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.

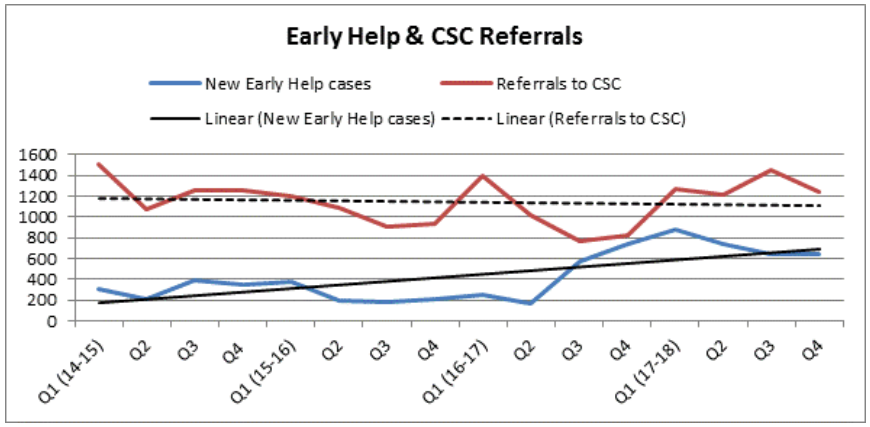
What we are pleased about

- 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.

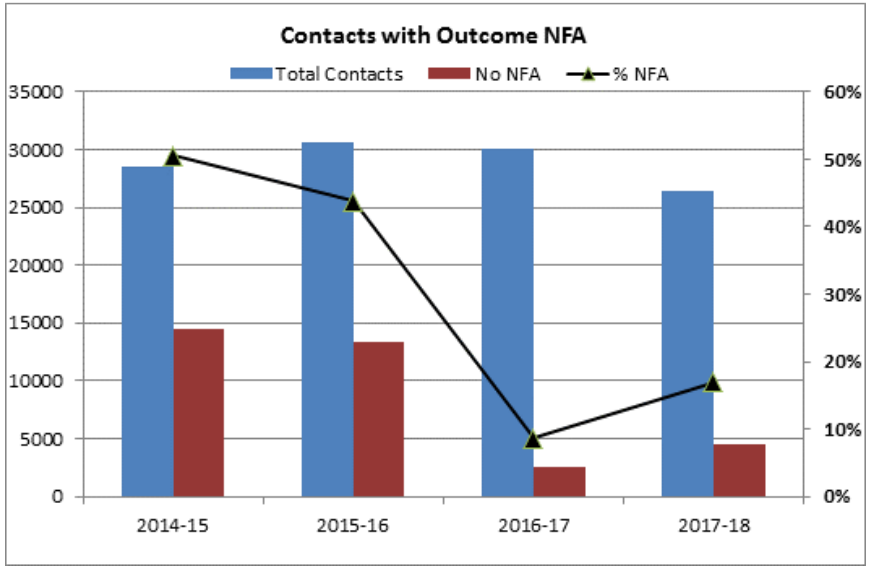
- The multi-agency audit highlighted some **positive practice;**
- 2017 saw a **sharp rise** in the use of EHAs, linked with conversion rates that went on to become referrals, which generally demonstrated improved understanding of thresholds;
- Across the year there was **positive use of the consultation 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.

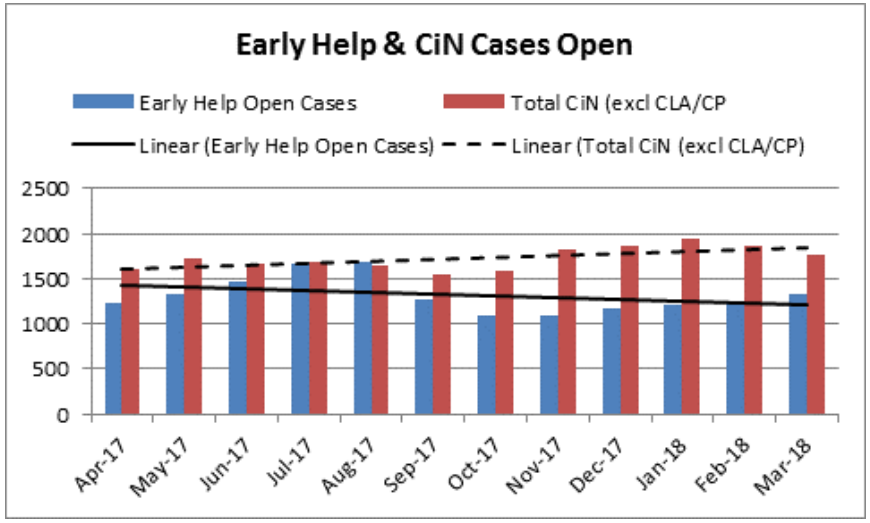


- A rise in the percentage of **re-referrals** to Children's Social Care over Q3 and Q4 following a period of stability.
- **Lack of impact** - over 50% of cases with EHAs with 'needs not reduced at closure', could explain why re-referrals to CSC peaked in 2017/18.
- A significant **data gap** has emerged 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

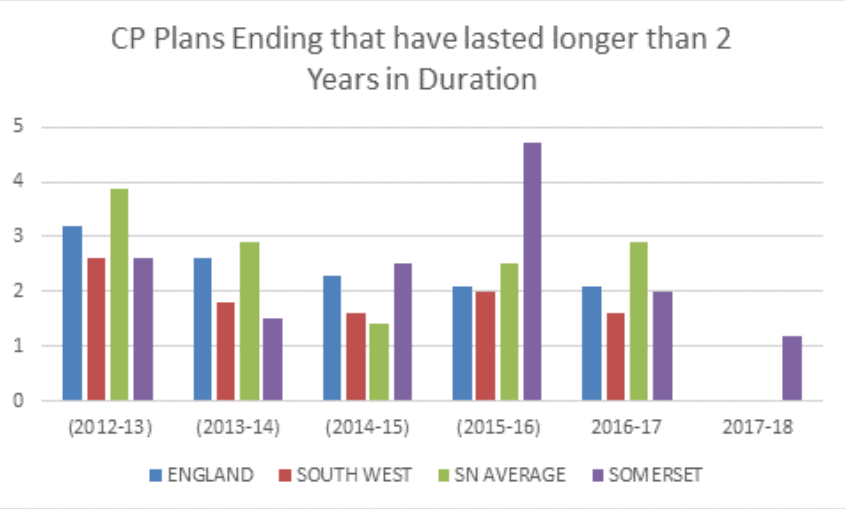
Type of abuse	No. at 31/3/18	% at 31/3/18	% at 31/3/17	% at 31/3/16
Emotional abuse	181	41.6	21.5	31.2
Neglect	224	51.5	69.7	57.7
Physical abuse	11	2.5	1.7	4.7
Sexual abuse	16	3.7	1.4	0.4
Multiple factors	3	0.7	5.6	6.1

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

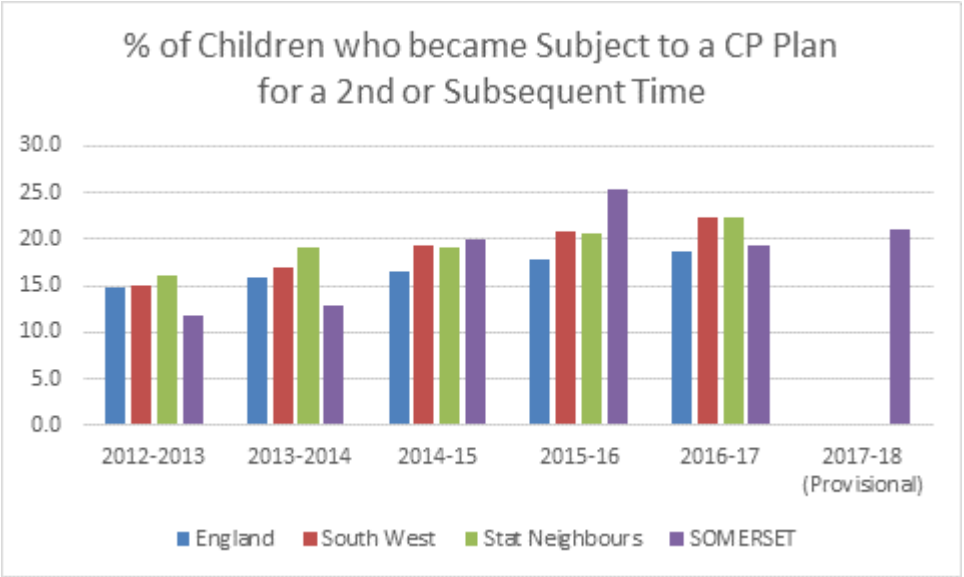
- The proportion of long term CP plans has steadily continued to reduce across the year.
- Safeguarding conversations - The Board reviewed three multi-agency practice examples of CP/CIN cases. These highlighted evidence of positive multi-agency practice and a number of learning themes for the Board including:
    - 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.

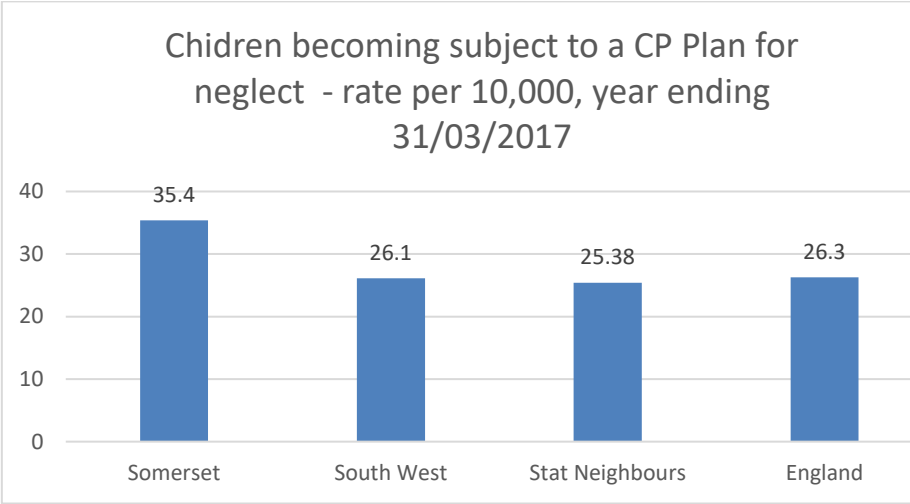
What we did

- 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.

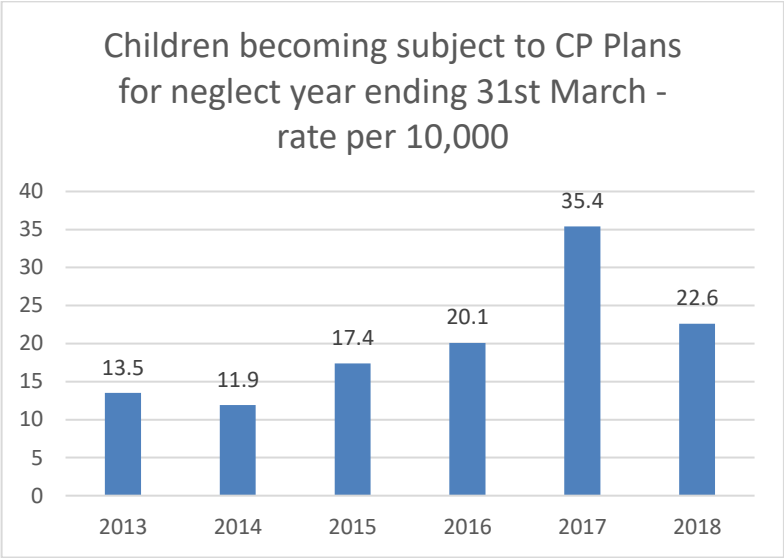
What we found

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.

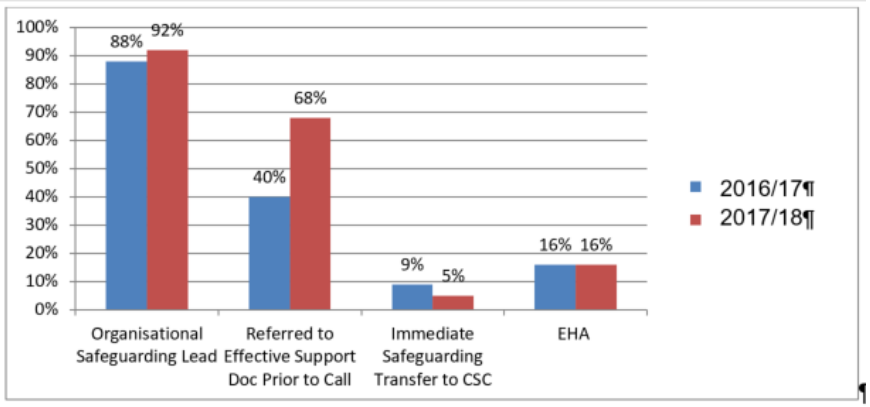
**These download figures count the number of times each publication has been downloaded from the SSCB website. They do not account for managers cascading the download within their own agencies.*

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.

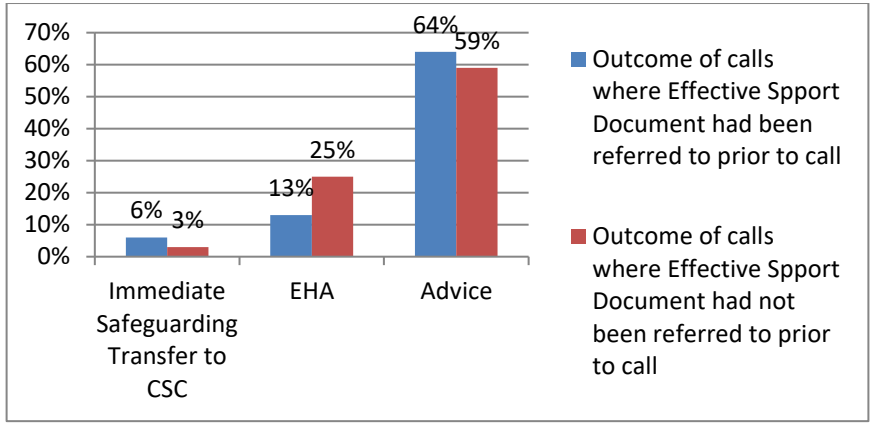
Comparison summary of calls to consultation line 2016/17 and 2017/18



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.

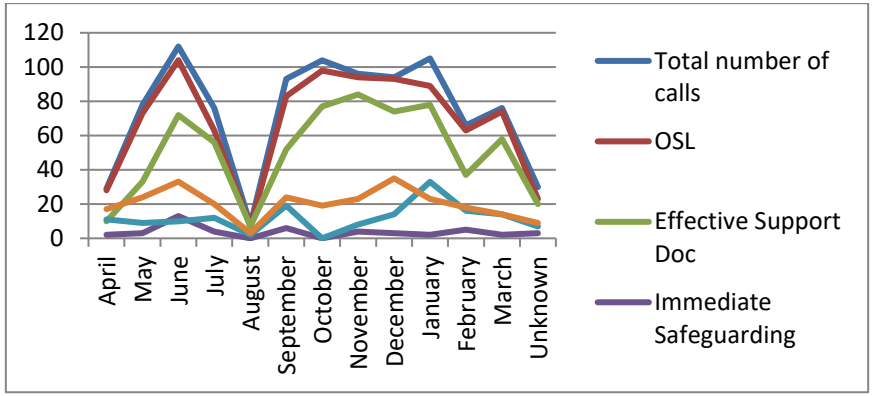
There has been a decrease of 28% in callers referring to the Effective Support Document prior to calling the consultation line, which could further indicate that practitioners are more aware of and comfortable with thresholds. Conversely, it could also suggest that practitioners are not using the Effective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

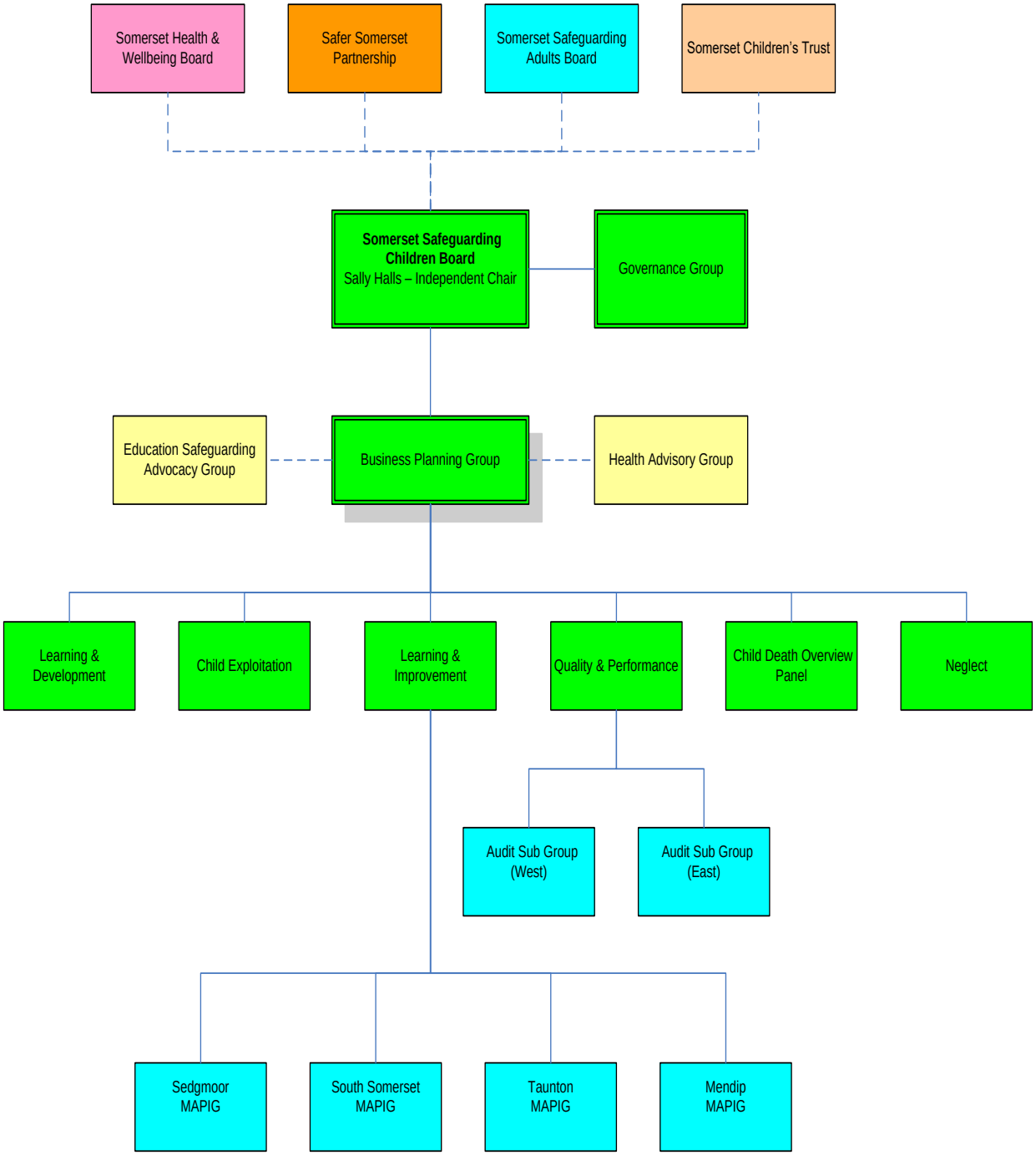
Training expenditure 2017/18

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:

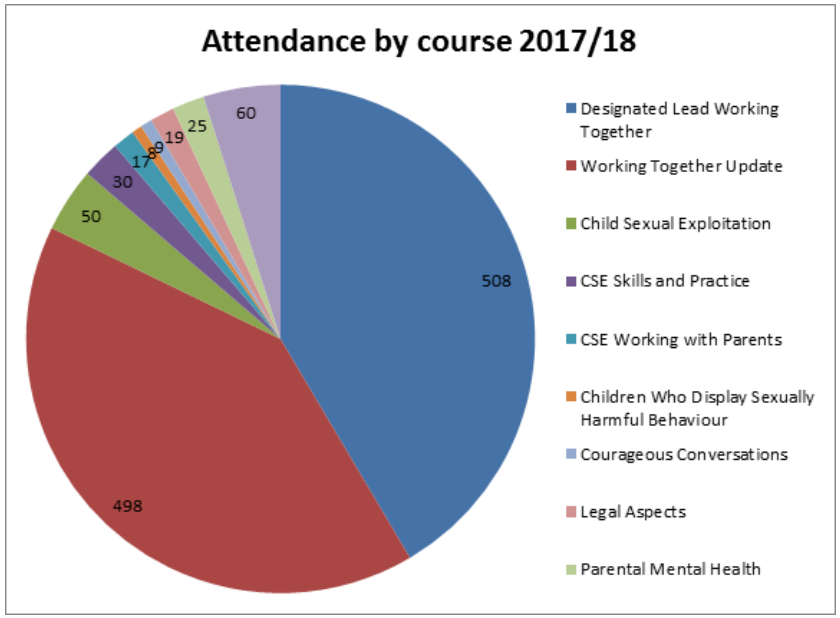
- Only 2 GPs sent information to the RCPC. One sent a letter rather than completing what was described as an "unwieldy conference report template", and the other information was handwritten. No GPs attended an RCPC. For one child there was no school nurse or hospital involvement so there was no input 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.

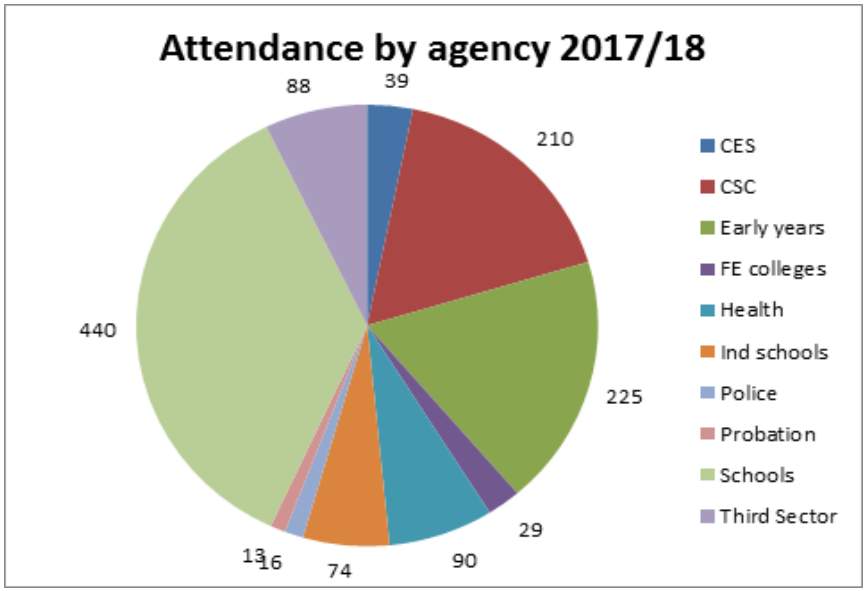
IMPACT:

- 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.

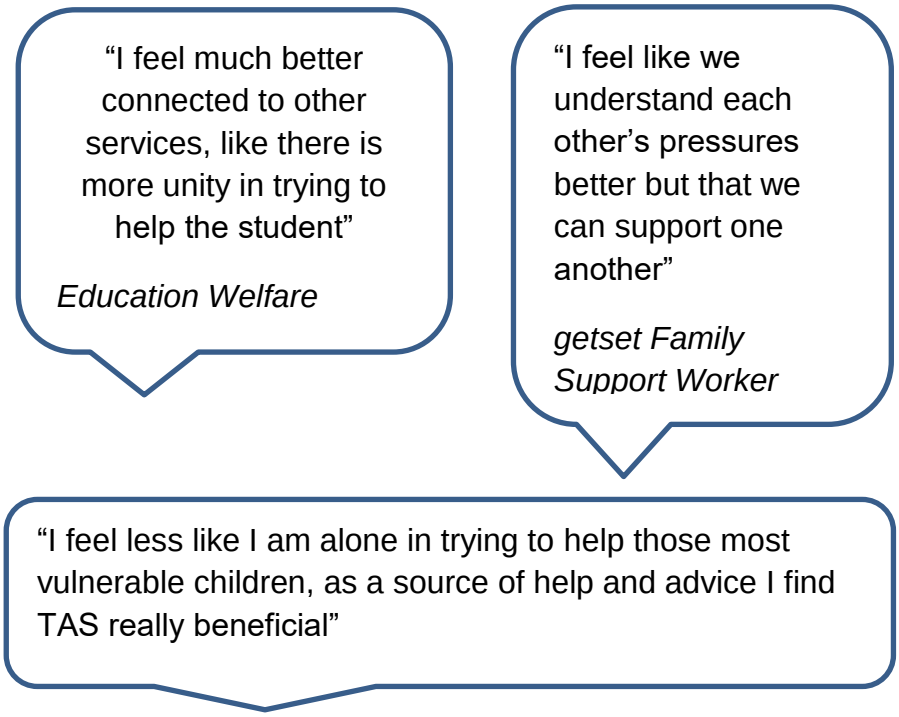
Organisation	Average attendance at TAS (Countywide)
School staff Designated safeguarding lead SENCO Parent & Family Support Adviser (PFSA) Other pastoral support Representation from feeder primary/infant schools	 98.2% 86.7% 97.7% 69.2% 83.1%
Police PCSO One/Inclusion team lead	 69.1% 21.0%
Children's 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.

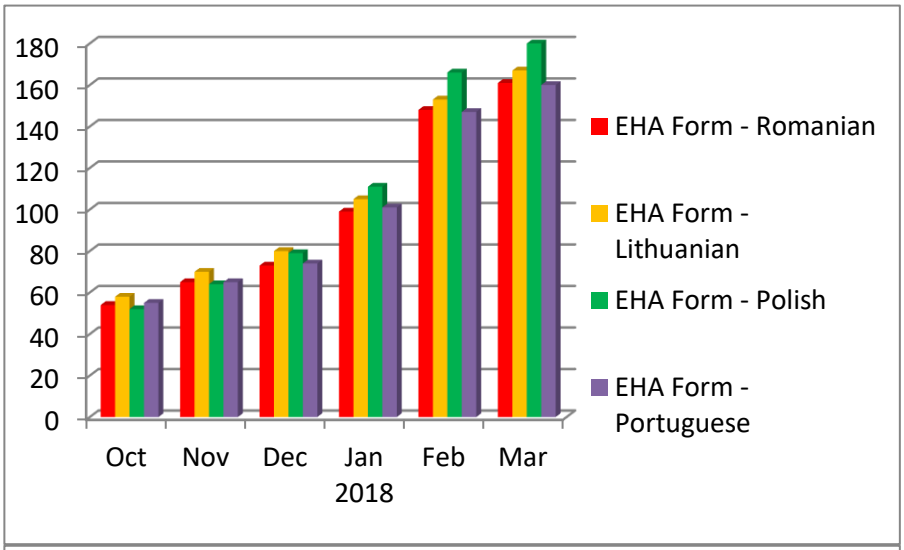
TAS meetings are utilising the virtual meeting rooms well but take up for team around the child meetings is still low. 'One' teams are really seeing the benefits which has seen a knock-on effect to other partners such as police, housing, health visitors and safeguarding leads.

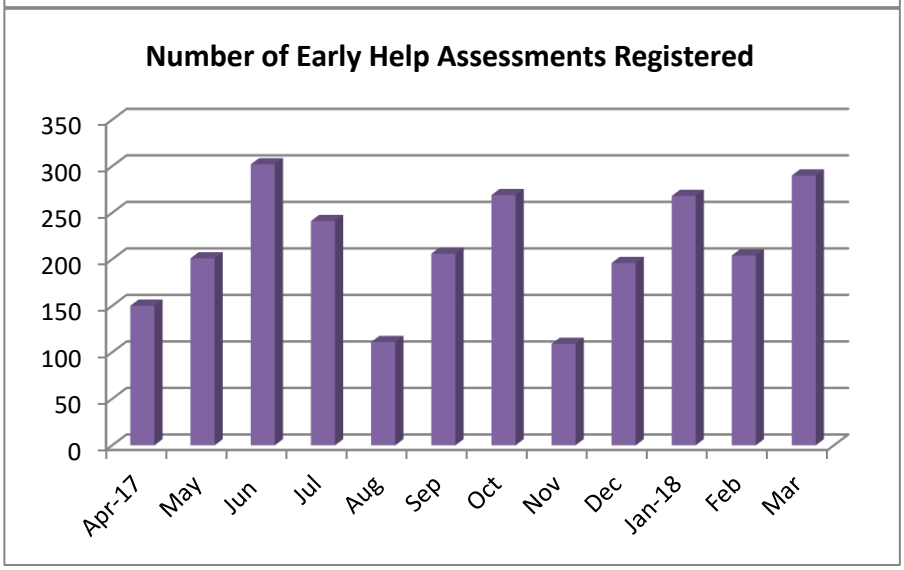
Key progress:

- 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.

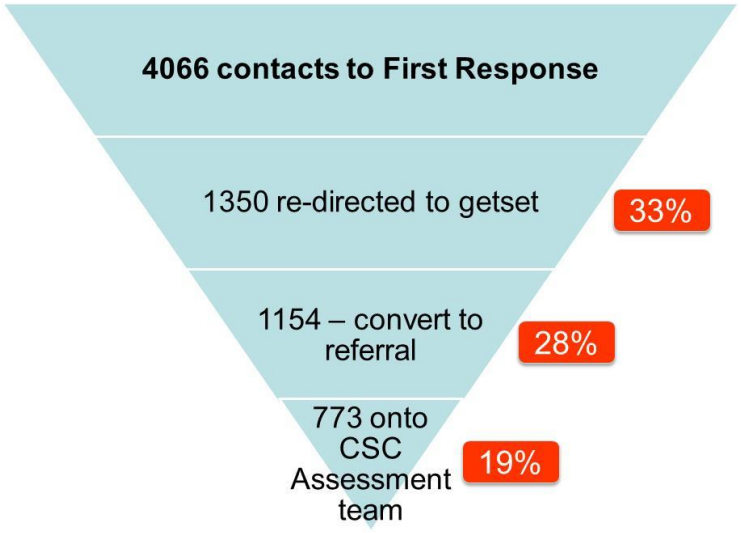
The right service at the right time?

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.