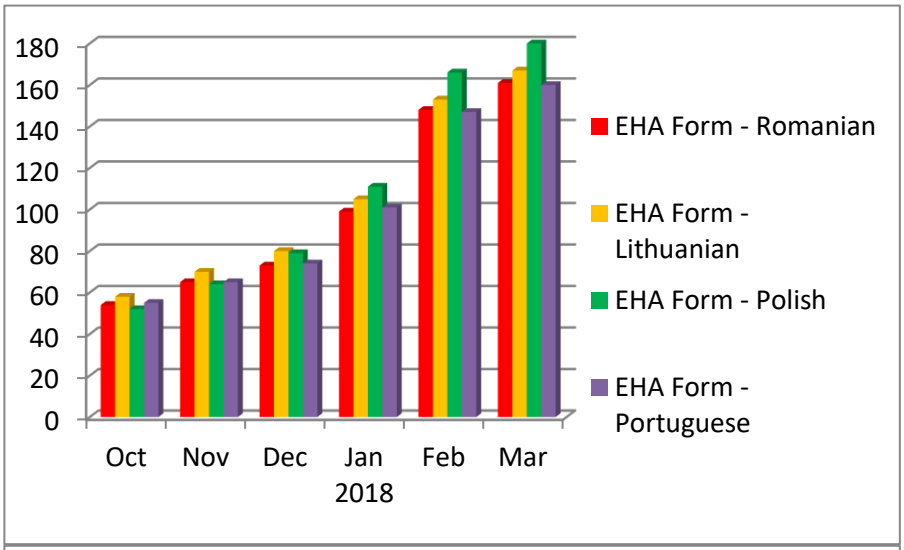
TAS meetings are utilising the virtual meeting rooms well but take up for team around the child meetings is still low. 'One' teams are really seeing the benefits which has seen a knock-on effect to other partners such as police, housing, health visitors and safeguarding leads.

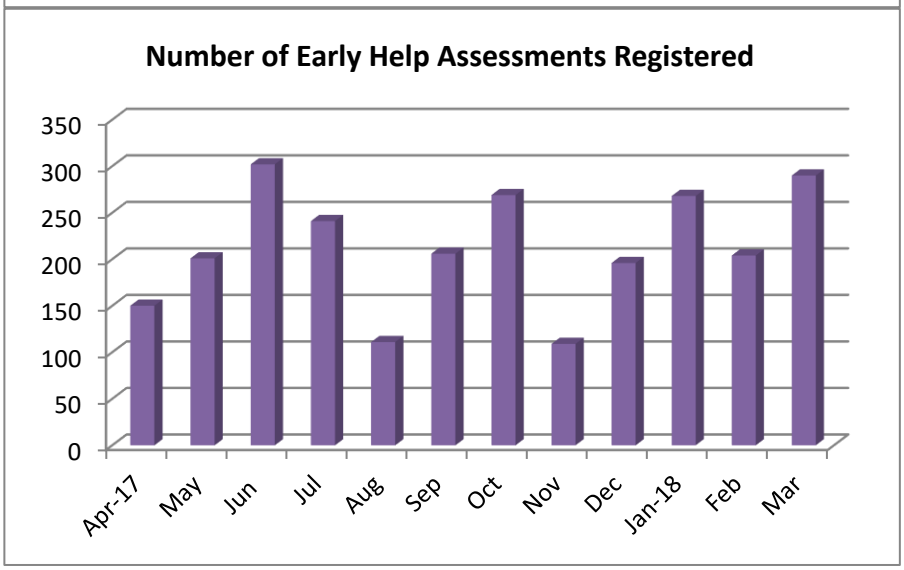
Key progress:

- Registered users have increased from 1,571 in April 2017 to 2,357 at the end of March 2018
- Entries in the 'Who's who' directory of professionals have increased to 1,441 at the end of March 2018.
- The Early Help Assessment (EHA) form has been downloaded 16,171 times (March 2018) compared to 7,418 at the end of March 2017.

Early Help Assessment

The following graph shows the number of EHA's registered with the Early Help Advice Hub across the last year.





There is still some targeted work to do with partners in terms of embedding the EHA as the early identification tool to develop a holistic picture of a child/young person's strengths and needs across all aspects of their life.

The graph below shows the most common non-English EHA forms downloaded over the last 6 months which shows a steady increase and an indication that Somerset is becoming more diverse.

Partnership working

The Early Help Strategic Commissioning Board is now well established with good multi-agency representation and clear action plans which are aligned to the CYPP. Chairs and vice chairs are also now in place for the 4 Early Help Area Advisory Boards and attend the strategic board to report on progress locally and to cascade the wider early help messages.

The Strategic Commissioner for Early Help is now in post (Feb 2018) whose remit is to evaluate the effectiveness, and strengthen, early help arrangements across Somerset.

Partnership delivery of early help is becoming stronger across Somerset as TAS meetings embed further and there are pockets of really good practice which need to be in place across the whole of Somerset, acknowledging models of delivery will be different to meet local needs. The launch of the thresholds guidance has been a key trigger for change across the partnership to address the 'refer on' culture that existed. Although there has been a reduction in inappropriate contacts to children's social care, the largest of which is from the education sector, there is still more to be done to tackle inappropriate contacts from other key partners.

The following are some examples of good partnership working:

Case Study 1:-

Through the Together Team, we were able to offer a single mother help with boundaries in relation; to her teenage daughter and awareness of appropriate behaviour at home and at school. The team also provided help with domestic health and safety and visit from fire service was arranged to promote safety at home and install fire angels. This was a team solution supported by getset, Children's Social Care and the school.

Case Study 2:-

There were some concerns within a local town Community about young people and their criminal behaviour and substance misuse. The young people were open to getset and individualised intervention was having a limited impact on their choices and decision making.

getset coordinated a multi-agency strategic response across over 15 different agencies, including CSC, YOT, Police, Housing, Community services, One Team, Education and many others.

One action from this was for getset to deliver 2 groups: Targeted parenting programme for the parents of the young people and a specific youth group intervention for the young people to coordinate a group response.

This youth group has now been running for 15 weeks and has considerably improved the situation. Anti-social behaviour (ASB) and criminality has reduced substantially, all 3 young people are accessing alternative education provision. So much so that all 3 are now in the process of reintegrating with universal youth provision within their communities.

Case Study 3:-

Child A had been open to getset, over the previous 3 years, over a number of occasions, primarily due to low level neglect of basic needs and education needs.

Despite a number of previous direct referrals to Somerset Direct, the threshold was not met for children's social care involvement.

However, through transfer meeting and conversations with the Assessment team manager we were able to evidence the chronic and persistent nature of the neglect, the impact of poor parenting and parenting capacity on the achievement and aspirations for the child and subsequently the most recent assessment has led to child in need planning being in place to effectively respond to the risk and need for this child.

Case Study 4:-

Child B had involvement with a range of services over the previous 5 years when a significant incident occurred at school resulting in post-traumatic stress. There were a range of concerns from all agencies that resulted in a children's social care (CSC) assessment.

However, through transfer meeting getset were able to work with CSC to establish clear protective factors and robust planning to effectively hold the case within L3 and prevent CSC involvement. This meant that statutory involvement was not required. We have now progressed this case further through effective support and partnership working and are looking to step this case down to L2 support within school over the next 4 weeks.

Case Study 5:-

Child C: Came from a very complex family with a range of environmental, complex health and emotional needs. The family of this child has been known to a wide range of services without clear partnership working in place. getset have been able to engage in a multi-agency process with housing and police, through the Police Priorities meetings, held fortnightly, and establish clear need and concerns. This has resulted in us moving forwards with appropriate support for that family which has resulted in a strategy meeting being called to review need and whether threshold is met for Section 47 to progress support.

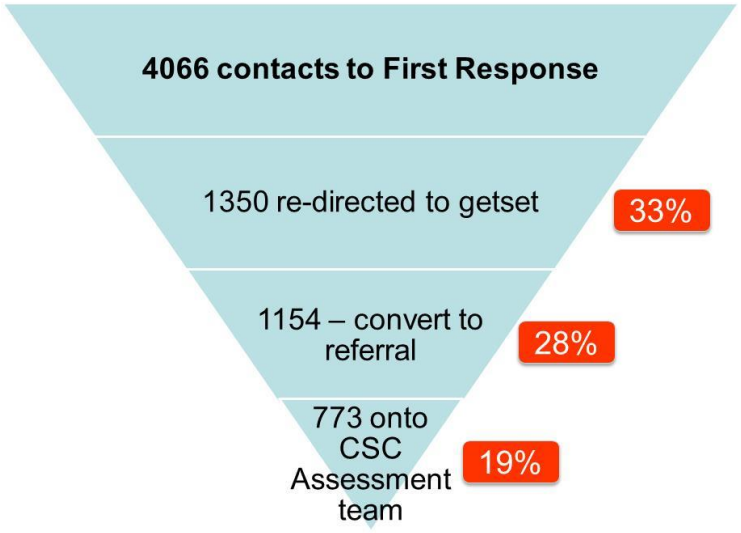
The right service at the right time?

The following table shows the number of contacts that have gone straight through to the Children's Social Care First Response Team over the period 1 April 2017 to 31 March 2018 which have subsequently been triaged and either re-directed to the early help advice hub or the referrer has been advised to complete an EHA. The total number of contacts received by the First Response Team over the same period was 19038.

This data provides a strong indication of the agencies who have a lack of understanding of the early help process as they are not applying thresholds correctly, not using the various models of early help delivery such as TAS or the One Teams to discuss need and not taking advice from either the consultation line for safeguarding leads or the early help advice hub.

Source	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**TOTAL**
Anonymous	0	12	14	8	23	54	33	51	27	33	43	53	**351**
Early Years Provision	1	5	2	0	2	1	0	0	3	0	1	1	**16**
Education	11	14	21	23	2	40	74	83	60	37	61	62	**488**
Emergency Service	1	0	0	0	6	10	11	2	6	9	14	9	**68**
Family/Relatives	15	26	19	43	21	84	138	85	63	133	119	102	**848**
Friend/Neighbour	1	0	3	0	3	1	2	5	1	3	4	10	**33**
General Public	0	0	0	10	0	0	4	0	9	2	3	4	**32**
GP	0	6	0	3	0	2	11	17	6	19	4	8	**76**
Health Visitor/Nurse	0	10	4	7	2	2	1	12	6	2	5	10	**61**
Hospital	2	1	0	3	7	10	8	12	20	22	15	9	**109**
Mental Health Partnership	2	2	1	4	11	17	9	14	14	9	11	6	**100**
Midwife	2	8	4	0	2	14	1	29	6	12	4	10	**92**
Other Housing	2	0	0	1	0	0	1	3	3	4	0	0	**14**
Other Local Authority	0	0	0	0	0	1	3	0	4	0	4	17	**29**
PFSA	1	7	0	0	0	4	2	6	4	1	7	10	**42**
Police	19	15	21	37	8	61	107	107	125	56	103	91	**750**
Probation	0	0	1	1	0	0	7	2	6	2	8	9	**36**
Self	0	0	0	4	0	6	0	0	8	2	0	3	**23**
Voluntary Organisation	0	6	0	2	1	14	20	10	16	11	12	11	**103**

The diagram below shows a 60 day snapshot of contacts coming into First Response.



Findings:

- Significant increase in anonymous and family/relative/parent led referrals to CSC – concern that professionals are seeking to avoid use of EHA.
- Could result in delays due to the number of inappropriate contacts that have to be triaged. The above totals 3271 inappropriate contacts which the First Response have had to triage which takes them away from triaging genuine child protection concerns.
- Police are not applying their BRAG rating to their contacts which would ultimately reduce their inappropriate contacts.
- Although the largest reduction in inappropriate contacts has been seen by the education sector there is still concern as to why Education settings are not using the TAS meetings.

Focus for next year

- Implement the 0-19 Family Support Service which will re-model the children's centre buildings and bring public health nursing and getset staff together within SCC.
- Further develop the early help performance dashboard which prompts discussion and challenge across the whole system
- Improve effectiveness of the Early Help Strategic Commissioning Board and the role of the 4 Early Help Area Advisory Boards to challenge partners and take responsibility for early help, being seen as everyone's business
- Re-launch of the local offer via Somerset Choices
- Further analysis of the inappropriate contacts to children's social care which result in 'no further action' and step-down to early help to understand issues and take any necessary action

- Establish ongoing communication and engagement channel across the early help workforce so that practitioners feel more confident in using the early help tools on professional choices and seeking advice from the EH Advice Hub
- Scope activity required to evidence impact of early help e.g. TAS, One Teams which will inform where early help processes, systems and services should have greater impact
- Continue to review the EHA with partners, and scope out activity required to be able to complete the form digitally making it quicker and easier to use.

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Somerset County Council
Somerset Health and Wellbeing Board –17th January 2018

Children & Young People's Plan 2016 – 2019
Report on progress of Year 2 (1 April 2017 to 31st March 2018)

Cabinet Member(s): Cllr Frances Nicholson – Cabinet Member for Children and Families
Division and Local Member(s): All
Lead Officer: Julian Wooster, Director of Children's Services
Author: Fiona Phur, Partnership Business Manager, Children's Services Commissioning
Contact Details: fzphur@somerset.gov.uk

Report Sign off	Seen by:	Name	Date
	Relevant Senior Manager / Lead Officer (Director Level)	Julian Wooster	9/07/18
	Cabinet Member / Portfolio Holder (if applicable)	Frances Nicholson	9/07/18
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	9/07/18
Forward Plan Reference:	FP/18/04/07		
Summary:	The Children & Young People's Plan 2016–2019 (CYPP) was approved by Cabinet in May 2016, and was further endorsed by Full Council in May 2016 - Appendix 4.1. This is a multi-agency plan that reflects the commitment of strategic partners and the Leader of Somerset County Council for children's services to be 'good' or 'better' in three years. This report provides a progress update on the second year of the CYPP against each of the 7 Improvement Programmes designed to improve outcomes for vulnerable children and their families.		
Recommendations:	That the Health and Wellbeing Board acknowledge the significant work that has been undertaken to date and endorse the improvements and achievements in delivering the 7 Improvement Programmes.		
Reasons for Recommendations:	The CYPP sets the vision and priorities for partners and this progress report for Year 2 of the plan evidences the improvements in delivery of Somerset Children's Services, particularly the functions of Children's Social Care.		
Links to Priorities and Impact on Service Plans:	The Children's Services improvement journey has been a key priority for the local authority since the Ofsted inspection in 2015, focusing on improving practice and quality of services. Since the implementation of the CYPP, Ofsted have undertaken their re-inspection of services for children in need of help and protection, children looked after and care leavers in November 2017 and judged children' services in Somerset "require improvement to be good". All subsequent actions will be focused		

	on the improvement journey to achieve “Good.”					
Consultations undertaken:	All due consultations were undertaken, during the development of the Children & Young People’s Plan (CYPP), prior to its approval by Cabinet in May 2016. There is continuing involvement in the delivery and monitoring of the CYPP by the Cabinet Member, Opposition Spokesperson, Children’s Scrutiny and Children’s Trust Executive and Board members.					
Financial Implications:	The Children and Young People’s Plan was approved and fully costed at Cabinet in May 2016. The CYPP has been prepared and is being delivered in a climate of continuing financial austerity for the public sector. The seven priorities outlined in the plan are to be met within the agreed budgets and staffing resources of SCC and its partners, taking into account anticipated reductions over the next three years. For SCC this plan is costed to look at the average spend of a “good” local authority utilising the CIPFA benchmarking tool and modelling what SCC’s budgets over the next three years should look like based on expected activity levels. SCC’s commitment to protect services that support Somerset’s most vulnerable children and families is reflected by the investment of an additional £6m in the Children’s Social Care base budget. Ongoing financial monitoring of the CYPP is reported by the Director of Finance through his regular reports to Cabinet.					
Legal Implications:	N/A					
HR Implications:	Workforce is the main theme of Improvement Programme 7 and the HR/OD Director has submitted his findings as part of the quarterly reporting arrangements.					
Risk Implications:	The principal risk lies in the failure to secure improvement which would not deliver the Council’s ambitions in relation to improved outcomes for children and young people in Somerset. This could also result in further intervention by the Secretary of State. There is a Corporate Risk for Safeguarding Children (ORG0009) and its current score is 15. There are a number of management actions and mitigations for managing this risk. SLT and the Cabinet Member regularly monitor the management of this risk.					
	Likelihood	**3**	**Impact**	**5**	**Risk Score**	**15**
Other Implications (including due regard implications):	These implications have been considered on an ongoing basis as part of the delivery of the 7 Improvement Programmes.					

Scrutiny comments / recommendation (if any):	The Children and Families Scrutiny Committee receive quarterly performance reports against each of the 7 Improvement Programmes.

1. Background

1.1. The overall aim of the Children & Young People's Plan 2016 – 2019 is to build the ambition and confidence across the partnership, showing partners' joint intentions and the framework by which we will improve. The plan is supported by more detailed strategies and actions through its 7 Improvement Programmes over the lifetime of the plan. The key features of our partnership plans are:

Prevention - and addressing issues early and effectively
Child and family centred – keeping children, young people and their families at the heart of everything we do
Collaboration - working with others to effectively use our resources in commissioning and delivery of services
Integration - providing joined up care and support that is not hindered by organisational, service or professional boundaries

1.2 The 7 Improvement Programmes are:

1. Supporting children, families and communities to be more resilient
2. Promoting healthy outcomes and giving children the best start in life
3. Improving emotional health and well-being
4. Building Skills for Life
5. Providing help early and effectively
6. Achieving effective multi-agency support for more vulnerable children and young people and developing an excellent children's social work service
7. Embedding a 'Think Family' approach across the workforce.

The CYPP has completed the second year of the plan (2017/18) with a detailed action plan focusing on 7 Improvement Programmes, with delivery boards across the partners of the Somerset Children's Trust having the responsibility for delivering against these programmes. Each delivery group has a chair, a SCT Lead Sponsor and member support to progress against their annual action plans. Quarterly reporting to the Children's Trust Executive in the form of Highlight Reports evidences where progress is being made and where barriers to success have been identified and overcome – Appendix 4.3.

This report highlights the activity and impact against each of the 7 Improvement Programmes at the end of the second year and the progress toward achieving the intended outcomes outlined in the CYPP.

2. Progress and Impact in Year 2

2.1 In addition to measures being used to assess the delivery of the 7 Improvement Programmes the CYPP also includes a set of overarching measures designed to assess "How we will know we made a difference". Progress against these measures is set out in Appendix 4.2. These include a number of outcome type measures which, by their nature can take a longer timeframe before showing improvement resulting from the activity within the improvement programmes. Work plans for 2018/19 will continue to focus on actions that will influence the achievement of these measures.

The SCT have considered the maturity of the partnership and whether this has effected a

more collaborative and collegiate approach. The Partnership Team promoted the CYPP and its progress with partners during a series of community events to promote the Young People's Strategy. They were able to report that operationally, staff report, and are able to demonstrate, the benefits of a stronger partnership approach; however capacity and resource are the barriers to full collaboration. It is intended to undertake a survey across SCT partners to ascertain a wider staff view and help to inform the development of the next CYPP.

2.2 The table below shows the main improvements over 2017/18.

	Children and Young People's Plan 2016 – 2019 7 Improvement Programmes **What have we achieved in 2017/18?**
Programme 1 Supporting children, families and communities to be more resilient	• West Somerset Opportunity Area and Department for Education social mobility programme action plan has been published and is now being implemented • The SEND Local Offer has been reviewed and refreshed, and a new platform and website developed to launch in Year 3 • There has been significant work towards increasing volunteering capability with the rebrand and launch of Somerset You Can Do listing and promoting opportunities • Work towards personalised budgets has been achieved, the Statement of Intent approved outlining how each partner applies their own personal budget process against the overarching statement of intent
Programme 2 Promoting healthy outcomes and giving children the best start in life	• A robust parenting offer has been provided through the online Parent Carer Toolkit, parenting courses and working with getset services • A second bid was submitted to NHS England for specialist Perinatal Infant and Mental Health services funding • Breastfeeding support in Somerset has been enhanced with volunteer Breastfeeding Champions trained across the county, and the launch of digital breastfeeding support • Great success has been achieved with the Smoking at the Time of Delivery campaign. As a result of the work across Somerset with the Smokefree Alliance by 2017/18 a fantastic 1000 extra babies were born smoke free since 2011 • Better relationships have been developed with General Practitioners to provide information to Education, Health and Care Plans • The Health and Well-being Survey has been launched in primary and secondary schools – the results are expected in September 2018 (Y3Q2)
Programme 3 Improving emotional health and well-being	• Increased our work on self-harm including the implementation of a self-harm action plan and two self-harm Tier 2 liaison posts • Provided greater access to mental health support through a single point of access, on-line counselling, greater emotional health and well-being work in schools and meeting referral

	targets into Child and Adolescent Mental Health Service (CAMHS) • The new Kooth online counselling service has increased mental health support at Tier 2, with 430 young people now registered and 104 receiving online counselling • The Schools Health and Resilience Education (SHARE) service is now implemented • Clinical Psychologist for the Emotional Health and Wellbeing Team has commenced in post • Phoenix service (Child Sexual Abuse support service) is now implemented with a positive uptake on requests for support • 406 staff have been trained in Emotion Coaching with uptake set to increase in Year 3 with primary phase staff
Programme 4 Building Skills for Life	• Team Around the School project has been embraced and established in all schools across the county, with quality assurance process to support their work • Greater access to careers and transition advice, especially for vulnerable learners and those distanced from education • 12 TalentEd Academies are now running across Somerset for vocational learners with over 200 young people engaged, these are making good contact with engaged employers in key Somerset employment sectors • There has been success in the High Risk of Being NEET work where 91% of students remain in their chosen destination
Programme 5 Providing help early and effectively	• Ofsted recognition of improvements in the getset service although more needs to be done by partners to achieve effective early help • Significant development work undertaken and a public consultation exercise held to inform proposals for an integrated Family Support Service which will encompass getset services, health visitors and school nurses as a first phase. This was approved by SCC Cabinet in February 2018. • The Neglect Strategy was launched at the Neglect Conference in November 2017 which was well attended by over 100 multi-agency delegates • The Young Person's Strategy work has progressed well with an action plan being drafted, and the development and implementation of the Community Adolescent Team (CAT) which will support young people at risk of coming into the care of SCC • Improved partnership work with the 4 local Area Advisory Boards including joint reporting through the Early Help Strategic Commissioning Board • Professional Choices early help tools and systems have been successfully embedded as a multiagency tool to do the job, with 1,913 multiagency professionals now registered • Launch of the Young carers Safeguarding policy and improved support for Young carers in school which will develop further with training in Year 3
Programme 6	• An improved Ofsted judgement in November 2017 has led to

Achieving effective multi-agency support for more vulnerable children and young people and developing an excellent children's social work service	the development and implementation of plans for Getting to Good. The recommendations from the Ofsted report are contained within the Year 3 action plan • There has been systemic leadership and supervision training across the management team, leading to better management overview and case direction • Development and successful implementation of Family Group Conferences leading to a reduction in children coming into local authority care and better support to remain with their families • Virtual School capacity has been increased to provide support for 16 to 18 year olds in care or leaving care to access education, training or employment. • Progress on joint work with the Somerset Safeguarding Children's Board led to the ratification of the Neglect Strategy, the launch of the Unborn Baby Protocol and the re-launched Missing Children Protocol
Programme 7 Embedding a 'Think Family' approach across the workforce	• Successful Assisted & Supported Year in Employment (ASYE) social worker programme • Although not reaching target of 75% permanent social care workforce, there is now 62.4% permanent front line social workforce in place • The multiagency Think Family Strategy is drafted for approval and implementation in Year 3

The Children's Trust Executive is pleased with the progress over this year but recognises there are still some areas where improvements have not met targets. The Executive is aware that recruitment and retention issues, a lack of relevant data to evidence progress and a lack of capacity across partners to drive the programme into its final year are of concern.

Year 3 of the CYPP

The action plans now in place for Year 3 show that there is still work to do to achieve the overall ambitions of the CYPP and the forward focus will be the implementation and evaluation of the CYPP over the final year. This takes the Authority beyond compliance and towards delivering improved quality, resulting in sustained improved outcomes for vulnerable children and young people in Somerset. The main areas of activity during year 3 will include:

- Development of the Family Support Service
- Implementation of the West Somerset Opportunity Area delivery plans
- Expansion of the Parenting Support offer; including advocacy for parents
- Delivery of actions from Ofsted recommendations
- Addressing placement sufficiency challenges
- Delivering the improved SEND Local Offer
- Developing stronger links between schools and their communities to address the needs of more vulnerable learners i.e. Elective Home Educated and Free School Meals, so they achieve in line with their peers
- Implementing the perinatal and infant mental health strategy
- Implement the Infant Feeding Strategy
- Launch new personal, social, health and economic (PSHE) training to teachers.
- Developing a more robust health contribution to education, health and care plans (EHCP)

- Embed the ethos of Think Family across the partnership
- Identify and implement effective early intervention work across the partnership
- Improved emotional health and well-being support with a focus on improving rates of self-harm
- Develop leadership attributes in Children's Services towards our 'Getting to Good' journey

Year 3 will also give an opportunity to prepare for the next CYPP through co-production events with children, young people, their carers and families, local communities and the people that work with children and young people. A draft CYPP is anticipated for sign off by the SCT Executive by the end of Quarter 3, Year 3.

3. Governance

3.1 As the CYPP is a partnership plan the partnership commitment is overseen by the Somerset Children's Trust Board which is Somerset's lead body in relation to the 'duty to co-operate' statutory responsibilities. The safeguarding aspects of the plan will be monitored by the Somerset Safeguarding Children Board. Each programme reports to a relevant multi-agency board and reports quarterly to the Children's Trust Executive and Children & Families Scrutiny Committee.

4. Background Papers

4.1 Somerset Children's Trust Children and Young People's Plan 2016 - 2019

4.2 Children and Young People's Plan Annual Dashboard

4.3 Children and Young People's Plan 2016 – 2019 Year 2 Quarter 4 Executive Summary

4.4 Somerset Children's Trust Governance Diagram

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Outcome Indicator			Comparators		
Outcome Indicator	Previous = Target / Baseline	Most Recent	National Average	Statistical Neighbour Group	Progress
Smoking status at time of delivery	13.6% 2015/16	13.1% 2016/17	10.70%	Not available	Improving year on year but still above National Average
Breastfeeding initiation	80.8% (2014/15)	81.8% (2016/17)	74.50%	Not available	Above National comparator
Breastfeeding at 6-8 weeks	49.4% 2014/15 [old methodology]	46.40%	43.20%	Not available	
Population vaccination coverage achieved across a range of immunisations for children and young people	90% + 2014/15	90% + 2015/16	Not available	Not available	Currently on target
Vaccination coverage – prenatal pertussis vaccine (delivered at more than 28 weeks gestation)	58% (Average monthly estimate) 2015/16	71.4% (Average monthly estimate for reported months) 2016/17	71.50%	Not available	
Seasonal flu vaccine for pregnant women	43.9% (Sept - Jan 2016/17)	47.1% (Sept - Jan 2017/18)	7.2% (provisiona	Not available	
Reception children measured as obese (4-5 years)	8.4% 2015/16	8.7% 2016/17	9.60%	Not available	Slightly worse, but still within national comparators
Year 6 children measured as obese (10-11 years)	15.3% 2015/16	16.4% 2016/17	20.00%	Not available	
Hospital admissions for injuries (0-14 years)_	120.6 Rate per 10,000 2015/16	121 Rate per 10,000 2016/17	101.5	Not available	Above national averages
Hospital admissions for alcohol specific conditions (0-17 years)	56.3 rate per 100,000 2013/14 - 2015/16	62.2 rate per 100,000 2014/15 to 2016/17	34.2	Not available	
Hospital admissions due to substance (drug) misuse (15- 24 years)	122.6 Rate per 100,000 2013/14 - 2015/16	113.5 rate per 100,000 2014/15 - 2016/17	34.2	Not available	
Hospital admissions for self-harm (10-24 years)	726.3 rate per 100,000 2015/16	777.7 rate per 100,000 2016/17	404.6	Not available	
Percentage of five year old children free from dental decay	74.2% 2011/12	76.9% 2014/15	75.20%	Not available	Rate slightly higher than national average
Self-esteem and resilience of secondary school pupils (14-15 years)	49% of boys reported a good level of self-esteem 2014	45% (Secondary Boys) 2016	52% of Secondary Boys in a wider sample of other parts of England	Not available	Girls showing considerably lower levels of self-esteem than boys
	22% of Girls reported a good level of Self-Esteem 2014	25% (Secondary Girls) 2016	34% of Secondary Girls in a wider sample of other parts of England	Not available	

Primary school persistent absence rate	8.3% March 17	9.8% (March 2018)	8.2% (2016)	7.63% (2016)	Rise from March 2017 and above comparators. Both comparators have seen an increase
Secondary school persistent absence rate	14.1% March 17	15.7% (March 2018)	13.1% (2016)	13.36% (2016)	Rise from March 2017 and above comparators. Both comparators have seen an increase
Disadvantaged learners achieving Expected Level in reading writing and maths at Key Stage 2 (disadvantaged learners include children who are eligible for Free School Meals, in Pupil Referral Units or have alternative provision, are Children Looked After or have been adopted)	36% 2015/16 [expected level]	43% (2016/17)	48% (2016/17)	42.4% (2016/17)	Significant attainment gap still remains in place. Attendance within vulnerable groups lower than for the wider cohort.
Percentage of disadvantaged learners achieving a standard pass in English and maths (disadvantaged learners include children who are eligible for free school meals, in pupil referral units or have alternative provision, are children looked after or have been adopted)	Not comparable with previous figures due to change in assessment	40.5% 2017	44.5% 2016/17	40.9% 2016/17	
Rates of young people participating in education, training and apprenticeships (17 - 19)	91.4% 20th Mar 17	90.9% March 2018	81.9% (2015/16)	Not available	Rate of all young people ETE has reduced
Rates of care leavers participating in education, training and apprenticeships (17 to 21)	57.5% Mar 17	61.7% March 2018	60% (2016/17)	58.9% (2016/17)	Rate of Care Leavers ETE is improving
Inadequate Early Years Settings	4 out of 553 (0.7%) Mar 17	3 out of 489 (0.61%) March 2018	5% August 2017	5% South West August 2017	Performance has dropped compared to last year, but still broadly in line with comparators.
Good and Outstanding Early years settings	94.8% Mar 17	95.5% March 2018	93% August 2017	95% South West August 2017	
Inadequate and requiring improvement Primary Schools	5.3% Mar 2017	14.9% (31/207) March 2018	10.3% (March 18)	12% (March 18)	
Good and Outstanding Primary Schools	94.7% (195/206) Mar 17	85% (176/206) March 18	89.7% (March 18)	88% (March 18)	
Inadequate and requiring improvement Secondary Schools	10.8% March 2017	21.6% (8/37) March 18	19.7% (March 18)	20.1% (March 18)	
Good and Outstanding Secondary Schools	86.5% (32/37) Mar 2017	78.38% (29/37) March 18	80.3% (March 18)	79.9% (March 18)	

Children looked After achieving Expected Level in reading writing and maths at Key Stage 2	23.3%	19% 2017	44.5% 2016/17	27% 2016/17	Attainment Levels below comparitors, however this can be impacted significantly by the small cohort size and levels of SEND. Performance broadly inline with National Average; however, higher percentage of persistent absence compared to last year (above comparators) and an increase in fixed term
Percentage of Children Looked After achieving a standard pass in English and Maths	Not comparable with previous figures due to change in assessment	6% 2017	18% 2017	16% 2017	
Persistent absence rate for Children Looked After	13% (2016)	14.76% 2017	10% 2017	10.9% (2017)	
% of Children Looked After with at least one fixed term exclusion	13.04% 2015	18.18% 2017	11.44% 2017	14.83% 2017	
Percentage of young people who went into sustained education at the end of Key Stage 5	New metric, no previous figures available.	58% of all young people 49% of disadvantaged young people 2017	66% of all young people 65% of disadvantaged young people England 2017	Not available	Broadly in line with England for all young people, but a significantly higher number of disadvantaged young people go into apprenticeships and sustained employment than England and significantly fewer go into sustained education.
Percentage of young people who went into apprenticeships at the end of Key Stage 5	New metric, no previous figures available.	8% of all young people 9% of disadvantaged young people 2017	7% of all young people 6% of disadvantaged young people England 2017	Not available	
Percentage of young people who went into sustained employment at the end of Key Stage 5	New metric, no previous figures available.	31% of all young people 37% of disadvantaged young people 2017	32% of all young people 20% of disadvantaged young people England 2017	Not available	
Percentage of young people who went to a destination that was not sustained at the end of Key Stage 5	New metric, no previous figures available.	8% of all young people 11% of disadvantaged young people 2017	8% of all young people 11% of disadvantaged young people England 2017	Not available	
Teenage conceptions (0-17 years)	17.2 rate per 100,000 2014	17.1 rate per 100,000 2015	20.8 rate per 100,000 2015	16.8 rate per 100,000 2015	Rate under national average and in line with South West average
Children are School Ready: Children achieving a good level of development at the end of reception	68.7% 2015/16	71% 2016/17	70.7% 2016/17	71.15% 2016/17	School readiness levels improving,
Number of Early Help Assessments completed across partners	238 starts (Mar 17)	4042 Last 12 months (April 18)	Not applicable	Not applicable	Numbers increasing
Demand on statutory services - contacts to Children's Social Care	30,152 (R12M) Mar 17	26,415 (R12M) March 18	Not applicable	Not applicable	Number of contacts has reduced, and the percentage of re-referrals has

Demand on statutory services- re-referrals to Children's Social Care	23.8% 2016	19.9% 2017	21.9% 2017	19.76% 2017	referrals has improved and is in line with comparators
First Time entrants into the criminal justice system (10 - 17 years)	318 rate per 100,000 oct 15 to sept 16	293 rate per 100,000 (October 16 to September 17)	304 rate per 100,000 (October 16 to September 17)	291 rate per 100,000 (October 16 to September 17)	Generally improving picture
Rate of proven re-offending (10-17)	31.7% april 14 to march 15	31.7% January 16 to March 16	42.1% January 16 to March 16	YOT family 40.3% January 16 to March 16	
Placement stability for Children Looked After *(percentage of children who have been looked after for at least 2.5 years who have been in the same placement for at least 2 years during the last 12 months)*	56.6% Mar 17	60.7% March 2018	68% 2015/16	69.6% 2015/16	Slight improvement from last year but significantly below comparators
Average time between a child entering care and being placed with its adoptive family	383 YTD Mar 17	398.9 YTD March 2018	558 (2013-2016)	490.1 (2013-2016)	Average number of days have increased, this can be influenced by the low numbers involved
Children Looked After	43.8 Rate per 10,000 Mar 17	47.7 Rate per 10,000 March 2018	62 Rate per 10,000 2017	54.6 Rate per 10,000 2017	Rates generally lower than statistical neighbours
Children in Need	155 Rate per 10,000 Mar 17	170 Rate per 10,000 March 2018	330.4 Rate per 10,000 2017	272.16 Rate per 10,000 2017	
Children subject to a Child Protection Plan	37.9 Rate per 10,000 mar 17	39.3 Rate per 10,000 March 2018	43.3 Rate per 10,000 2017	37.4 rate per 10,000 2017	
The turnover rate for social workers service wide	16.04% May 17	16.45% March 2018	13.6% 2017	14.5% 2017	There has been little change in turnover since May 2017 and is above comparators. Rate for Frontline SW only is lower at 13.75%
Percent of Social work staff who are permanent	75.67% May 17	78.12% March 18	84.2% 2017	87.82% 2017	Improving
Somerset will be ranked in the top quartile nationally in the education indicators	See RAG narrative	See RAG narrative	See RAG narrative	See RAG narrative	School Ofsted rankings declined slightly, but GCSE results improving. Use of the CSC service is generally increasing
Somerset will be ranked in the top quartile nationally in the social care indicators	See RAG narrative	See RAG narrative	See RAG narrative	See RAG narrative	

Somerset will be ranked in the top quartile nationally in health performance indicators	See RAG narrative	See RAG narrative	See RAG narrative	See RAG narrative	However Social work turnover and Percent of Permanent staff has improved. Health measures generally worsening, but in line with comparators

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Somerset Health and Wellbeing Board

January 17th 2019
Report for Information

Somerset Health Protection Assurance Report

Lead Officer: Alison Bell, Consultant in Public Health
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	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant	7. 01.19
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence (Cabinet Member)	17.12.18
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	17.12.18

Summary:	The Somerset Health Protection Assurance Report documents the progress made during the last 12 months and the identified priorities for the next year. In summary the Director of Public Health is assured that systems are in place to protect the health of the population, however there are opportunities during 2019 to strengthen these. Throughout 2018 there have been significant challenges within and affecting Somerset that required a system wide response, while these challenges were met there were questions raised regarding capacity and opportunities identified for improvement through planning, prevention and mitigation. These lessons are captured throughout this document and reflected within the 2019 strategic priorities, which are: 4.1 Communicable Diseases Ensure robust communicable disease incident and outbreak response arrangements are in place and embedded across the Somerset system. Key actions include: • Support Public Health England to finalise the Incident and Outbreak Response Framework across the South West; • Work across the partnership to ensure actions required for local implementation; and • Review and agree the Somerset Health Protection

	Memorandum of Understanding. 4.2 Environmental Hazards Ensure initiatives to reduce or mitigate the impacts of environmental hazards on population health are supported and prioritised. Building on existing organisational priorities, key actions include: • Support targeted projects to review and improve water quality in vulnerable institutions such as educational establishments; • Support adoption of the Somerset Air Quality Strategy and projects identified to improve air quality; and • Raise awareness of the impact on health from housing standards and support local initiatives to address significant hazards such as Legionella. 4.3 Infection Prevention and Control Ensure infection prevention and control priorities address local need and reflect national ambition. Recognising areas for improvement identified during 2018 and the context surrounding infection prevention and control, key actions include: • Identify initiatives to improve community infection prevention and control amongst vulnerable populations, specifically intravenous drug users and the homeless; • Raise awareness of the national strategy to address antimicrobial resistance and support / develop local initiatives as appropriate; and • Support the CCG to reduce the burden of disease associated with Gram Negative Blood Stream Infections 4.4 Resilience Ensure local and regional emergency response arrangements are in place to protect the health of the population. Working closely with local and regional forums, key actions include: • Maintain a system wide understanding of priorities and challenges within the emergency planning, resilience and response community and ensure that lessons identified in major incidents (such as Salisbury / Amesbury) are embedded in local system response; • Support activity and coordination between local groups and regional forums; and • Consider the role of communities in reducing the impact of winter pressures on primary and emergency / urgent care.

	4.5 Screening and immunisation Ensure screening and immunisation programmes meet national standards and where work is required to increase uptake, reflect local priorities to achieve national standards. In support of the existing screening and immunisation programme in Somerset, key actions include: • Undertake a health equity audit on uptake of one specific screening programme to be determined; • Secure access to uptake data on screening and immunisation programmes at lower geographical levels in order to identify where remedial action is required to improve overall coverage, as this has fallen across all immunisation programmes during 2017/18; and • Improve uptake of the seasonal flu vaccination for those working directly with vulnerable service users.
Recommendations:	That the Health and Wellbeing Board notes the report, and endorses the priorities proposed for 2018/19 covering: 1. Communicable Diseases; 2. Environmental Hazards; 3. Infection Prevention and Control; 4. Resilience; and 5. Screening and Immunisations.
Reasons for recommendations:	The Somerset Health Protection Forum and Director of Public Health have identified actions within these priorities as key issues to address in order to be assured that suitable arrangements are in place to protect the health of the Somerset population and reaches vulnerable populations within Somerset .
Links to Somerset Health and Wellbeing Strategy	This report supports the following Improving Lives in Somerset Strategy priorities: Priority 2. Safe, vibrant and well-balanced communities able to enjoy and benefit from the natural environment. Priority 4. Improved health and wellbeing and more people living healthy and independent lives for longer.
Financial, Legal and HR Implications:	This is a statutory role of the Director of Public Health acting on behalf of the Secretary of State for Health. There are no direct financial implications as a result of this report.
Equalities Implications:	There are no equalities implications arising directly from accepting this report. The identified priorities for the coming

	year will help to address health inequalities. The recommendation to undertake a health equity audit on the uptake on one adult screening programme during 2019, will give insight into uptake of programmes among different groups that make up our local population.
Risk Assessment:	Failure to address the identified priorities could lead to the Director of Public Health being unable to be assured about arrangements in place to protect public health in the county.

1. Background

1.1. The Director of Public Health (DPH) of Somerset County Council has a statutory duty to seek assurance that measures are in place to protect the health of the Somerset population. In order to make sure that the DPH is fully informed about the work of partners and can be so assured, the Somerset Health Protection Forum was created in March 2013.

2. Options Considered and reasons for rejecting them

2.1. Considered and not relevant.

3. Consultations undertaken

3.1 No consultations have been undertaken, this is an assurance report

4. Implications

4.1. The Somerset Health Protection Forum needs the endorsement of the Health & Well-being board on the recommendations proposed, including work priorities for next year, to ensure partners can commit resources (staff time) to working to address these priorities

5. Background papers

5.1 Somerset Health Protection, Strategic Action Plan. 2017-18

Somerset Health Protection

Assurance Report

December 2018

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Contents

Introduction

Health Protection seeks to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation[1].

The Somerset Health Protection Forum comprises professional partners holding health protection responsibilities and has a collective role to provide assurance on behalf of the Director for Public Health to the Health and Wellbeing Board.

Working alongside accountability structures of individual partner organisations, the aim of the Health Protection Forum is to ensure effective and integrated systems are in place for protecting population health, with specific reference to: communicable diseases; environmental hazards; infection prevention and control; resilience; and screening and immunisation.

Providing a mechanism for strategic multi-agency working, the forum enables professional discussion in relation to maintaining effective and efficient health protection systems across Somerset. This ensures that, as a collective of responsible organisations, challenges, risks and opportunities are identified prioritised and addressed as efficiently as possible.

The purpose of this report is to give an overview of the work that has taken place during the past 12 months, the key issues and risks arising, and the priorities for the year ahead.

[1] PHE, *Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public health Functions and Entry to Premises by Local Healthwatch representatives) Regulations 2013*, 2013.

1. Strategic Action Plan Priorities 2018

To ensure the Health Protection Forum has a focused agenda and forward plan, a Strategic Action Plan is developed annually. This identifies the priorities and actions to be monitored over the coming 12 months as approved by the Health and Wellbeing Board.

The priorities for 2018 were: **Overall System Resilience; Flu Immunisations; Air Quality; and Tuberculosis.** Progress against the agreed actions is summarised as follows:

1.1 Overall System Resilience

An area of concern of the Director of Public Health was the overall resilience of the health and social care system and the capacity of system to cope with additional pressures caused by incidents such as severe weather and outbreaks.

1.1 Action 1:

- Ensure that the Somerset Health and Social Care Emergency Planning Group is effective in delivering its purpose.

This group is coordinated by the Somerset CCG and has met 5 times during 2018 in accordance with an agreed schedule and work programme. The group is scheduled to meet quarterly throughout 2019 and has the support of its membership. Further detail of the work completed, including issues identified during the March 2018 snow response, is within the Resilience section of this report.

1.1 Action 2:

- Work with PHE to organise Health Protection Regulations training for District Council Officers.

Health Protection Regulations Training was delivered in the South West by Public Health England during September 2018. This was made available to all members of the Health Protection Forum and attended by representatives for all District Councils Environmental Health teams and Somerset County Council Public Health.

1.1 Next Steps Overall System Resilience:

To continue progress, work to strengthen and formalise links between the Somerset Health and Social Care Emergency Planning Group with the Local Health Resilience Partnership, Local Resilience Forum and the Health Protection Forum.

Finalise the Somerset Communicable Disease Incident and Outbreak Operational Response Plan and based on the PHE Framework and plan to test this via a desk top exercise.

From 2019 ‘training’ will be added to the standing agenda of the Health Protection Forum to ensure further opportunities are highlighted across the local health protection system.

1.2 Flu Immunisations

Uptake of immunisation programmes offered to the residents of Somerset are not reaching targets but are in line with the national average. It is important however to continue monitoring progress and identify areas requiring attention, particularly following the introduction of the new NHS England scheme to cover all social and domiciliary care and hospice staff.

Monitoring of flu vaccination coverage is co-ordinated through a Somerset specific group led by the Clinical Commissioning Group and a wider South West group led by NHS England. SCC Public Health are not cited on flu vaccination coverage by practice or by target group in a timely manner, which limits our ability to assure the system of good flu vaccination coverage

1.2 Action 1:

- Ensure all immunisation and screening programmes are performing, monitor the uptake data and perform a ‘deep dive’ assurance process on the programmes where there are concerns.

Due to poor attendance a limited deep dive was held on flu planning at the September meeting. In light of the flu-specific co-ordination functions previously described it was not deemed necessary to reschedule this discussion.

Flu vaccination coverage, including that of health care workers, is communicated to the A&E delivery board to ensure it is high on the health and care system agenda.

1.2 Action 2:

- Work with partner organisations to improve the communication channels with care providers in Somerset to ensure that guidance and support reaches the target audiences.

In addition to those care homes commissioned by Somerset County Council and the Clinical Commissioning Group, which receive information from these organisations. It has been identified that the District Councils Environmental Health function maintain contact lists for all care and residential homes within Somerset, with officers also visiting annually to undertake food inspections. These channels have been made available to distribute seasonal advice relating to flu vaccinations and outbreak information.

As in 2017/18, NHS England provided additional funding in 2018/19 to support the delivery of flu immunisations for health, care and social care staff. This is available to

those providing direct care and employed in residential care homes, nursing homes, domiciliary care providers and voluntary managed hospice providers.

Local awareness and uptake of this offer has been supported by members of the forum through available channels as previously described.

1.2 Action 3:

- All health protection forum members to review their staff flu vaccination programme to ensure a more effective approach to improve uptake amongst staff (In particular frontline health and social care staff). Work with services across the Somerset County Council to determine a strategic approach to improving the staff flu vaccination programme.

All member organisations have delivered staff flu vaccination programmes as appropriate, cognisant of national guidance and good practice. The 2018/19 staff programme delivered by SCC yielded lower uptake than in 2017/18. Factors attributable to the decline are likely to be related to a change in delivery format however a programme review is underway to inform any necessary changes for 2019/20.

In addition to the South West flu group, for the 2018/19 flu season the CCG have identified a flu lead to maintain oversight of local provider activity, including staff vaccination rates. At the time of the last report vaccination rates across the system were improved upon from 2017/18.

Next Steps Flu Vaccinations:

District Councils, SCC and CCG will continue to be utilised to disseminate information to the care home and domiciliary care sectors and seek feedback for future improvement.

Work with the LMC and NHS E to ensure access to coverage of flu vaccination, by GP practice and target groups, to enable in year targeted work to improve uptake.

Seek staff uptake feedback from eligible providers across the system to establish the barriers and incentives for vaccination.

Due to a change in available delivery options and the desire to increase uptake, the County Council staff vaccination programme was hosted through drop in clinics in GP surgeries close to staff work places. The programme resulted in lower uptake than in 2017/18 therefore improvements such as delivery of system-wide clinics will be explored.

1.3 Air Quality

The main impacts of air pollution are a range of respiratory conditions, cardiovascular disease, cancers and birth defects and it is estimated that 29,000 people in the UK die of air pollution related causes annually.

1.3 Action 1:

- Consult on the Somerset Air Quality Strategy and seek adoption by partners.

The public consultation has been completed. Although responses were low in number they were of good quality and generally supportive.

Next Steps Air Quality: A report is in preparation which will recommend minor changes to the draft strategy and/or website and adoption by partners 2019. Steps to continue this work will be reflected in the 2019 strategic priorities.

1.3 Action 2:

- All partners to ensure progress of the four identified priorities by the steering group.

Next Steps Air Quality: The website will be finalised to reflect consultation responses and recent developments before a formal launch and adoption of the Strategy by partners. Pending adoption of the Strategy, priorities can be pursued opportunistically by partners.

1.3 Action 3:

- Monitor national developments and bid, if appropriate, for funds to improve air quality in air quality management areas.

Somerset local authorities have not so far been included in the list of those subject to Ministerial direction and therefore have not had access to relevant funds.

Next Steps Air Quality: Monitor bid opportunities during 2019.

1.4 Tuberculosis

Between 2015-2017 Somerset had 23 cases of TB. In 2016 the TB treatment completion rate for Somerset residents was 42.9%, but this did relate to a very small number of cases. The England rate during comparable time period was 84.4% for England and 78.8% for South West. This means that Somerset is significantly worse for treatment completion for TB than the South West or England average and no areas reach the WHO target for treatment completion (85%).

Based on the South West TB strategy and NICE quality standards for TB, a workplan was established for Somerset, to ensure there is equity of access to effective

diagnosis, treatment, contact tracing and follow up of all TB patients, according to their needs. The following progress has bene made:

- The CCG has embedded the national TB specification into one of the acute trust contracts, however, mindful of capacity have not achieved this in the other local acute trust. The CCG has drafted a paper suggesting a regional approach to managing complex patients and outbreaks, but not clear where this can be progressed
- The national programme to provide latent TB infection tests for people arriving from high incidence countries has been limited to areas of the UK reporting high incidences of TB. This approach doesn't account for the issue of workers from high prevalence countries being resident in low incidence areas, as seen in Somerset. This issue has been raised with the National Strategy team, through PHE.
- Patient who have been diagnosed with TB are where appropriate referred form HIV testing, the pathway between HIV testing and respiratory teams needs to be developed.
- Patients in Somerset who are referred to their respiratory service do receive rapid diagnostic molecular testing for TB. There is known to be a gap relating to paediatrics however there is no progress to report in addressing it.
- Under local arrangements anyone homeless and diagnosed with active pulmonary TB should be offered accommodation for the duration of their treatment. To achieve this there is an in-principle agreement between the District Council, County Council and CCG that agencies would work together to secure housing for the duration of their treatment. It is not believed that a formal policy is required at this time.

2. Core Business

2.1 Communicable Diseases

As reported above, work to develop a communicable disease incident and outbreak response framework and operational plan template was conducted during 2017. The forum has sought for this work to be finalised during 2018 however agreement on the approach to planning remains unresolved regionally. The forum understands that resource has been allocated to resolve the outstanding issues by early 2019. An operational plan for single case management is in place locally

During 2018, we have had 72 outbreaks of communicable diseases. The majority related to Influenza like illness or diarrhoea and vomiting. Additionally we have had 29 incidents, that span a broad range of threats to public health ranging from industrial fires and carbon monoxide exposure to outbreaks involving swimming pools, visits to open farms, Shiga Toxin-producing E-coli (STEC) outbreaks and probable cases of meningococcal disease.

A key success in Somerset has been the lack of measles cases or outbreaks, despite a significant outbreak in the North of the South West patch and ongoing outbreaks in

Europe. The lack of cases in Somerset is believed to be due to good primary immunisation schedule coverage and targeted communication work undertaken this year.

Additionally colleagues in PHE handle individual cases of notifiable diseases, of which there are 32 in England, with the clinicians caring for them. A summary of the 2018 reports are listed below

Somerset

Infection	Rate per 100,000 population												Trend	Comparison to 2017-3**
	2015-4	2016-1	2016-2	2016-3	2016-4	2017-1	2017-2	2017-3	2017-4	2018-1	2018-2	2018-3		
Scarlet Fever	2.8	9.6	10.6	5.1	3.8	7.6	4.5	1.8	5.2	19.8	10.6	2.7		↑
Invasive group A streptococcal infection	2.2	2.0	0.9	0.9	1.8	0.9	1.1	1.3	1.8	2.0	3.8	1.4		↑
Measles	0.0	0.4	0.0	2.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2		↑
Mumps	0.4	0.4	0.2	0.0	0.2	0.4	0.7	0.4	0.0	0.4	0.2	0.2		↓
Pertussis	5.9	2.4	1.6	4.6	3.8	2.0	3.4	2.5	3.6	2.7	1.4	2.9		↑
Meningococcal infection*	0.6	0.4	0.5	0.0	0.7	1.6	0.4	0.4	0.2	0.4	0.0			↓
Campylobacter	27.3	26.6	35.3	39.5	24.4	24.5	34.9	40.3	26.5	25.6	44.1	35.5		↓
Cryptosporidium	5.1	2.0	3.5	6.6	8.0	3.1	6.3	3.8	3.6	3.2	3.4	5.2		↑
Escherichia coli STEC	0.2	0.0	0.9	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.9		↓
Giardia	6.1	5.1	5.3	7.1	4.6	4.0	5.9	6.8	6.1	5.0	8.3	5.6		↓
Salmonella Enteriditis	0.6	0.7	0.7	2.4	0.7	0.4	0.5	1.8	1.4	0.2	1.4	1.8		→
Salmonella Typhimurium	0.9	0.5	0.9	0.7	0.4	0.7	0.4	2.2	1.1	0.4	0.5	1.3		↓
Shigella	0.7	0.4	0.4	0.9	0.7	0.5	0.0	0.2	0.5	0.5	0.0	0.4		↑

*Data for the latest quarter is currently undergoing validation and is therefore not yet available.

**For meningococcal infection this comparison is between quarter 2 2018 and quarter 2 2017

Figure 1: Somerset Rates of notification of diseases to PHE during 2018

Next steps: There are changes regarding PHE prescribing arrangements during outbreaks. Once the communicable diseases framework is finalised the detail of how Somerset responds to communicable disease outbreaks as a system needs to be worked through.

2.2 Environmental Hazards

As reported within 1.3 Air Quality, the public consultation on the draft strategy is complete and progress has been made as follows:

- The Website has been launched to inform the public, businesses, drivers and developers about what they can do to help improve air quality in Somerset in the choices they make. This can be accessed at: https://somersetairquality.wordpress.com/
- SCC Public Health now comments on planning applications for major developments with a view to minimising the need to travel by car in urban areas
- Environmental health officers have considered how best to monitor small particle pollution (PM2.5) with subsequent operational recommendations made.

In 2019, following final amendments the Somerset Air Quality Strategy will be put to partners for formal adoption.

Next steps will be to access available air quality monitoring data to look at trends and see where actions are needed by individual partners or the forum collectively

Key Lesson Learned: Capacity issues continue to limit the ability of both county and district councils to develop bid ready schemes for competitive funding sources made available by central government as areas with substantial exceedances of current limits are much more likely to have bids approved. This emphasises the importance of partners adopting the strategy and identifying local opportunities to work collaboratively.

2.3 Infection Prevention and Control

The Somerset Infection Prevention and Control Group is led by the CCG with key priorities including Healthcare Acquired Infections and Gram-negative blood stream infections (GNBSI). Somerset has the 7th highest national number (not rate) of GNBSI and there is a national ambition to reduce these numbers by 50% by 2021.

A Somerset Strategy for the Prevention and Control of Infection has been produced, for a system wide approach. The purpose of this document is to set out the CCG's and Somerset system responsibility and objectives for infection prevention and control and the work plan to ensure these are met.

Somerset has well developed structures and processes for IPC in healthcare settings. However, there is a lack of an equitable and effective infection prevention service for primary care, care homes and social care. This leads to gaps in provision of organism and patient specific risk assessment and advice which potentially has implications for care and use of health care resources and the spread of infection. The CCG has submitted a business case to secure infection control posts that can address this gap during 2019.

Key Lesson Learned

Nationally and within Somerset there has been an increase in bacterial infections among Persons Who Inject Drugs (PWID), with two clusters seen within Somerset in 2018. Through system wide working, involving the drugs and alcohol service, commissioners, the CCG, local PH team and PHE have ensured in future, local drug and alcohol services will receive training and toolkits to support their clients, adopt safer practices and ensure that in future information regarding outbreaks are communicated more clearly across the system. This work needs to continue in 2019

2.4 Resilience

The primary forums for emergency planning, resilience and response in Somerset are the Avon and Somerset Local Resilience Forum and the Avon and Somerset Local Health Resilience Partnership. As these forums have wide geographical and

organisational coverage, the Somerset Health and Social Care Emergency Planning Group exists to support and coordinate local tactical health and care EPR activity.

The Health Protection Forum maintains links with each of these groups to ensure any priorities identified are addressed within the context of the wider system. Key areas of local planning for 2018 have included trust capacity coordination; communicable diseases; mass casualty response; mortuary provision and 4x4 transport.

Incidents within or affecting Somerset and requiring multi-agency coordination included have included severe weather (snow); utility failure; fire; and winter pressures. The learning and further actions from these incidents are captured within multi-agency debriefing processes and actioned accordingly.

Exercise Nighthawk was conducted in June of 2018 to test the multi-agency arrangements outlined in the Hinkley Point B Nuclear Licensed Site Off-Site Emergency Plan. Members of the forum participated as appropriate to their role within their own organisation and provided feedback where required.

Key Lesson Learned

Due to organisational structures it is difficult for NHS England representatives to attend all the health protection forums within their jurisdiction. Whilst the DPH is sighted on the NHS E annual assurance return it has not been possible for the Health Protection Forum to discuss the assurance framework for health system resilience with NHS England. To address this, consideration will be given to whether the emergency planning lead for the Somerset CCG could fulfil this function, by becoming a member of the Health Protection Forum.

2.5 Screening and Immunisations

2.5.1 Screening

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

Current screening programmes cover:

- Cancer screening (breast, bowel and cervical);
- Adult screening (abdominal aortic aneurysm and diabetic eye); and
- Antenatal and new-born screening (foetal anomaly, infectious diseases in pregnancy, sickle cell and thalassaemia, new-born and infant physical examination, new-born blood spot and new-born hearing)

Each quarter NHS E provides a report to the Health Protection Forum to provide assurance to the DPH that the local population is achieving the expected coverage according to national targets, in summary:

Cancer Screening.

Breast cancer screening rates in Somerset at 77.9% (compared with England of 75.4%) is good and above the lower threshold target. However, cervical cancer screening coverage in Somerset at 74.3% (compared with England of 72%) is just below the lower threshold national target. The bowel cancer screening rate is 62.7%, is higher than national rates and achieves the target level of 60%.

Antenatal Screening.

Data for antenatal screening programmes is provided at a trust level, see Figure 2. Approximately 10% of women receive antenatal care and screening from an out of area provider, which we do not receive data for. A request to the change in format of reporting from NHS England will be made in 2019.

Adult Screening.

The Diabetic Eye (DE) and the Abdominal Aortic Aneurysm (AAA) Screening programmes continue to perform well, meeting and exceeding targets at 84.5% and 85% respectively in Q4 of 2017/18.

Indicator	Lower threshold1	Standard2	Geography	2017	Q4 2017/18
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Somerset	77.9	
			England	75.4	
2.20ii - Cancer screening coverage - cervical cancer (%)	75	80	Somerset	74.3	
			England	72.0	
2.20iii - Cancer screening coverage - bowel cancer (%)	55	60	Somerset	62.7	
			England	58.8	
				2016/17	Q4 2017/18
2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage (%)	≥ 95%	≥ 99%	Somerset	0.0	
YDH			YDH		99.80%
T&S			T&S		99.50%
			England	99.5	
2.20x - Sickle Cell and Thalassaemia Screening – Coverage (%)	≥ 95.0%	≥ 99.0%	Somerset	0.0	
			YDH		100
			T&S		99.2
			England	99.3	
2.20xi - Newborn Blood Spot Screening – Coverage (%)	≥ 95.0%	≥ 99.9%	Somerset	0.0	96.4
			England	96.5	
2.20xii Newborn Hearing Screening – Coverage (%)	≥ 97%	≥ 99.5%	Somerset	0.0	99.3
			England	98.4	
2.20xiii - Newborn and Infant Physical Examination Screening – Coverage (%)	≥ 95.0%	≥ 99.5%	Somerset	0.0	
			YDH		98.1
			T&S		99
			England	93.5	
2.20v – Diabetic eye screening - uptake (%)	≥ 70.0%	≥ 80.0%	Somerset	0.0	84.5
			England	82.2	
2.20iv – Abdominal Aortic Aneurysm Screening – Coverage (%)	≥ 75%	≥ 85.0%	Somerset	86.5	85
			England	80.9	

Figure 2: Somerset NHS Screening Assurance Report 2018

Whilst coverage is adequate the DPH remains concerned that particularly vulnerable sections of our local population e.g the homeless, adults with learning disabilities or those living in areas of higher deprivation, have access to these programmes and where required necessary adjustments are made to ensure equitable access.

Screening Incidents:

Incidents can damage the trust the population has in screening programmes and so it is vital that any incidents that occur are managed well. In January of 2018 NHS E identified an IT issue resulting in some local services not inviting all eligible women for their final screen in the 3 years before their 71st birthday, this did affect some Somerset women.

NHS E has carried out a thorough investigation including a detailed analysis of data and advice from experts and clinicians. The fault has now been identified and fixed and women who did not receive their final routine invitation and are registered with a GP are being contacted and offered the opportunity to have a catch-up screen.

This incident was well managed and the DPH kept informed throughout to ensure national messages were reinforced locally.

Additionally an incident has occurred within the cervical screening programme, however, information was not shared with the DPH and this is being followed up with NHS England.

Next Steps:

Work to improve notification of screening incidents to the DPH.

Undertake a Health Equity Audit on one of the adult cancer screening programmes, in partnership with NHS E

Work with NHS E to get complete reporting on antenatal screening programme coverage for Somerset residents

2.5.2. Immunisations.

There is a national childhood and adult immunisation programme, that are offered through primary care, school nursing and for some vaccines through pharmacies and midwifery in Somerset, (Figure 3). Coverage is broadly in line with the national average however there has been a small decline across most antigens this last year.

Childhood	Vaccine
	Meningitis B
	Rotavirus
	Diphtheria, tetanus, pertussis, polio and Hib
	Pneumococcal (PCV)
	Hib/MenC booster
	Measles, Mumps and Rubella (MMR)
	Flu (annually aged 2-7)
	HPV
	Tetanus, diphtheria and polio adolescent booster
	MenACWY
Adult	Pneumococcal
	Flu (at risk and over 65s)
	Shingles
	Pertussis (during pregnancy)

Table 1: NHS Immunisation Programmes

Indicator	Lower threshold1	Standard2	Geography	2017/18	Q4 2017/18
3.03i - Population vaccination coverage - Hepatitis B (1 year old)			Somerset	100.0	100
			England		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	90	95	Somerset	94.0	94.1
			England	93.4	92.6
3.03iv - Population vaccination coverage - MenC	90	95	Somerset	no	no
			England		
3.03v - Population vaccination coverage - PCV	90	95	Somerset	94.1	94
			England	93.5	92.8
3.03i - Population vaccination coverage - Hepatitis B (2 years old)			Somerset	100.0	
			England		
Population vaccination coverage Rotavirus (1 year)	95		Somerset	NA	91.2
			England		90.3
Population vaccination coveraeg Men B	NA		Somerset	NA	93.8
			England		92.5
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	90	95	Somerset	96.7	96.4
			England	95.1	95
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	90	95	Somerset	94.2	93
			England	91.5	91.2
3.03vii - Population vaccination coverage - PCV booster	90	95	Somerset	94.1	92.7
			England	91.5	91.2
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	90	95	Somerset	93.8	94.6
			England	91.6	91.2
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	90	95	Somerset	96.2	92.5
			England	95.0	90.8
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	90	95	Somerset	96.3	96
			England	92.6	92.7
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	90	95	Somerset	90.3	90.1
			England	87.6	87.2

Figure 3: Somerset Childhood Immunisation Coverage 2017/18

Indicator	Lower thr	Standard	Key			Geograph	2015/16	2016/17	2017/18
3.03xii - Population vaccination coverage - HPV (%)	80	90	<80	80-90	>=90	Somerset	85.8	83.3	0.0
						England	87.0	87.2	0.0
3.03xiii - Population vaccination coverage - PPV (%)	65	75	<65	65-75	>=75	Somerset	68.2	67.7	0.0
						England	70.1	69.8	0.0
3.03xiv - Population vaccination coverage - Flu (aged 65+) (%)	70	75	<70	70-75	>=75	Somerset	70.5	70.5	72.4
				70-75		England	71.0	70.5	72.6
3.03xv - Population vaccination coverage - Flu (at risk individuals) (%)	50	55	<50	50-55	>=55	Somerset	45.7	48.5	48.1
						England	45.1	48.6	48.9
3.03xviii - Population vaccination coverage - Flu (2-4 years old) (%)	30	40	<30	30-40	>=40	Somerset	42.0	44.5	48.5
						England	34.4	38.1	43.5
3.03xvii - Population vaccination coverage - Shingles vaccination cover	50	60	<50	50-60	>=60	Somerset			
						England	54.9	48.3	0.0

Figure 4: Somerset Adult Immunisation Coverage 2017/18

Particular priority was given to the flu programme in 2017/18, due to the complexity of the programme and the importance it has in reducing mortality and preventing additional pressures on the health system. The uptake data is detailed below in Table 2.

	Somerset (%)				England (%)			
	14/15	15/16	16/17	17/18	14/15	15/16	16/17	17/18
Over 65s	70.6	70.5	70.5	72.4	72.7	71	70.5	72.6
At risk under 65s	47.4	42.9	48.5	48.1	50.3	45	48.5	48.9
Pregnant Women	38.2	42.5	43.9	47.1	44.1	42	44.9	47.2
Carers	36.9	36.9	46.5		-	-	-	

Table 2: Flu vaccination coverage of target groups

Flu vaccination of care home staff is a particular concern within Somerset, due to the number of influenza like illness (ILI) outbreaks in care homes last year. Within the health and care sectors, vaccinating frontline health and social care staff is vital in reducing the spread of flu to vulnerable service users. In the 2017/18 flu season NHS England announced a scheme to fund the flu vaccine for care home staff . This came late in the programme and data was not recorded to enable assessment of coverage. This offer was again made in advance of the 2018/19 flu season and as the announcement has come earlier, this will hopefully enable better uptake and will also be recorded by READ coding the offer through GP practices.

SCC worked with partners to ensure communication of this offer to care home providers, domiciliary providers and hospice staff. For the first time our District Council colleagues were used to help cascade messages. We look forward to being able to measure the impact of this improved information cascade on coverage rates.

Incidents:

During the latter part of 2018 a vaccine cold chain incident affected 80 children under the care of 1 GP surgery in Somerset was notified to the DPH. The response was coordinated across the system with all parents of children affected contacted and offered a re-vaccination.

Key Lesson Learned

The ability to access detailed coverage data is vital to taking appropriate steps to increasing uptake and protect the health of Somerset residents. With this information would come the ability to identify surgeries or geographies where coverage was lower, enabling delivery of targeted work with providers and the local populations. Additionally, receipt of the NHS E section 7a assurance report in a timely manner, will enable the Health Protection Forum to fulfil its assurance role.

A notable success for 2018 is that Somerset has not seen any rise in measles cases linked with the significant outbreak occurring in the North of the South West region or the ongoing outbreaks in Europe.

4. Priorities for 2019

The following list of priorities for the Health Protection Forum in 2019, resulted from the annual priority setting meeting. The following priority actions within its areas of core business:

4.1 Communicable Diseases

Ensure robust communicable disease incident and outbreak response arrangements are in place and embedded across the Somerset system.
Carrying this priority forward into 2019, key actions include:

- Support Public Health England to finalise the Incident and Outbreak Response Framework across the South West;
- Work across the partnership to ensure actions required for local implementation; and
- Review and agree the Somerset Health Protection Memorandum of Understanding.

4.2 Environmental Hazards

Ensure initiatives to reduce or mitigate the impacts of environmental hazards on population health are supported and prioritised.

Building on existing organisational priorities, key actions include:

- Support targeted projects to review and improve water quality in vulnerable institutions such as educational establishments;
- Support adoption of the Somerset Air Quality Strategy and projects identified to improve air quality; and
- Raise awareness of the impact on health from housing standards and support local initiatives to address significant hazards such as Legionella.

4.3 Infection Prevention and Control

Ensure infection prevention and control priorities address local need and reflect national ambition. Recognising areas for improvement identified during 2018 and the context surrounding infection prevention and control, key actions include:

- Identify initiatives to improve community infection prevention and control amongst vulnerable populations, specifically intravenous drug users and the homeless;
- Raise awareness of the national strategy to address antimicrobial resistance and support / develop local initiatives as appropriate; and
- Support the CCG to reduce the burden of disease associated with Gram Negative Blood Stream Infections

4.4 Resilience

Ensure local and regional emergency response arrangements are in place to protect the health of the population.

Working closely with local and regional forums, key actions include:

- Maintain a system wide understanding of priorities and challenges within the emergency planning, resilience and response community and ensure that lessons identified in major incidents (such as Salisbury / Amesbury) are embedded in local system response;
- Support activity and coordination between local groups and regional forums; and
- Consider the role of communities in reducing the impact of winter pressures on primary and emergency / urgent care.

4.5 Screening and immunisation

Ensure screening and immunisation programmes meet national standards and where work is required to increase uptake, reflect local priorities to achieve national standards.

In support of the existing screening and immunisation programme in Somerset, key actions include:

- Undertake a health equity audit on uptake of one specific screening programme to be determined;
- Secure access to uptake data on screening and immunisation programmes at lower geographical levels in order to identify where remedial action is required to improve overall coverage, as this has fallen across all immunisation programmes during 2017/18; and
- Improve uptake of the seasonal flu vaccination for those working directly with vulnerable service users.

5. Conclusion

In summary the Director of Public Health is assured that systems are in place to protect the health of the population, however there are opportunities during 2019 to strengthen these and ensure that particularly vulnerable populations are reached by heath protection interventions.

Throughout 2018 there have been significant challenges within and affecting Somerset that required a system wide response, while these challenges were met there were questions raised regarding capacity and opportunities identified for improvement through planning, prevention and mitigation.

These lessons are captured throughout this document and reflected within the 2019 strategic priorities, underpinning which is review and development of the Somerset

Health Protection Memorandum of Understanding to ensuring roles, responsibilities and relationships are clear across the system.

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Somerset Health and Wellbeing Board

17th January 2019
Report for decision

Annual Report of the Director of Public Health 2018 – Emotional health and wellbeing: looking through the lens of self-harm
Lead Officer: Trudi Grant / Director of Public Health
Author: PNJ Tucker / Public Health Specialist
Contact Details: 01823 359449

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant / Director of Public Health	17/12/2018
	Cabinet Member / Portfolio Holder (if applicable)	Cllr Christine Lawrence – Cabinet Member for Public Health and Wellbeing	17/12/2018
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	17/12/2018

Summary:	This report analyses available data to help understand the apparent high rates of self-harm in Somerset. It finds that the picture is highly complex, with only hospital admissions easily measurable. Such admissions are typically the result of paracetamol overdoses by young women rather than self-cutting (as self-harm is often discussed). The report concludes that the most effective interventions are to promote and support the mental health and emotional wellbeing of all young people, but especially girls, rather than provide specialist services. This makes mental health a matter for all, not just the NHS.
Recommendations:	**That the Somerset Health and Wellbeing Board:** **1. endorse this report.** **promote cooperation between public and third sector bodies in providing prevention and early intervention wellbeing services for children and young people in Somerset.** **2. support the Prevention Concordat for Mental Health and the Prevention Framework for Somerset.** **3. plays host to a workshop on self-harm to discuss findings with partners**

Reasons for recommendations:	Evidence presented in this report suggests that investment in prevention will be more effective, and cost-effective, at reducing the incidence of self-harm – especially as seen in hospital admissions – than the provision of specialist services at tier 3 and 4.
Links to Somerset Health and Wellbeing Strategy	The report focuses particularly on Priority 2 of the Health and Wellbeing Strategy: • Families and communities are thriving and resilient.
Financial, Legal and HR Implications:	***There are no direct financial, legal or HR implications.*** ***It should be noted that:*** • The report has implications for the potential use of future NHS England funding for children and young people's mental health. Devoting resources to prevention of self-harm can reduce the financial cost of hospital admissions (finance). • The report has potential implications for the respecifying of school nurses' role (HR).
Equalities Implications:	The risk of self-harm is greatest amongst young people, young women in particular. Although the patterns are complex, the risk of self-harm is generally higher in minority groups. The report identifies inequalities in relation to self-harm and suggests how they can be reduced.
Risk Assessment:	***Not applicable.***

1. Background

1.1. In Public Health England's statistical profiles, Somerset has a 'red dot' for self-harm admissions to hospital, meaning that the rate of admissions is significantly higher than England as a whole. In the past, this we have assumed that this was simply the result of effective admission and assessment of self-harm at Somerset hospitals. In recent years the rates have risen, and Somerset has diverged further from the national average, and so this year's Annual Public Health Report has examined the statistics in detail to improve our understanding.

1.2. Analysis of the figures shows that the majority of self-harm admissions are for overdoses, particularly of paracetamol and other painkillers, and are

predominantly taken by young women. The majority of these admissions are 'one-off', implying that they are a response to a personal crisis rather than a symptom of longer term mental ill health. Evidence suggests that these overdoses are very rarely attempted suicides, and there is no simple link between self-poisoning and the bulk of 'low level' self-harm, which is predominantly self-cutting.

1.3. These patterns suggest that the response should be to strengthen the support available to young people, especially girls, at Tiers 1 and 2 (universal services and those for relatively common and low-level need). This will promote their resilience in the face of the unavoidable difficulties of adolescence; evidence suggests that availability of such support is patchy and uncoordinated in the county. Rather than being a health problem that needs treatment in the NHS, this support will often be through schools, although parents, GPs and other professionals would benefit from more available guidance and services to improve young people's wellbeing. In addition, we conclude that 'emergency admissions for self-harm' is an inadequate measure of the prevalence of self-harm.

2. Options Considered and reasons for rejecting them

2.1. The production of an annual report is a statutory requirement for all Directors of Public Health and there is no option not to produce it. The contents of the report are entirely at the discretion of the DPH.

3. Consultations undertaken

3.1. The report has been produced after discussions and contributions from a range of people in Somerset who have responsibilities for young people who have harmed themselves, or who are at risk of doing so. Because of the sensitivity of the subject these opinions are generally anonymized in the text.

4. Implications

4.1. Financial, HR and equalities implications are described above.

4.2. The findings of the report indicate an opportunity to improve mental health and emotional wellbeing of school age children, and thereby reduce the impact of self-harm admissions on acute care in Somerset.

5. Background papers

5. The Annual Report of the Somerset Director of Public Health 2018, 'Hospital Admissions for Self-Harm in Somerset', is published at: http://www.somerset.gov.uk/organisation/departments/public-health/

5. The Prevention Concordat for Mental Health is published at

https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

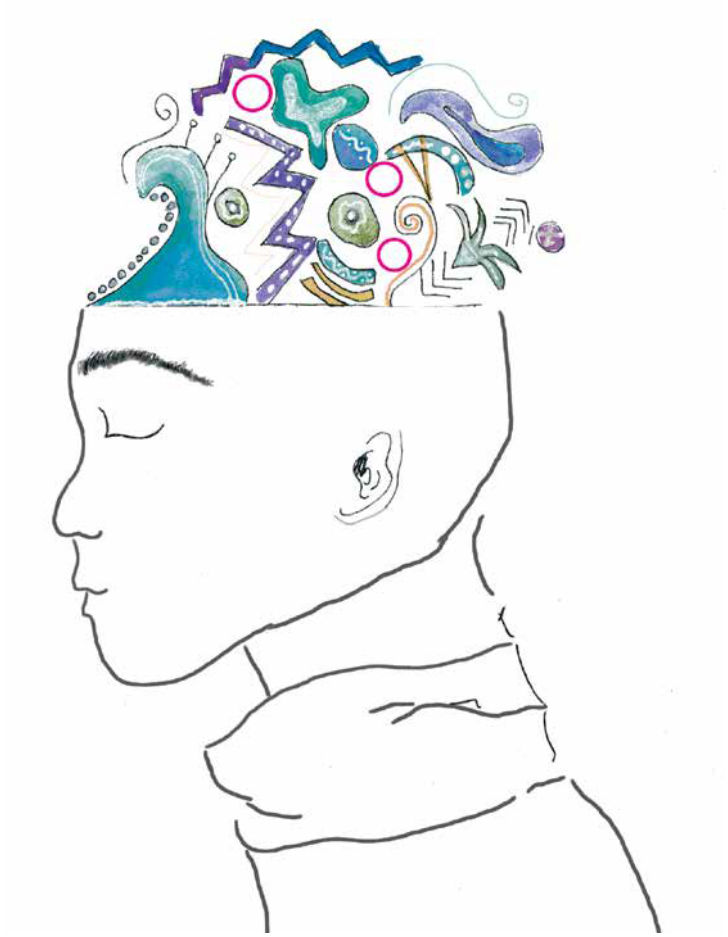
The Somerset Wellbeing Framework at:

https://www.cypsomersethealth.org/wellbeing_framework_-_getting_started

and the Prevention Framework for Somerset at:

- http://www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=122999

Emotional Health and Wellbeing



Picture with thanks and acknowledgement to the Somerset young people who developed the LifeHacks resource.

Looking through the lens of self-harm

Annual Report of the Director of Public Health for Somerset 2018

Contents

Foreword

The emotional resilience of our population is important to us all. It is particularly important to the development of a young person progressing into adult life. The recent national focus on mental health has been a huge step forward in helping to dispel some of the myths and stigma associated with it, but there is still a significant way to go before mental health, and the services associated with it, are given the same level of attention as physical health.

Many of us can give a good account of what we should be doing to improve our physical health, but there has been far less focus on improving our emotional health and resilience and ensuring we have the skills to cope with the stresses and strains of everyday life and the responsibilities it holds.

One indicator of emotional resilience is the level of self-harm amongst the population. In 2016/17 there were 1,371 emergency admissions to hospital for self-harm across the whole Somerset population, but our understanding of the issue has been limited. Many people have a preconceived idea of what self-harm is and the possible reasons for it, but the issue is far from simple; in fact it's really complex. Because of this, it's important that we try to understand it more, starting with a definition that we could all use. The National Institute for Health and Care Excellence (NICE) uses the following definition:

"Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress."[1]

There are lots of facts and figures in this report and it does help with our understanding of self-harm in a small way, but the figures do not tell the whole story; they merely help us to raise the issue and indicate where there is a need for more work and more understanding.

In short, this is the first chapter of the story. Hopefully, it will capture the attention of the reader sufficiently to want to understand more, to want to help raise the profile of this largely hidden issue and to want to help do their bit to improve emotional resilience, particularly of our young people.

This year, I have used the Annual Public Health Report to try and achieve three things. Firstly, to gain a greater understanding of self-harm; secondly, to raise the profile of this issue in order to help tackle to stigma associated with it; and thirdly, to raise the importance of us all developing and maintaining our skills to cope appropriately with the stressors of everyday life.

The data supplement (APHR statistical annex) that accompanies this report can be found at the following link: http://www.somerset.gov.uk/organisation/departments/public-health/

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Director of Public Health, Somerset County Council

Executive Summary

Our ability to cope with stressful or traumatic situations, sometimes called our “emotional resilience”, can be different between individuals and at different times in our lives.

This report looks at the issue of emotional resilience, through the lens of self-harm. This is an indicator frequently used to help understand levels of distress and unhappiness within our community.

In Somerset we have seen an increase in presentations for self-harm in our hospitals and there is increasing concern from parents, schools and young people themselves about rising levels of self-harming behaviour.

This report has investigated emergency hospital admissions for self-harm and has found the increase in admissions is particularly driven by rising rates for girls and young women aged between 10 and 24. Rates were found to particularly peak at around the age of 15.

Rising emergency admission rates are, however, considered the tip of the iceberg. In a 2018 survey of Somerset secondary school pupils, 28% of females and 19% of males reported that they sometimes hurt themselves in some way when they feel stressed or worried.

The information contained in this report still only presents part of the picture. There is far more to be done to understand the level of emotional resilience, particularly that of our children and young people. There is a need to develop a greater understanding of self-harming behaviour, and what support is needed to help young people, their parents, teachers and others to better promote positive emotional health and wellbeing and resilience.

Fundamentally, we need to reduce the stigma associated with self-harm, and improve access to the support available. We need to help young people to develop the skills they need to cope with more stressful and traumatic situations in a less harmful way.

Perhaps the question we should be asking is not

“Why would you do that to yourself?”

but

“What led you to feel the need to hurt yourself?”

Introduction

Emotional resilience is our ability to adapt to stressful situations and cope with life's ups and downs. The word "resilience" actually comes from the Latin word "resilio" which means to "bounce back". Resilience does not take away life's difficulties, but it is what helps us to deal with problems and live through challenging times. A resilient person bends rather than breaks under pressure; is flexible and adaptable, rather than rigid and resistant. A resilient group or community also flexes and responds to adversity, supporting and protecting its most vulnerable members.

Positive indicators for community resilience include levels of social connectedness, which these days can include digital connectedness as well as people-to-people connectedness; the amount of support we have or feel we have from others around us, or conversely, how alone or isolated we feel; and levels of acts of kindness to others through formal or spontaneous voluntary actions.

Of course, things do not always turn out well, and there are some less positive measures we can look at to understand how resilient we are as a nation or a community. The most well-known indicator is the rate of death by suicide. Rates of suicide are monitored locally and nationally for just this reason. Whilst each individual death is a personal tragedy, the overall rate or trend of suicide tells a story about the health of our community and the hidden challenges which lie beneath the surface. Self-harm is another such indicator. Levels of self- harm also tell us a story. They tell us about levels of acute distress, about unhappiness and about a desire for things to be different. Each individual act of self-harm tells a story but all of those stories together say something very powerful.

What is self-harm?

The nature and context of self-harm

Self-harm is a significant health issue which impacts not only on the wellbeing of the individual, but also on friends, families and communities, together with an impact on health, education, social care and criminal justice services.

Definitions of self-harm

Definitions of self-harm are numerous and vary but a short definition is provided by the National Institute for Health and Clinical Excellence (NICE) defining self-harm as:

"an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress"

The Royal College of Psychiatrists state that at a wider level, self-harm *"may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs."*

Self-harm is a universal phenomenon which crosses all cultures, ethnicities, creeds and classes.

Self-harm is not usually an attempt to complete suicide (although it is considered a risk factor of suicide) or seek attention, but a way of expressing deep, emotional feelings, such as low self-esteem. It can also be a way to cope with traumatic events or situations, such as the death of a loved one, or an abusive relationship.

Self-harm may include:

- swallowing poisonous substances
- non-lethal overdoses
- cutting your skin
- burning your skin (usually with cigarettes)
- scratching or picking at your skin
- biting, including severe nail biting
- hitting or punching either yourself or an object
- punching and banging against things
- deliberately breaking your bones
- embedding items in the skin
- pulling out your hair

The National Preventing Suicide in England Strategy and the recent Public Health England Suicide Prevention Planning Guidance, highlights that self-harm, including attempted suicide, is the single biggest indicator of suicide risk. Similarly, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness indicated that self-harm was reported in 52% of under 20s who completed suicide[2].

The need to improve knowledge and good practice in supporting children and young people who self-harm needs to be a golden thread through all efforts to improve the mental health and emotional wellbeing of children and young people. This requires a whole system approach to look at self-harm both as a coping mechanism and as a risk factor to suicide.

Within this context, addressing self-harm in children and young people is recognised as a national priority[3]. A recent Young Minds report on "Talking self-harm"[4] reports that that:

- 1 in 12 children and young people are said to self-harm
- Over the past 10 years inpatient submissions for young people who self-harm has increased by 68%
- In females under 25 years admissions have increased by 77% in the last 10 years
- 77% of young people feel they don't know who to turn to with questions about self help
- 97% of young people believe that self-harm should be addressed in schools
- UK is thought to have the highest rates in Europe

'WHY I SELF-HARM'

- STATEMENTS FROM SERVICE USERS

Below are a series of statements provided by young people about why they self-harm:

"To convey feelings difficult to put into words"

"To express experiences as something visible"

"To replace emotional pain with physical pain"

"To escape traumatic memories"

"To stop feeling numb, disconnected or dissociated"

"To express suicidal feelings and thoughts, without completing suicide"

"To communicate severe distress"

Source: Salford University Training Day "Reducing and Identifying the Risk of Self-Harm"

The Somerset Transformation Plan for Children and Young People's Mental Health and Wellbeing (2015-2020) sets out the strategic direction, vision and principles for the changes to Child and Adolescent Mental Health Services. Self-harm is addressed within this plan as a key area for concern. The plan states that this should be seen within the context of mental health promotion, the emotional health and wellbeing agenda and action to prevent self-harming behaviours in the first place.

Reasons for self-harming behaviour

It is often difficult to understand why people self-harm, reasons can be complex and individual. Some people have said that by deliberately hurting themselves they are temporarily able to change their state of mind to better cope with painful feelings. Self-harm in these cases seems to provide a mechanism for dealing with intense emotional pain. Individuals report that the behaviour can help them to cope with negative feelings and to feel more in control. Others report feelings of wanting to punish themselves. Self-harm can be a way of relieving overwhelming feelings that build up inside, when people feel isolated, angry, guilty or desperate. However, acts of self-ham can also lead to a burden of emotional guilt and secrecy which can have a negative effect on a child, young person or adults' ability to build and maintain relationships. This compounds the problems even more. Self-harming can also become a pattern of addictive behaviour.

Some reasons given for self-harm among young people include:

- being bullied
- not getting on with parents
- stress and worry about academic performance and examinations
- parental separation or divorce
- bereavement and loss
- relationship breakdown
- illness or health problems
- unwanted pregnancy
- experience of abuse including sexual abuse
- difficulties with sexuality
- low self-esteem
- feelings of being rejected.
- pressure from social media

A person is more likely to harm themselves if they feel:

- people don’t listen to them
- hopeless
- isolated, alone
- out of control
- powerless – it feels as though there's nothing they can do to change anything.

People who self-harm usually try to keep it a secret from their friends and family. They often injure themselves in places that can be easily hidden by clothing, and they are very careful to hide the damage and scars.

Signs of self-harm include:

- signs of depression, such as low mood, tearfulness, a lack of motivation or interest in anything, or a lack of energy

- signs of low self-esteem, such as blaming themselves for any problems, or thinking they are not good enough for something.
- unexplained cuts, bruises or cigarette burns, usually on the wrists, arms, thighs and chest
- insisting on always keeping covered, even in hot weather

Dispelling the myths

Despite its prevalence and impact, our understanding of self-harm is incomplete and remains surrounded by myths and misconceptions.

Most commonly there is a belief that self-harm is an "attention seeking behaviour". Given that most self-harm is carried out in private and over a long period before help is sought, this is an unhelpful myth that often leads to a young person feeling more alone and not listened to.

Another belief is that people who self-harm must enjoy it. There is no evidence that people who self-harm feel pain differently from anyone else. The harming behaviour often causes people great pain. For some, being depressed has left them numb and they want to feel anything to remind them they are alive, even if it hurts. Others have described this pain as punishment.

The secrecy surrounding self-harm has led to a level of stigma that limits understanding and prevents a more open dialogue which would enable young people to access the support they need.

The Young Minds and Cello[5] report highlighted the following challenges:

- A third of parents would not seek professionals help if their child was self-harming
- Half of GPs feel they don't understand young people who self-harm and their motivations
- 1 in 3 teachers don't know what to say to a young person who self-harms

> *"You don't need to understand to listen and try to support me."*
>
> (Young Person with experience of self-harming)

5

What do we know about self-harm in Somerset?

Statistical definition of self-harm

Before moving on to discuss what we know about self-harm locally, it is important that we have a good understanding of what is measured.

In England, emergency hospital admissions are used as proxy for the prevalence of self-harm. It is, however, widely recognised that these hospital admissions do not reflect the true scale of self-harm. As discussed above, self-harm is often a hidden behaviour, which makes estimating the true prevalence difficult. It has been suggested that "community occurring self-harm" is far more prevalent than self-harm as measured by admissions[6].

In the self-harm statistics, admissions attributed to a different main cause, such as drugs and alcohol, are usually excluded in public health analysis, but there may be a fine line between these presenting issues for admissions.

Self-harm has been highlighted as an issue across the south-west region with only one upper-tier/unitary area, North Somerset, that is not significantly worse than England; this is true of all ages and of young people. Furthermore, it is a Somerset issue; the Somerset statistics for self-harm admissions are significantly higher than both the England and the south west average.

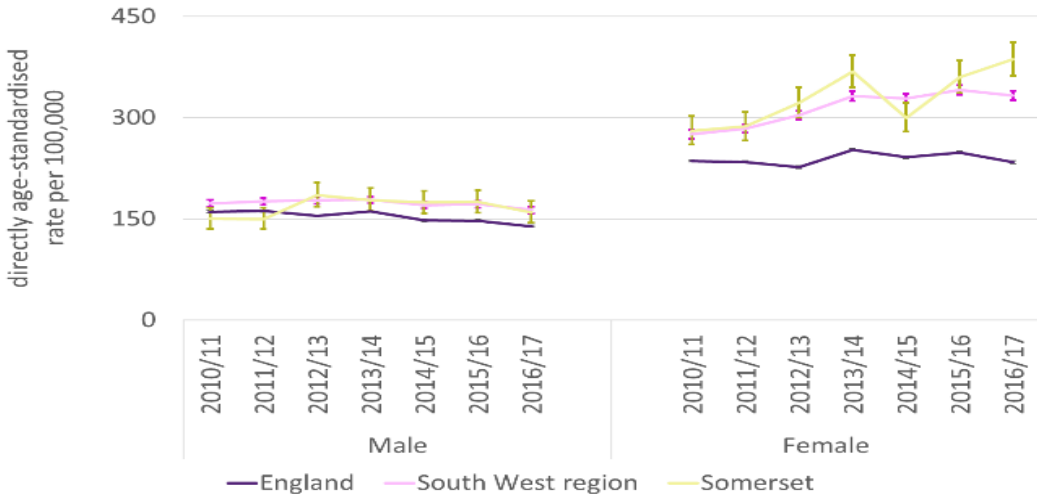
Self-harm admissions in Somerset

As can be seen from the graph below, many of the admissions are of younger age groups and this will be explored in more detail later. Probably as you would expect, almost all admissions for intentional self-harm were emergency admissions. We will focus the rest of this analysis predominantly on emergency admissions unless otherwise stated.

Published data from the Public Health Outcomes Framework (PHOF)[7] allows the Somerset levels of admissions for self-harm to be compared against national and regional data. Figure 1 shows Somerset's emergency self-harm admissions rates for all ages per 100,000 population. Somerset rates are significantly higher than the national rate for both males and females. The female rate is most concerning, being higher than the national and south-west rates and showing an increasing trend over time. Somerset had the 14th highest female rate of all upper tier local authorities in England (152 in total) for 2016/17, with the male rate being 55th.

Figure 1 illustrates that while the issue of self-harm is of concern for both males and females, the numbers and the rates are significantly higher for girls and women. In the next sections we have used other sources of data to investigate further.

Figure 1: Emergency hospital admissions for self-harm trend over time by sex, 2010/11 - 2016/17

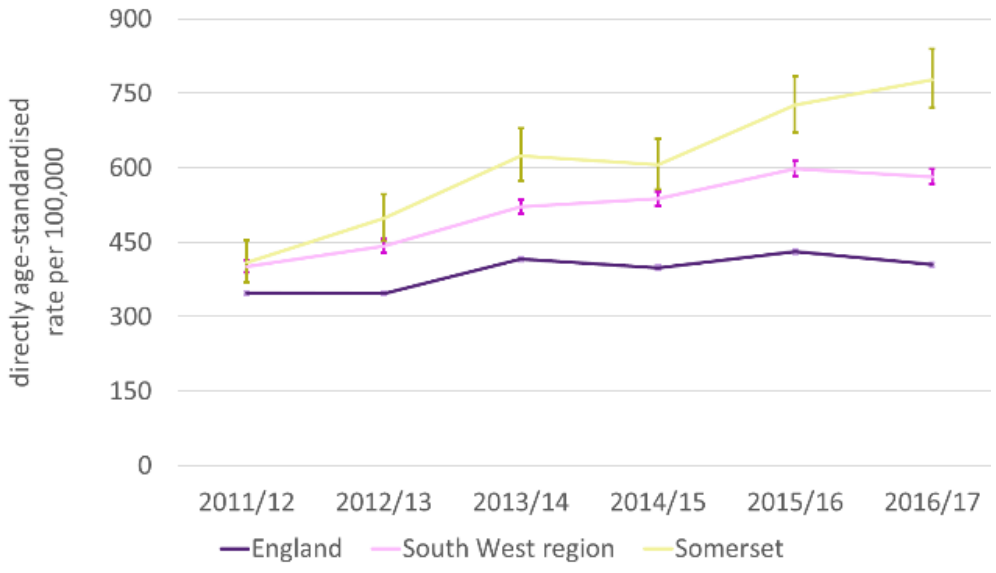


(Source - Public Health England, Public Health Outcomes Framework)

Young people's self-harm admissions

We can use the Public Health England Child Health Profile, for people aged 10-24, to investigate the patterns of admission broken down by age (but not sex) in a little more detail. The definition is similar, but includes all admissions, not just emergencies. As seen in Figure 2, Somerset's rates are consistently higher than the England and regional averages. Somerset has the fourth highest rate of hospital admissions for the 10-24 age group out of the 152 upper tier local authorities.

Figure 2: All hospital admissions for self-harm of young people (aged 10-24) trend over time, 2011/12 - 2016/17

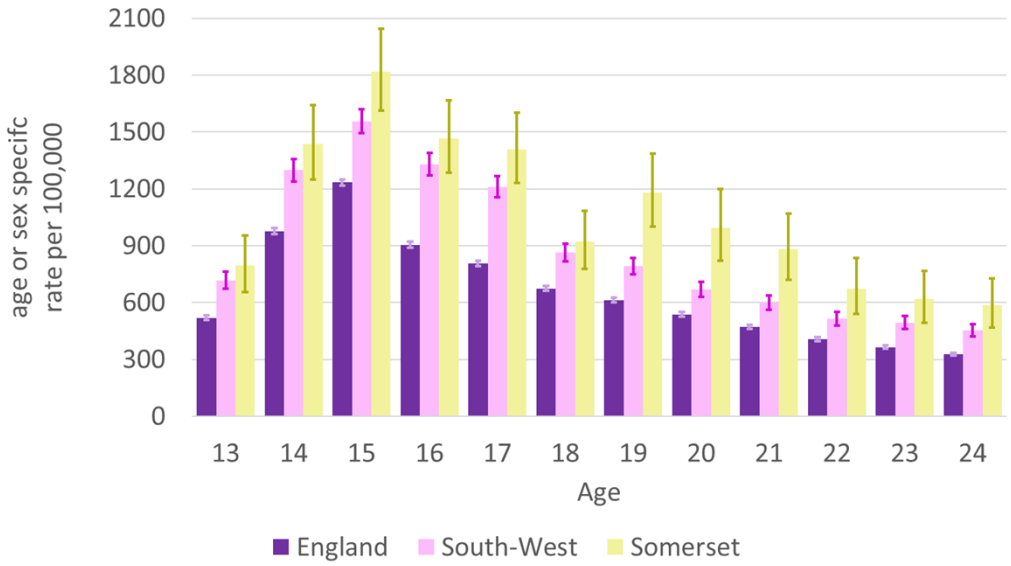


(Source - Public Health England, Child Health Profile)

So far we have only considered the total number of admissions, rather than the number of people admitted. A data source called “Hospital Episode Statistics” allows us to consider the number of people admitted. We have examined the period 2013/14 and 2017/18 for emergency admissions with a main cause of intentional self-harm.[8] The findings back up the picture we have so far.

Females are around twice as likely to be admitted than males, and young people aged 15-24 are the most likely age group to be admitted. Interestingly, the 45-54 and 55+ Somerset rates are similar to the rates for England and, statistically speaking, significantly lower than the south-west rates. Figure 3, showing the admissions broken down by both age and sex, demonstrates that the difference between the sexes is marked in the younger age groups (10–14 and 15–24). This difference is not seen to the same extent in the older age groups.

Figure 3: Individuals with an emergency self-harm admission per year by ten-year age-sex bands - 2013/14 - 2017/18



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Looking at single years of age (Figure 4) allows a more detailed look at the rates within the 15-24 age band. Emergency self-harm presentations by children under the age of 14 years are fortunately small and therefore have been suppressed for under the age of 13 years.

As can be seen in Figure 4 there is a distinct pattern of presentation for girls. Presentation for girls start to rise at around 13 years. The rates rise to a peak at age 15 and then decline year-on-year. This pattern of presentation is mirrored for England and the south west. However, the Somerset rates for girls and young women are significantly higher for each year of age than for peers across England. No similar pattern is seen for boys.

8

Figure 4: People aged 15-24 with an emergency admission for self-harm per year by sex and single year of age - 2013/14 - 2017/18

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Re-admission ratios (repeat admissions to hospital)

Re-admission ratios allow us to measure repeat admissions and are simply the number of admissions divided by the number of people. A ratio of 1 would mean that everyone who was admitted at all was admitted only once; a ratio of 2 means that everyone was admitted twice in a year, and so on.

Table 1 looks at re-admission ratios amongst those people who have at least one re-admission in the same financial year. This shows that re-admissions for self-harm are lower in Somerset than both the national and regional ratios.

Table 1: Self-harm emergency re-admission ratios for self-harm amongst people with re-admissions

	England	South west	Somerset
Re-admissions ratio amongst people with 1+ re-admission per year	1.25	1.25	1.19

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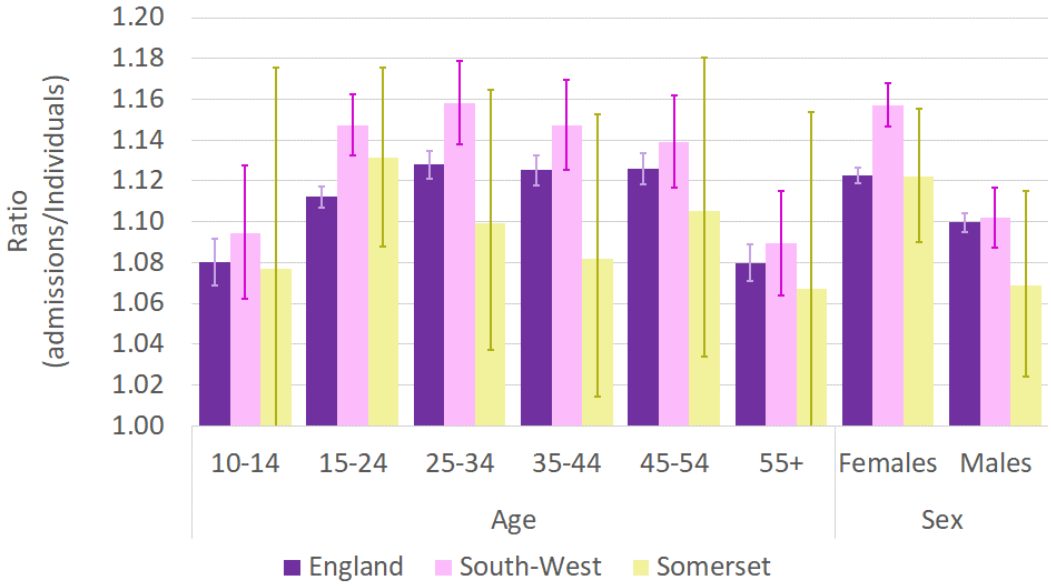
Figure 5 shows that in Somerset, for younger age groups (especially 15-24) more people are admitted to hospital each year for self-harm but on average fewer have a repeat admission in Somerset. This finding goes some way to helping us understand the overall rates of admission for self-harm. It now seems unlikely that the higher rates in Somerset are as a result of more people being admitted more often.

Figure 5: Self-harm emergency re-admission ratios per year by 10 year age bands and by sex, 2013/14 - 2017/18



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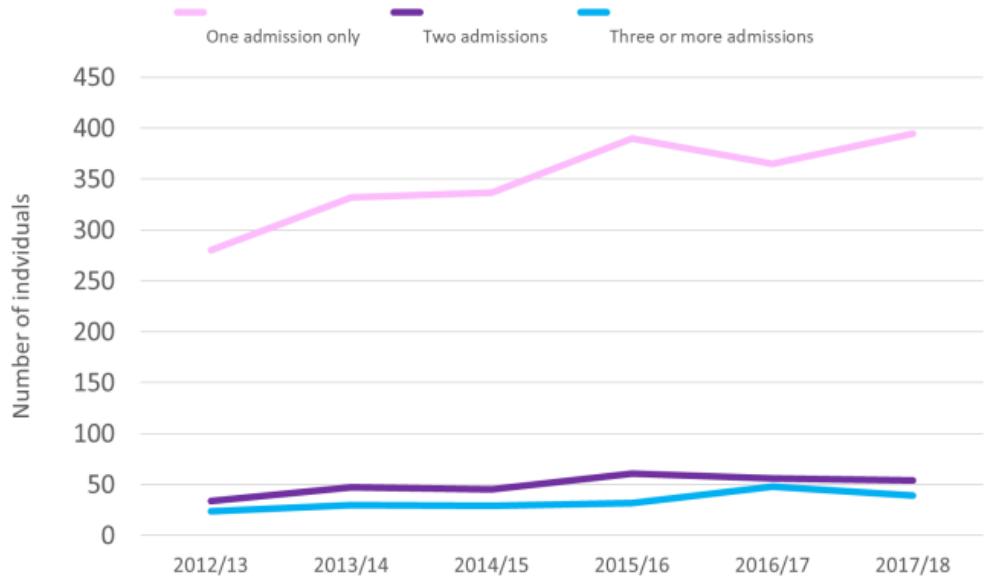
Specifically looking at the number of self-harm admissions for 10-24 year olds, Figure 6 shows a higher and increasing number of young people have one admission only; those with two or more admissions has stayed relatively low and constant over time. It would seem from this evidence that single admissions are driving increased rates in Somerset.

Figure 6: Number of self-harm admissions for young people aged 10 – 24



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Emergency admissions for self-harm - methods

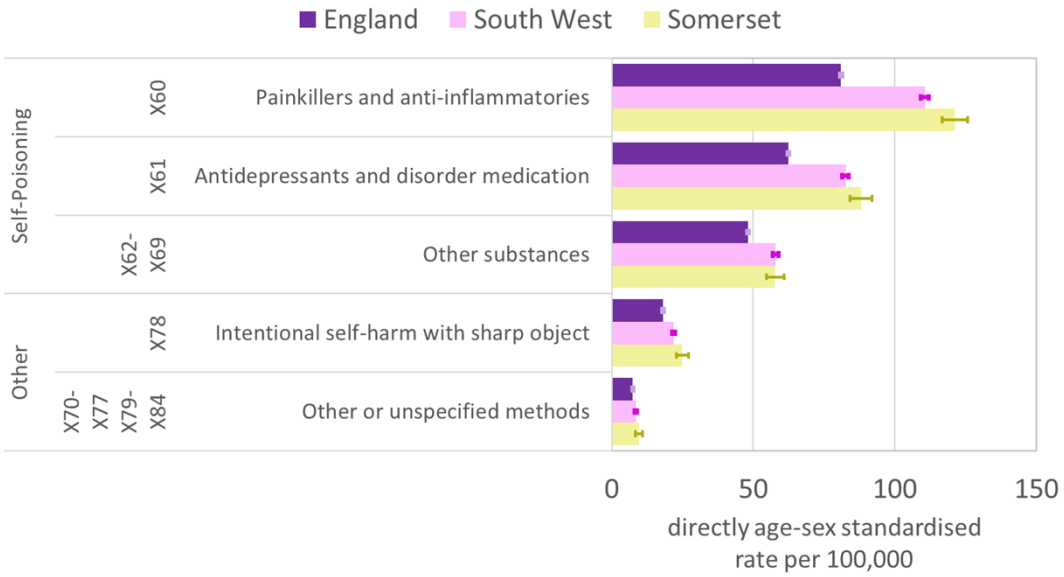
Turning our attention to the types of self-harm that warrant a hospital admission, it is important to understand the main codes used in hospitals that make up the national self-harm indicator.

The analysis of self-harm methods is based on admissions not individuals, because the same people may present with different methods of self-harm at different times. These methods are given different ICD10 (International Clarification of Disease) codes. This allows national and international comparisons to be made.

Figure 7 shows the emergency admissions to hospital by the recorded method of self-harm. Somerset admission rates are significantly higher than England for all methods. In Somerset there are annually about 1,350 emergency admissions against all of the codes for self-harm. The highest, approximately 1,200 emergency self-harm admissions (89% of all presentations in Somerset) are due to self-poisoning, sometimes referred to as overdose.

The ICD-10 codes are very detailed and medical , particularly in the case of some of the poisoning codes. Therefore, although not an official definition, code X60 (intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics) can be thought of as overdoses due to over the counter medications such as paracetamol, ibuprofen and aspirin. Similarly code X61 (intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified) can be thought of as anti-depressants and anti-disorder medication for conditions, such as Parkinson's and Epilepsy. The largest group of presentations for self-harm due to poisoning in Somerset, is coded as x60, those which are over the counter medicines such as paracetamol, aspirin and ibuprofen.

Figure 7: Emergency hospital admissions (all ages) for self-harm by method, 2013/14 - 2017/18



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Emergency admissions for self-harm by all methods are most common for females aged 15-24. In addition, Somerset has significantly higher rates for females in this age group when compared to England across all methods.

Admission due to overdose as a result of painkillers and anti-inflammatories, and admissions as a result of intentional harm with sharp objects, were higher for females aged 15-24. Rates for younger females aged 10-14 are also attributable to these methods. The rate for males aged 15-24 admitted due to overdose as a result of painkillers are also significantly higher than for England. However, the rate for girls of this age locally is still more than three and half times higher than for boys.

It should be noted that the guidance for paracetamol overdoses was changed in 2012 (this is a change to guidance, not coding of admissions, so we do not see a commensurate fall in another type of admission). Bateman et al. (2014) found that:

"There was a significant increase in the number of admissions following the implementation of this guidance estimating an increase from 31.1 per 1,000 to 49.0 per 1,000."[9]

Naryan et al.[10] found that

"Changes to the management guidelines for paracetamol poisoning in September 2012....have particularly increased paediatric hospital admissions for paracetamol poisoning."[11]

This change of guidance was applicable nationally and may account for some of the overall upwards trend for this method of self-harm, but it does not explain why Somerset has significantly higher admission rates than nationally.

Although the admission rates of self-harm with sharp objects are smaller, they should not be overlooked: these too are significantly higher in Somerset for 15-24 year olds and for females aged 10-14 than the south-west and England averages.

In Somerset, 40% of individuals with an emergency admission due to intentional self-harm with a sharp object also had one due to self-poisoning in the same year. However, only 4% of those with self-poisoning were also admitted for self-harm with a sharp object. This suggests that two in five people who cut themselves (seriously enough to be admitted) will also take an overdose, while someone with a self-poisoning admission is very unlikely (3 in 100) to also have an admission caused by self-harm with sharp objects[12].

Self-harm and social deprivation

We have already looked at patterns of self-harm admissions by age, gender and method. We can also look at patterns within Somerset by geographical spread and the social deprivation.

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to

measure a broad concept of multiple deprivation, made up of several distinct dimensions, or domains of deprivation.[13] We can investigate admissions for self-harm to see if there is an association with deprivation.

Figure 8 and Figure 9 show that emergency self-harm admissions are statistically significantly higher in more deprived communities. People living in the most deprived 20% of Somerset (quintile 1) are two and a half times more likely to be admitted for self-harm than people living in in the least deprived 20% (quintile 5).

Figure 8: Self-harm emergency admissions (all ages) by deprivation within Somerset, 2012/13 – 2017/18

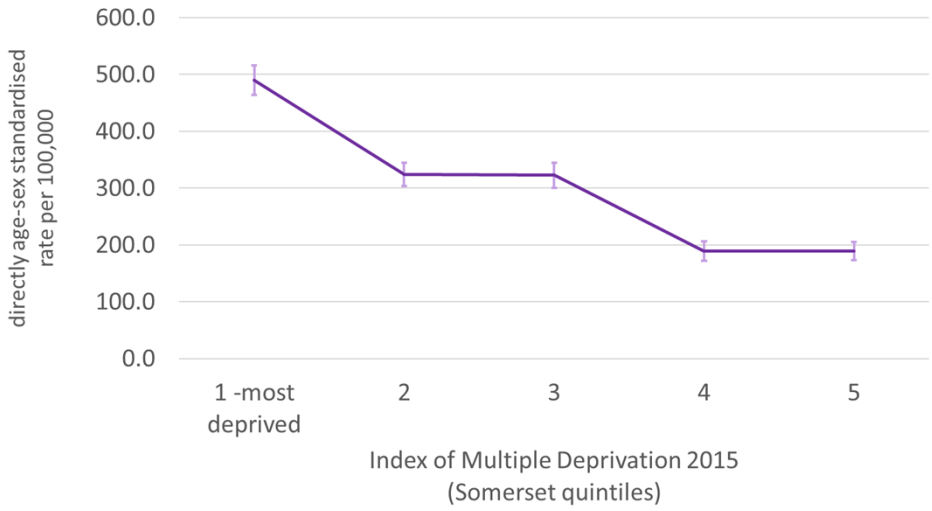

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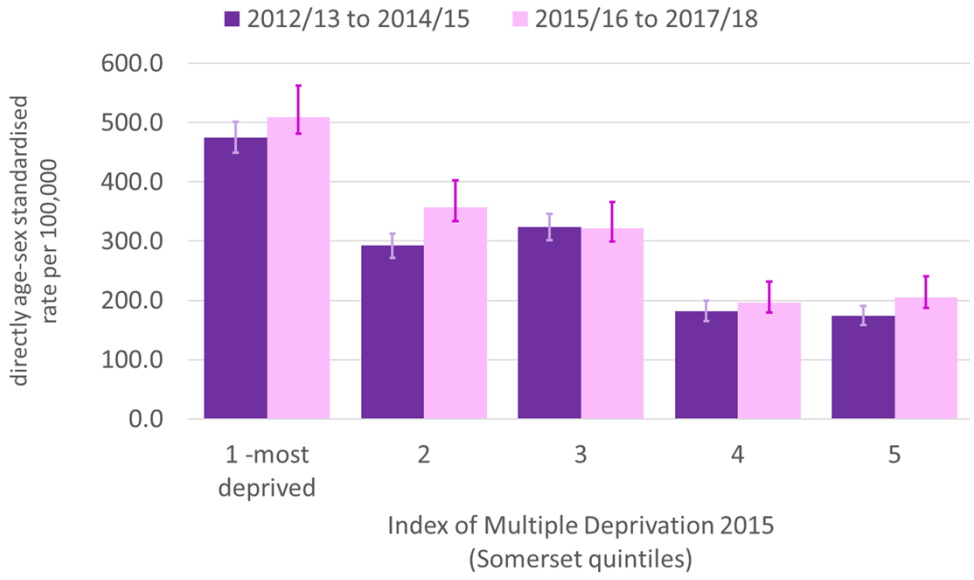
Figure 9: Self-harm emergency admissions all ages by deprivation within Somerset, 2012/13 – 2017/18



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13

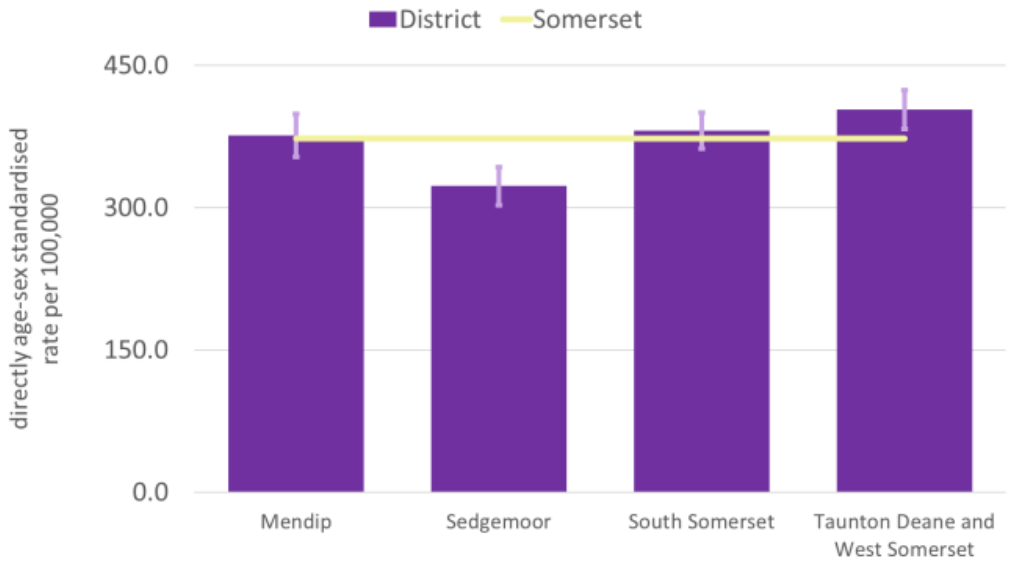
Figure 9 shows how rates for each of the deprivation quintiles have changed between the three-year pooled periods, 2012/13-2014/15 and 2015/16-2017/18. Whilst there is an upward trend between the two time points, for almost all the quintiles, this is only a statistically significant difference in quintile 2.

More detailed analysis[14] which examines the data by age and sex, finds two distinct patterns. There have been statistically significant increases amongst young people aged 15-24 of both sexes in the most deprived quintile and amongst females aged 10-14 and 15-24 in the second-most deprived quintile. However, there have also been statistically significant increases for young women aged 15-24 and 25-34 in the least deprived areas. Self-harm is currently predominantly higher in in more socially deprived areas but it is also increasing in the least deprived areas of the county.

Self-harm emergency admissions by district

We can also look at the differences in rates of hospital admissions between districts. (West Somerset has been combined with Taunton Deane due to small numbers). Figure 10 shows there are significantly lower rates of admissions from Sedgemoor when compared to the Somerset average (this is particularly seen for females aged 15-34); and significantly higher rates for Taunton Deane and West Somerset (the cumulative effect of slightly higher rates in all age-sex groups).

Figure 10: Individuals (all ages) with an emergency hospital admission for self-harm 2013/14 - 2017/18



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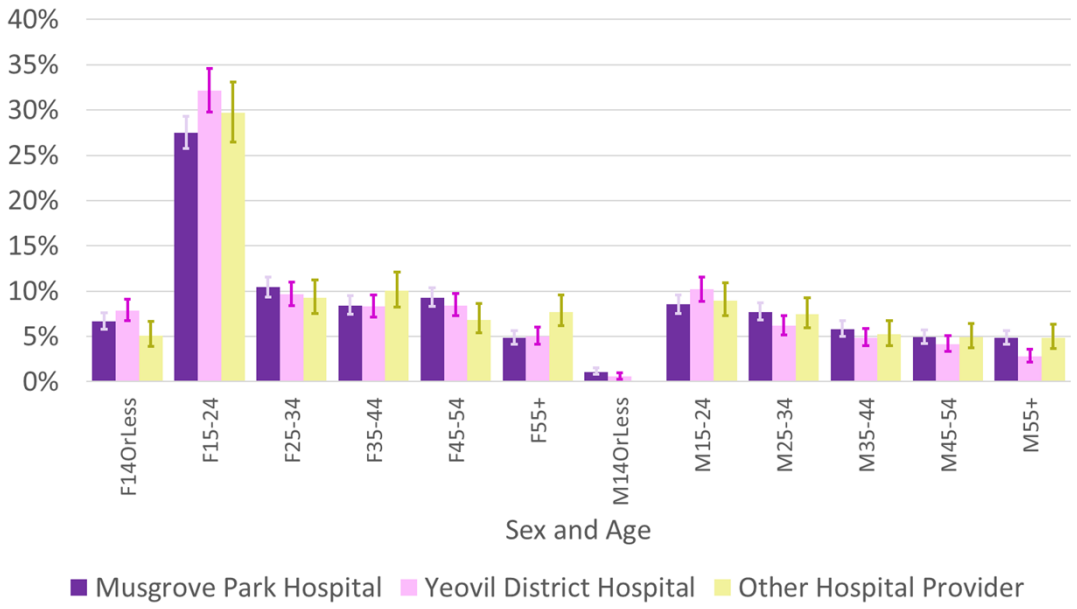
As can be seen in Figure 11, there is little difference in admission rates for self-harm to each of the local NHS hospital trusts, with the highest proportion of admissions to all hospitals being amongst females aged 15-24.

14

Figure 11: The proportion of emergency hospital admission of Somerset residents for self-harm by age-sex bands and NHS hospital trust 2013/14 - 2017/18



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Gaps in our understanding

This analysis uses information available to us to understand patterns of self-harm. However, we recognise that there are significant gaps in our knowledge, particularly because we cannot link the data held by different organisations. Some areas that we would like to understand further are:

- The overall prevalence of self-harm in the population
- Self-harm amongst vulnerable and protected groups
- The patterns and reasons behind self-harm behaviours
- Links with specialist services such as mental health, substance misuse and domestic abuse services
- Correlations with other diagnoses
- The links between self-harm and suicide
- Self-harm method and life-course approach.
- Discharge destination
- Multi-method presentations[15],[16]

15

What are people telling us about self-harm and mental health?

The discussion so far has been based on hospital presentations, which does not give us much information about other types of presentation or need. To get a deeper understanding we need to listen to the people who have experienced self-harm, to parents and to people working in related support services.

The experience of children and young people

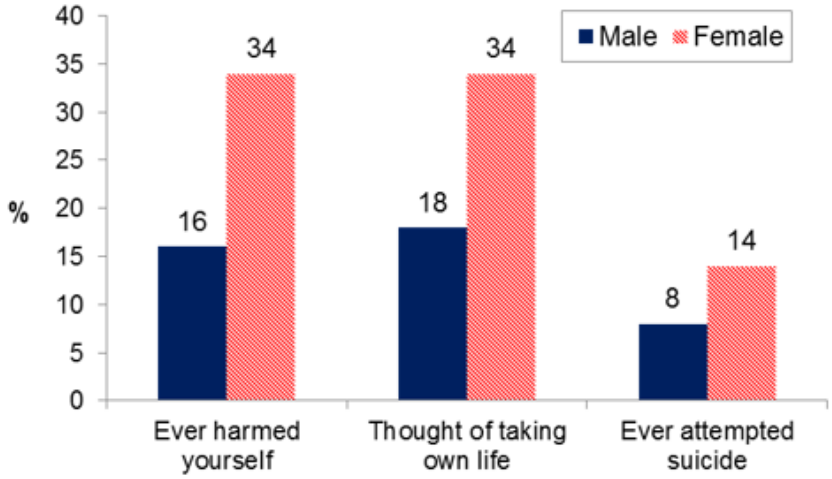
Self-harm is one of the questions included in the Somerset Children and Young People Survey[17] and is probably the best source of information we have about the overall prevalence of self-harming behaviour among Somerset young people. In spring 2018, this survey found that 28% of secondary school aged girls, and 19% of boys at least sometimes dealt with a worrying problem by hurting themselves (Figure 12).

These figures are similar to findings in the 2016 survey, where a rather differently phrased question gave figures of 34% for girls and 16% of boys having "ever harmed yourself" (Figure 13). Importantly, these figures are consistent with the view that self-harm is more widespread than is covered by emergency admissions alone.

Figure 12: Percentage of secondary pupils responding that, when they are struggling/ feel bad or stressed/have a problem that worries them, they at least "sometimes" deal with it by the means described above

	Boys		Girls	
1	Spending time on the computer/ gaming etc.	89	Relaxing (e.g. listening to music, being active etc.)	91
2	Relaxing (e.g. listening to music, being active etc.)	89	Crying	88
3	Speaking to/confronting the person who is causing you to worry	56	Speaking to/confronting the person who is causing you to worry	56
4	Lashing out in anger (verbally or physically)	55	Lashing out in anger (verbally or physically)	52
5	Crying	45	Spending time on the computer/ gaming etc.	52
6	Eating more	37	Eating less	49
7	Eating less	24	Eating more	47
8	Hurting themselves in some way	19	Hurting themselves in some way	28
9	Drinking alcohol	10	Drinking alcohol	15
10	Smoking	8	Smoking	10
11	Taking drugs	6	Taking drugs	6

Figure 13: Self-reported self-harm and suicidal thoughts for Somerset schoolchildren 2016



Source: SCYPS/SHEU

The experience of parents

Parents need access to information and resources to help them to understand and respond to the needs of their children. Seeing your child deeply unhappy or in acute emotional distress is extremely challenging. Fear and stigma associated with mental health problems, and with behaviours such as self-harm, make things even harder. And of course, parents feel a sense of guilt or failure, however misplaced this may be. As the "Cello" report says:

"Parents associate a young person self-harming with failed parenting and shame; many are frightened to let the issue "out of the home": over a third say they would not seek professional help."[18]

The experience of professionals

In compiling this report, we have talked to a range of professionals, four themes emerged from these discussions. These are outlined below.

Self-harm is a complex – and it has many forms

Whilst self-harm is usually taken to be cutting oneself and self-poisoning, it can also take other forms. The self-harm will inevitably be a symptom of other issues, worries and concerns. It's not an easy subject to talk about and not all professionals feel equipped to respond.

"National research in 2012 found 53% of GPs thought that self-harm had increased, with only 4% thinking it was in decline. Normally young people are less concerned than GPs, teachers and parents about issues, but self-harm is the one issue where everyone shares an equally high level of concern."[19]

Having a better understanding of the different needs behind self-harm and the patterns of presentation will be helpful in formulating an appropriate response. We can see, for example, even from this limited analysis that there is a peak of presentation for young women at around 15 years of age, the majority of which do not appear to re-present.

Self-harm as a response to increasing pressure on young people

Anecdotally, teachers, health professionals and others have said that there is increasing evidence of difficulties due to emotional distress and mental health problems among young people in Somerset. Professionals attribute this anecdotally to:

- overall, increased stress and pressure for children and young people from the internal and external expectations of a modern world
- the impact of social media (evidence suggests that social media contributes 25% to the shaping of young people's views on self-harm, albeit significantly less than the 45% from talking to friends)
- the need to perform well academically

The perception of increasing mental health problems may, of course, also reflect the greater willingness to discuss mental health problems and so be, counterintuitively, a "good thing".

If stress is indeed a causal factor, there are a range of steps which can be taken to support young people, schools and families to understand and manage stress better and to develop both individual and group resilience.

Furthermore, whilst raised as an issue of concern, it should also be noted that social media can also be source of support and social interaction, particularly in more rural sparsely populated areas. This was a finding from the qualitative research done by the Rural Youth Project to support the 2014-15 Joint Strategic Needs Assessment[20].

The complexity of "the system" - difficulty finding information and help

Parents, children and teachers have said repeatedly that they find it difficult to know where to turn for help in relation to emotional distress and mental health problems, and more broadly, how they support teenagers struggling with the normal challenges of adolescence and guiding them towards appropriate coping mechanisms when in distress. Dr Alex Murray told us that many GPs find a typical appointment slot far too short to deal with self-harm appropriately, and they need more information on where to refer young people who harm themselves, especially those who do not reach the threshold for CAMHS.

For self-harm specifically "nearly four in five young people say they don't know where to turn"[21]. This is something which, particularly in the digital age, we should certainly be able to do something about.

Access to support

CAMHS is both the main, formal provider of mental health services for children and young people and the best known. CAMHS are commissioned to provide specialist community and inpatient provision for 0-18 years olds with severe, complex and

persistent mental health conditions. They offer a number of different treatments by a range of professionals. Following an admission to hospital for self-harm, all children and young people receive a risk assessment which would help inform the most appropriate route of support.

Self-harm is for the most part perceived as a mental health problem and there is a general frustration about access to help. The expectation is quite widely held that this support should come from the Child and Adolescent Service (CAMHS).

CAMHS, however, are services for children and young people who require specialist treatment for a mental health problem and not all young people who are self-harming have a mental health problem. They are experiencing distress, they are hurting, they may be confused, fearful, angry and sad; but the fact that the majority of hospital presentations are single episodes tells us that we should not over-medicalise this issue, but understand it, and respond more effectively in other ways. Of course, intervention needs to be appropriate and timely and there are examples where appropriate support could reduce the demand at the higher levels.

Recognising that many young people utilise and are familiar with online services, Somerset has invested in Kooth, an online support and counselling service specifically for young people aged 11 to 18. This service is highlighted further in the next section of this report.

What have we learnt so far?

Self-harm is a complex issue and one which is of concern to young people, their families and their teachers. In writing this report, we have heard concerns that people admitted to hospital for self-harm may not have easy access to appropriate support. Parents, carers and young people have a clear need for easily accessible information and support around self-harm. There is also a view that services other than CAMHS are patchy in coverage, uncoordinated and often under-resourced.

From the emergency admissions data, it would appear that the higher rates of admissions for self-harm are largely driven by rates for young women aged between 10 and 24 and predominantly are as a result of paracetamol overdose. Most of the admissions are a single occurrence with no repeat admission within one year for self-harm.

Whilst young women appear to be significantly at risk of admissions for self-harm, and need a particular focus, we must not forget that this is an issue for all ages and for some boys and men.

It is clear from the survey of secondary school pupils 2018 that the emergency admission rates only provide part of the picture regarding the prevalence of self-harm. Self-harming behaviour is more widely experienced by Somerset young people and to a degree is a “hidden issue”.

Promoting and protecting the mental health of children and young people in Somerset

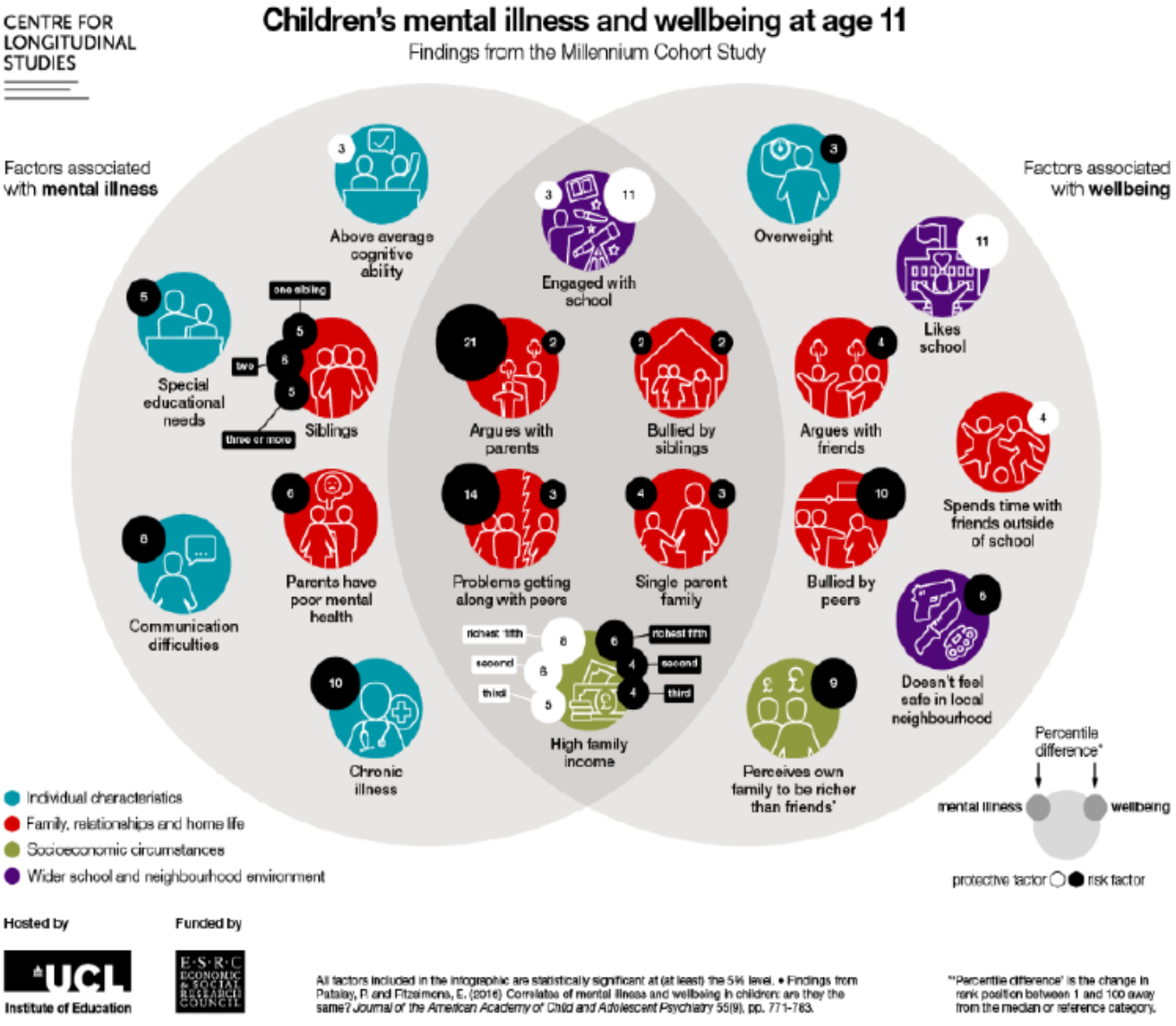
Mental health is central to all health and wellbeing. It is defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, as individuals and as communities. Good mental health is more than the absence of mental illness - it is the foundation for wellbeing. It is something you have to take care of, rather than take for granted. It is based on creating the right conditions for good mental health and wellbeing and on ensuring early interventions are in place when things start to go wrong. Improving mental health goes hand in hand with improving physical health for children and young people. Evidence and action to promote and protect positive mental health is clearly set out the in Positive Mental Health for Somerset Strategy (2014) and the national Prevention Concordat for Better Mental Health (2017).

Protective and risk factors

It is important to focus both on the factors that help promote mental health, as well as to reduce the risk factors that damage mental health. Good mental health allows children and young people to develop the resilience, referred to earlier in this report, to cope with whatever life throws at them and grow into well-rounded, healthy adults.

Figure 14 illustrates the interplay between intrinsic factors such as "enjoying school"; external factors such as being bullied; biological factors such as being overweight; development factors such special educational needs; social factors such friends and family; and socioeconomic factors such as poverty.

Figure 14: Protective and Risk Factors for Children



Prevention

Professor Sir Michael Rutter, renowned Child Psychiatrist, suggests we should think about resilience in the same way that we think about biology. If you want to protect people against infections, you don't put them in a cocoon and stop them ever having contact with bacteria and viruses - you expose them. But you expose them in ways that they can cope with, either through natural exposure or through vaccination. So the psychological equivalent is to say: what could we do to enable children to cope successfully with hazards? Because challenges, stress – that's part of growing up and you have to learn to cope, and the only way you learn is through exposure, but in small "safe" doses.

Evidence from a series of reports examining the prevalence of Adverse Childhood Experiences (ACEs)[22] in the Welsh adult population and their impact on health and wellbeing across the life course shows that there are key resilience assets that **every** child benefits from. These include experience of: *adult availability*, *a range of opportunities, being treated fairly, culturally engaged, having supportive friends and having good role models.*

Work undertaken in Somerset in partnership with primary, middle, secondary and special schools, as well as pupil referral units, has drawn from recent research[23], [24] resulting in the development of a Somerset Wellbeing Framework in collaboration with schools, parents (parent carer forum), the SHARE team (Somerset Partnership), Parent and Family Support Advisors and the Educational Psychology Service.

Somerset Wellbeing Framework

The framework has been developed to support schools to promote a whole-school approach to mental health and wellbeing, based on resilience and community building for staff, pupils and families. What this translates to is a conscious and fundamental shift in how schools respond to the children and young people in their setting with much greater emphasis, at a universal level, on building resilience.

Somerset County Council's Public Health Team has worked with schools to pull together the key findings from this work and to develop the framework as a whole-school approach. The key features of the framework are:

- Developing a sense of belonging and connectedness with the place you go to school; where you feel safe, valued and where you are enabled to develop a sense of purpose
- Building positive and caring relationships where children and young people have a voice, are heard and listened to by the adults around them and are given the opportunity to develop and practice emotional literacy
- Development of individual skills around self-care and a deeper understanding of how to promote/support wellbeing for yourself and others
- Access to the right information at the right time which is appropriately aimed at young people and includes ways to enhance wellbeing, prepare for times of stress and organisations that young people can contact
- Availability of suitable/relevant/expert services and resources when they are needed including staff with good levels of awareness and understanding around mental health, promoting resilience and managing young people's mental health behaviours including self-harm
- All of the above linked to wider community of the schools including parents and adults within children and young people's services

22

The main reason teachers say young people *stop* self-harming is that they learn to cope better with the emotions associated with it. There is an opportunity to educate about the emotional states that can lead to self-harm. Teaching emotional awareness and literacy creates a platform for raising the topic of self-harm in context.

The Somerset Wellbeing Framework includes targeted support with access to help for those that need more:

- Skilled staff and wellbeing leads
- Prompt identification of children and young people that need more
- Appropriate school-based intervention
- Links to local specialist provision
- Reviewing and monitoring mechanisms.[25]

'I feel positive about this work and difference it will make to the children and families in my school. It provides a great framework for improving what we do and there seems to be much more join up and clarity about where we can get additional support.'

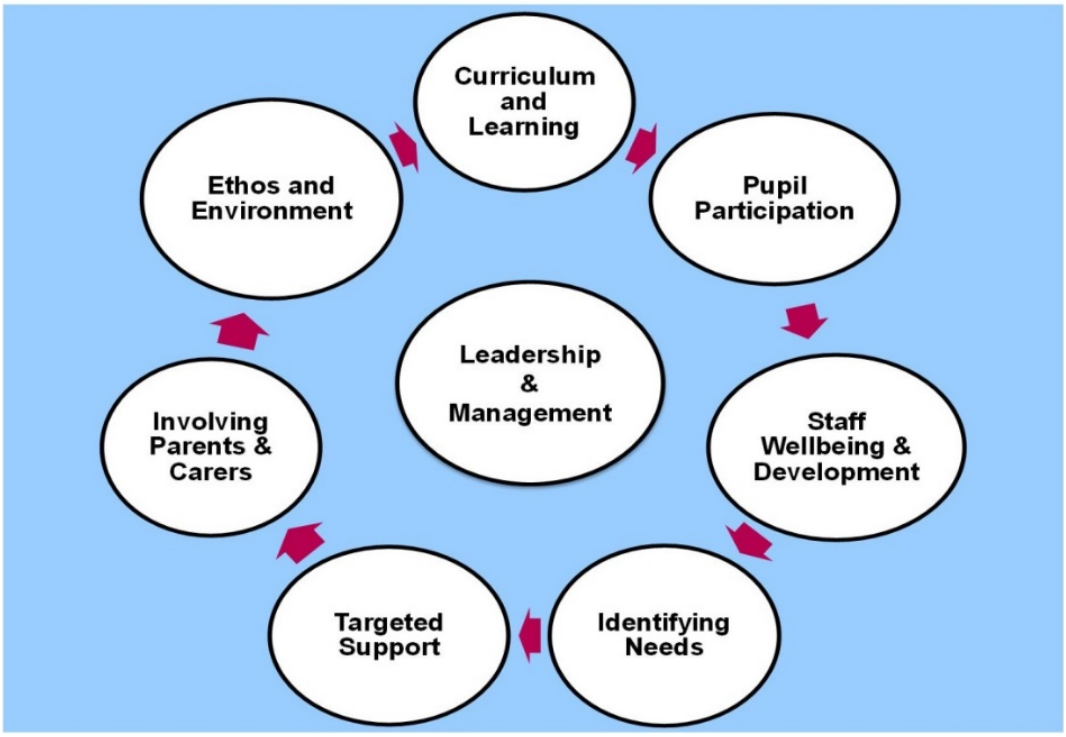
Head Teacher - Primary School

"Mental and emotional health has become a real issue in recent years and we know it is something we have to prioritise if we want the best out of young people. This framework will help us to gauge where we are and what more we can do."

Deputy Head – Secondary School

The framework uses the "eight principles" model developed by Public Health England (Figure 15) to achieve a holistic approach to wellbeing. The principles underpin an effective whole-school approach and provide the scaffolding needed to cover every aspect of school life.

Figure 15: Eight principles of a whole school approach



The latest research about promoting wellbeing suggests that there are some basic building blocks that have a real impact and - practiced from an early age - will provide a strong foundation for children and young people's emotional health. The pillars (Figure 16) are framed around three areas that coincide with the school year:

- developing a sense of belonging
- forming and sustaining positive relationships
- adopting healthy lifestyles

Schools, alongside families, are well placed to provide the support children and young people need to explore and develop these pillars. The importance of schools as a setting to promote and protect mental health has been identified nationally. Additional resources are being made available for schools through the NHS; these will focus on early intervention and whole school approaches for positive mental health.

Figure 16: Three Pillars of Wellbeing

Sources of support

Whilst prevention is extremely important, so is access to timely and appropriate help and support. As we have seen, children and young people's mental health is everybody's business – not just the business of specialist services.

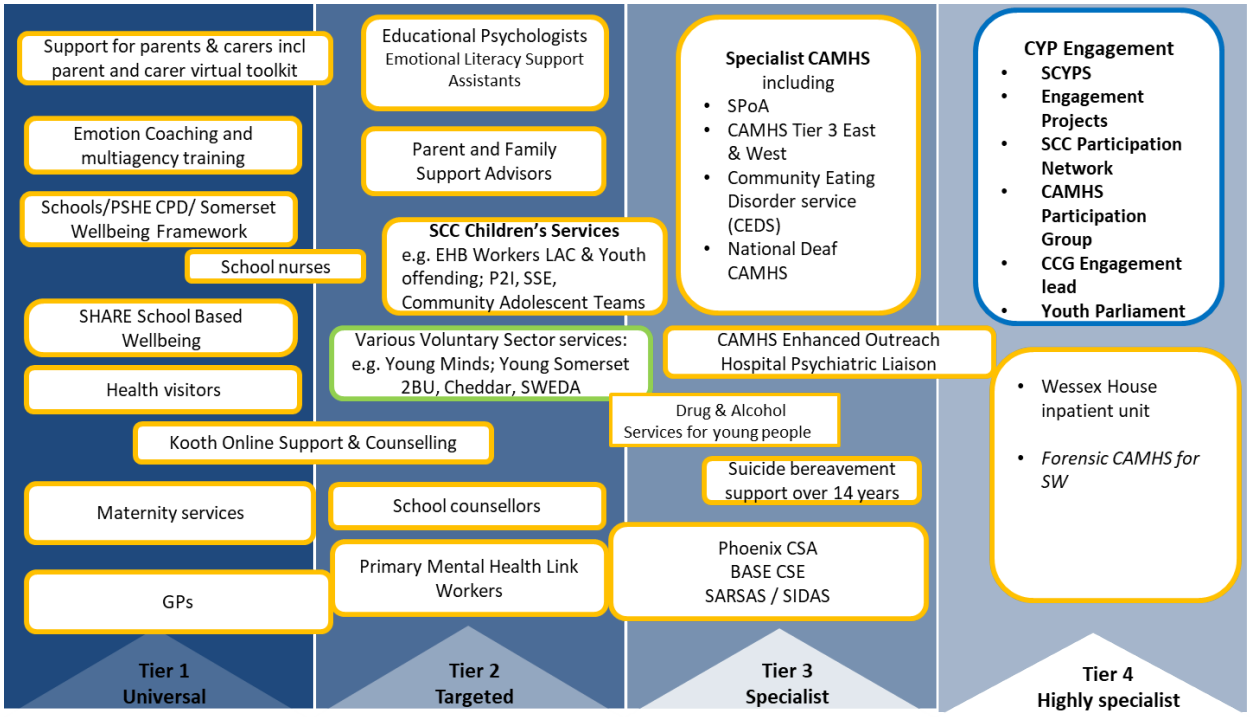
Help and support can be found in many forms and settings; in schools and communities, as well as health, social care and voluntary settings. Sometimes the most effective help and support comes informally from family and friends. Indeed, often only the most serious and recurrent self-harm is ever seen by health services.

> *"Having the time and opportunity for self-management may be enough for some people to make it through a difficult patch and of course, increasingly help and support is sought and available online."*
>
> *Dr Alex Murray, GP and CCG Clinical Lead for Mental Health*

The three most common ways of coping with problems/worries, amongst Somerset secondary school pupils, were "playing computer games" (boys), "playing music" (girls) and "talking to someone about it" (both).

Figure 17 below, describes a range of different support available in Somerset to meet different levels of need. This is by no means all that is available, but it serves to illustrate both the range of provision and something of the complexity which makes it difficult for young people, parents and teachers to work out where to go for help.

Figure 17: Emotional health and wellbeing support services for children and young people in Somerset

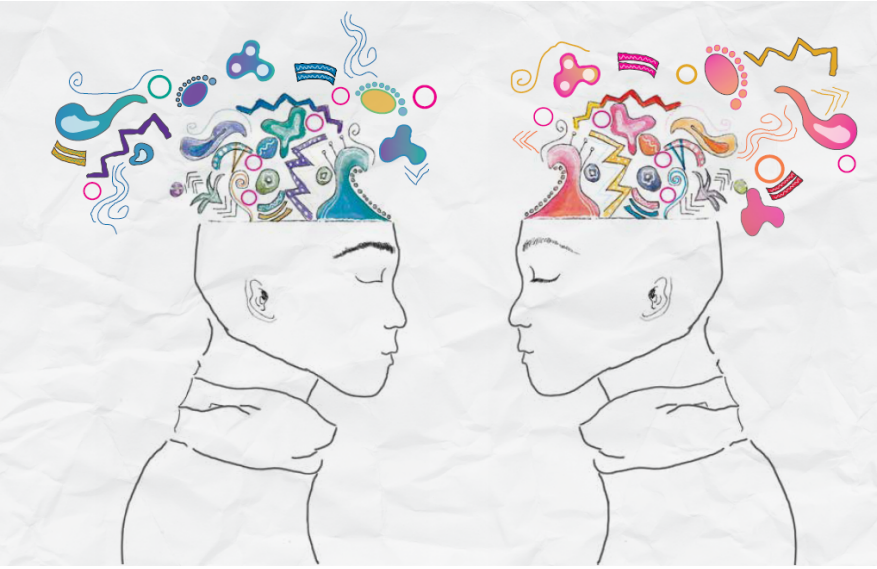


Some other important sources of help

Emotion Coaching

Emotion Coaching is a programme which teaches pupils and their teachers the principles of resilience and stress management. Year 8 students in schools who received Emotion Coaching are more likely to be able to say "no" to someone who is asking them to do something that they don't want to do (66% vs. 59%). Teachers who have engaged with the programme have reported more effective management of emotional and behavioural issues at school.

LifeHacks



Young people in Somerset have helped developed "Lifehacks[26]" to support themselves and each other.

Resources which have been produced include The Little Book of Mental Health LifeHack – Looking After Yourself which is packed with ideas and links to support people's own mental health and includes true stories from people who've tried them out.

There is also a Little Book of Mental Health LifeHacks to Support a Friend which is packed with ideas and links to support the mental health and again includes true stories from friends who've tried them out.

"We've been thinking about how to help ourselves manage our mental health and how to help our friends when they're struggling too. So we've come up with a set of LifeHacks to help you and your friends to keep mentally healthy!

Mental health is something you DO, not something you HAVE. We want to help you and your friends take action for positive mental health!"

Young person involved in

26

Online support

> *'I got all my support via the internet from other young people like me when I was self-harming. They didn't judge me and they understood it was a coping mechanism and not linked to me necessarily wanting to kill myself. There is such a panic about self-harm and other young people understand what it's really about.'*
>
> *A Somerset Young Person*

Social media has become a space in which we form and build relationships, shape self-identity, express ourselves and learn about the world around us. We must therefore strive to understand its impact on mental health. Social media is often cited as adding pressure on young people, but the internet can be a support as well. Social media platforms can promote a sense of community and facilitate the provision of emotional support.

"Kooth" is an online programme (https://kooth.com/) commissioned in Somerset to provide online support and counselling for young people aged 11 to 18. Kooth recognises that services have to "be where the young people are", especially in times of difficulty.

Facebook's suicide prevention tool launched in the UK in January 2016. If users believe a friend's post indicates self-harm or is suicidal in nature, as well as reaching out to them directly, users are able to anonymously report the post to Facebook. The post will be reviewed by Facebook's support team, and if appropriate, the author of the post will be offered a series of options via a private message screen, including access to support lines, resources or a prompt to reach out to their friends and family for help.

Harm Reduction

Unfortunately, for some young people "self-management" may actually mean harming themselves. The evidence suggests that this is typically cutting the body, rather than the overdoses identified as typical of emergency hospital admissions. Indeed, we know that some charities teach young people how to cut themselves safely – cleanly and hygienically – to reduce the physical danger. (Needle exchange is a similar type of harm-reduction initiative.) Self-harm can be a way for young people to cope with pressures at school or work, bullying, breakdown of relationships or sexual physical or emotional abuse.

> *'I "needed" to harm to punish myself for being what I believed to be a terrible person and to clear the fog in my head. As soon as I did, I'd feel in control, calm and as through a reset button had been pressed in my head.'*
>
> *MIND - Understanding self-harm 2013*

It is a difficult paradox that deliberately harming yourself is something that you do to try to help yourself with things that feel unmanageable. However, this underlying intention of taking care of yourself is exactly what can be harnessed to help people find a more constructive way forward. Although it takes time, courage and determination, there are ways to learn to manage difficult feelings differently and to be freed from the painful burden of self-harming urges.

Conclusion and Recommendations

This year, I have devoted my report to looking at emotional resilience and self-harm, particularly in relation to children and young people.

In Somerset we have seen an increase in presentations for self-harm in our hospitals and there is increasing concern from parents, schools and young people themselves about rising levels of self-harming behaviour.

This report has investigated emergency hospital admissions for self-harm and has found the increase in admissions is particularly driven by rising rates for girls and young women aged between 10 and 24. Rates were found to particularly peak at around the age of 15.

Rising emergency admission rates are, however, considered the tip of the iceberg. In a 2018 survey of Somerset secondary school pupils, 28% of females and 19% of males reported that they sometimes hurt themselves in some way when they feel stressed or worried.

The more important message is that the pattern of self-harm we are seeing in Somerset is telling us something about the emotional distress which young people are experiencing.

The information contained in this report still only presents part of the picture. There is far more to be done to understand the level of emotional resilience, particularly that of our children and young people. There is a need to develop a greater understanding of self-harming behaviour, and what support is needed to help young people, their parents, teachers and others to better promote positive emotional health and wellbeing and resilience.

Fundamentally, we need to reduce the stigma associated with self-harm, and improve access to the support available. We need to help young people to develop the skills they need to cope with more stressful and traumatic situations in a less harmful way.

Of concern is the fact that too often people simply do not know where to turn for help, or worse, feel that they won't get help until they get more ill or the situation reaches a crisis point. We cannot ignore the fact that many, including GPs, feel frustrated and concerned about lack of access to appropriate support for young people experiencing personal emotional distress.

The gains from promoting and protecting the emotional health and wellbeing of children and young people are known to be lifelong. The economic case for investing in prevention is clear. We need to understand that while prevention is about the provision of services, it is also about protecting children and young people from adverse experiences, about building resilience and about developing a culture of emotional literacy. If we are to reduce admission rates for self-harm and reduce the frequency and scale of self-harming behaviour in our young people, we will need to mobilise a whole system approach with all stakeholders and partners working together to bring about change.

Recommendations

This report is just the start of the conversation. The task of addressing the issue of self-harm and promoting positive mental health needs to be everyone's business and will require concerted and co-ordinated action. I have set out below some recommendations for action in Somerset.

Recommendation 1
We need to bring the issue of emotional resilience and self-harm into the open to help reduce the stigma associated with it. Talking openly about the issue will help people to access the right support when they need it.

Recommendation 2
There is a need to develop more accessible guidance and information about self-harm. This needs to be supported by increased knowledge, confidence and skills in responding to a situation of self-harm both for families, schools and health and care services.

Recommendation 3
All schools should adopt the Somerset Wellbeing Framework to support and promote positive emotional health and wellbeing and, where appropriate, could consider developing school based self-harm policies.

Recommendation 4
Health and care services need to ensure that the mental health of children and young people is given greater prominence, ensuring that prevention and early intervention is addressed as well as treatment.

Recommendation 5
The importance of developing stronger individuals, families and communities has to be at the heart of developing resilience. A joined-up approach to this would provide a far greater impact than organisations operating independently. A more proportional approach will be needed, focusing particularly on addressing the needs of individuals, families and communities living in more challenging circumstances.

Recommendation 6
Given increased national investment in mental health, Somerset Clinical Commissioning Group has a significant opportunity to invest in improving the emotional health and wellbeing. Working closely with local authorities and schools, investment in developing emotional resilience and early intervention is paramount.

Recommendation 7
There is a need for us to deepen our understanding of self-harm practices and understand more about the emotional resilience of children and young people in Somerset and what can be done to improve it.

Recommendation 8
Finally, and above all, we need to continue to listen to what children and young people are telling us about their experiences and to work with them in designing the solutions.

Acknowledgements
I would like to thank all those who have contributed to this report, those who have supplied data and those who have supplied advice and information both directly and indirectly. I hope this is the beginning of a much deeper and longer conversation in Somerset.

I would particularly like to thank the following people for their contributions:

Pip Tucker; Christina Gray; Jack Layton; Alison Bell; Kerry Allen and CAMHS team members; LifeHacks Young People's Group; Fiona Moir; Louise Finnis; Dr Alex Murray; Young Somerset and the multi-agency Self-Harm Steering Group; Jacqueline Burns

Appendix 1

Prevention Concordat for Better Mental Health

https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

The Concordat advocates:

- Needs and assets assessment, with the effective use of data and intelligence (*such as http://www.somersetintelligence.org.uk/mental-health/*)

- Partnership and alignment
  Upstream prevention (stopping people developing issues in the first place) – to save the pressure on emergency services and the police

- Translating need into deliverable commitments
  Somerset's emerging Improving lives and Fit for my future strategies both cover mental health. When these strategies are complete we should use them to improve the services we provide.

- Define success outcomes
  Commissioning mental health services jointly or in alignment requires shared success and performance measures

- Leadership and Accountability
  The Somerset Health and Wellbeing Board is committed to promoting good mental health and prevention of mental ill-health, and stands ready to lead improvements.

Appendix 2

Positive Mental Health - Joint Strategy for Somerset 2014-19

This strategy advocates the following:

- Involve young people and their families in the co-design, co-production and co-delivery of services to support their health and wellbeing
- Make sure that everyone in the children and young people's workforce is well informed about emotional and mental health
- Invest in parenting programmes which are low cost, high value interventions which can be developed and delivered in a flexible and inclusive way
- Protect children, young people and families from risks such as exposure to bullying, violence, discrimination and from the effects of harmful drinking and substance misuse
- Invest in interventions for behaviour and for conduct disorder which have been identified as a "best buy for mental health" with potential savings from each case through early intervention estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems

Consideration needs to be given to how education on self-harm could be included in the curriculum via Personal, Health, Social and Education (PHSE) classes and other appropriate curriculum areas. As mentioned, consistent language that teachers, GPs and others can use when talking to young people about self-harm would be welcomed by them[27].

The report suggests there is an urgent need to develop new policies and procedures that clearly provide guidance and information regarding self-harm to all key stakeholders. This needs to be supported by an increase in knowledge around self-harm across all groups to ensure a more consistent and empathetic response is given and all groups provide better support to a young person who is self-harming.

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[1] https://cks.nice.org.uk/self-harm

[2] https://sites.manchester.ac.uk/ncish/ ; Preventing Suicide in England: a cross-government outcomes strategy to save lives, Department of Health and Social Care, September 2012; Suicides by children and young people in England - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, May 2016

[3] The Five Year Forward View for Mental Health; Dept. of Health and Social Care, Public Health England and NHS England, January 2017; Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing, Dept. of Health and NHS England, March 2015

[4] https://cellohealthplc.com/new-research-talking-self-harm-lifts-lid-on-hidden-despair/
[5] https://cellohealthplc.com/new-research-talking-self-harm-lifts-lid-on-hidden-despair/
[6] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2817%2930478-9

[7] These are 'directly age-standardised' meaning that that differences in the population size and age structure are accounted for in the calculation. The definition is the number of finished first consultant episodes where the patient was admitted via an emergency method and where the main external cause recorded is given an appropriate code International Classification of Disease 10 (ICD-10) code:

- X60-X69 (intentional self-poisoning); X70-84 (intentional self-harm by other and unspecified means).

[8] Rates are calculated using Office for National Statistics (ONS) mid-year population estimates for relevant years and a simple line of best fit trend has been extended for the most recent year (2017) without published data using Microsoft Excel's Forecast function. Individuals are identified by unique identifier and either CCG of residence for Somerset or the ONS Government Offices for the Regions Code for the South-West. The England calculation simply include everyone in the dataset and represents activity in English hospitals; this does mean there may be small numbers of admissions of people from other countries and admissions where the residency was unknown. The calculation uses First Admissions Episodes rather than First Consultant Episodes. However, the number of admissions for self-harm where the patient was in the care of more than one consultant during their hospital stay is negligible.

[9] https://bpspubs.onlinelibrary.wiley.com/doi/pdf/10.1111/bcp.12362

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[12] Please note that this does not account for any admission which might be caused by multiple self-harm methods, as only the main cause is considered. It also does not account for multiple admission across different years. It may also be affected by people's age and sex.

[13] English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
[14] Analysis undertaken by Somerset Public Health
[15] https://www.bmj.com/content/342/bmj.d2218

[16] https://www.nice.org.uk/guidance/cg16/chapter/1-guidance

[17] http://www.somersetintelligence.org.uk/scyps/

[18] https://cellohealthplc.com/pdfs/talking_self_harm.pdf

[19] https://cellohealthplc.com/pdfs/talking_self_harm.pdf

[20] http://www.somersetintelligence.org.uk/jsna/
[21] https://cellohealthplc.com/pdfs/talking_self_harm.pdf

[22] https://www.publichealthnetwork.cymru/en/news/welsh-adverse-childhood-experiences-ace-study/
[23] The Centre of Resilience for Social Justice at the University of Brighton
[24] Reading University's Andy Research Clinic around the Pillars of Wellbeing: *Purpose, Relationships and Lifestyle 2017*
[25] https://www.cypsomersethealth.org/wellbeing_framework:_intro

[26] https://www.cypsomersethealth.org/?page=new_lifehacks

[27] https://cellohealthplc.com/pdfs/talking_self_harm._pdf

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Health and Wellbeing Board Work Programme – Jan 2019

Agenda item	Meeting Date	Details and Lead Officer
Health and Wellbeing Board Meeting (11am start)	**17 January 2019**	
Annual DPH Annual Report		Pip Tucker / Trudi Grant
Somerset Health & Care Integration		Rosie Benneyworth & Ian Triplow
Health Protection Forum Annual Report		Jess Bishop/Alison Bell
Somerset Safeguarding Children Board (SSCB) Annual Report		Louise Bath/Sally Halls
CYPP		Fiona Phur
Health and Wellbeing Board Meeting (11am start)	**21 March 2019**	
JSNA 2019		Pip Tucker
Positive Mental Health for Somerset Annual Report		Andrew Keefe (CCG), Louise Finnis
Click Somerset		South Somerset DC
Strategic Housing Framework		Mark Leeman
Health & Care Integration		Rosie Benneyworth & Ian Triplow
Improving Lives Performance Framework		Catherine Falconer & Amy Shepherd
Health and Wellbeing Board Meeting (11am start)	**23 May 2019**	
Healthwatch Report		Emily Taylor

Health and Wellbeing Board Work Programme – Jan 2019

Sexual Health Update		Alison Bell & Michelle Hawkes
Health and Care Integration		Rosie Benneyworth & Ian Triplow
End of Year Performance Report		Amy Shepherd
Annual Report of the HWBB		Christina Gray
Somerset Safeguarding Adults Board (SSAB)		Stephen Miles + Independent Chair (request for this item to be late on agenda)
Health and Wellbeing Board Meeting (11am start)	**11 July 2019**	
Health and Wellbeing Board Meeting (11am start)	**26 September 2019**	
Health and Wellbeing Board Meeting (11am start)	**14 November 2019**	