NORTH SOMERSET SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2016-2017

Published November 2017

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1 – FOREWORD AND INTRODUCTION

Our Vision: "Children and young people of North Somerset will be seen, listened to and valued to ensure they are safe, thriving and reaching their full potential."

Welcome to this, the Annual Report of the North Somerset Safeguarding Children Board (NSSCB) for the period 2016 / 2017. Readers of previous NSSCB reports will note a change of style – the purpose being to make this report friendlier to read whilst still painting a picture of safeguarding Children and Young People activities across North Somerset.

The work of the Board's sub-groups is a crucial part of our ability to deliver our strategic objectives as set out in our business plan. That work, which is reported in more detail within this report, is continually on-going. Without the commitment of sub-group members – all of whom are volunteers, the work of the Board would not be achievable.

During this reporting period, we have, unfortunately, needed our Serious Case Review (SCR) sub-group to meet on several occasions.

We have published one SCR ("Holly") in July 2016 - further details are within the sub-group's report, and work is ongoing on another two. Those reports will be published in due course.

I am particularly grateful for the work of the Young People's Sub-group. The leadership shown by the two co-chairs – both of whom have moved onto higher education, has been inspirational. Their commitment and dedication set a high achievement bar for others to follow plus the work of their sub-group has helped the Board to identify and focus on our key safeguarding priorities of Neglect, Domestic Abuse, Sexual Exploitation and Missing.

Over the past 12 months the Safeguarding Children Board has developed closer working links with the North Somerset Safeguarding Adults Board. You will note in some of the sub-group reports that they are joint sub-groups. Working together in that way has enabled both Boards to develop working practices which offer opportunities to reduce duplication of work, reduce the number of meetings and offer a greater understanding of the links between vulnerable children and vulnerable adults.

The Board held its annual development day in February 2017 and the following key priorities were identified for the Board and its sub-groups to focus over the next three years. The Board's vision was also agreed (as above).

• Priority One	Early Intervention
• Priority Two	Neglect
• Priority Three	Sexual Exploitation/ Missing
• Priority Four	Domestic Abuse

Safeguarding the most vulnerable people in our communities is a responsibility we all shoulder and share. I offer my sincere thanks to all who contribute to the work of North Somerset's Board and also to all those within our communities who provide care and assistance in many other ways to those who need safeguarding.

The report details achievements made throughout the year and areas of challenge. This then feeds into the 'next steps'.

The key priorities are detailed in the Business Plan which can be found in **Appendix 1**.

There is a section within the appendices in relation to board attendance (**Appendix 2**). As can be seen there are still some challenges to be overcome for regular meaningful attendance by some partners. Accepting the difficulties that the requirement to attend numerous Boards across their areas, it is vital to ensure local children are safeguarded, that we have regular and appropriate attendance.

Tony Oliver,
Independent Chair, North Somerset Safeguarding Children's Board

NOTE: Readers will note there is a discrepancy in style of reports; this is where reports are either joint adult and children sub-groups reports or multi-agency reports which cover more than one authority.

2 - LEGAL FRAMEWORK, MAIN FUNCTIONS AND RESPONSIBILITIES OF THE SAFEGUARDING CHILDREN BOARD

Section 13 of the Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the Local Authority) that should be represented on LSCBs.

It is independently chaired (as required by statute) and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in North Somerset.

There is an agreed role description for all Board members, recognising that some members do not represent their agencies but represent professions or sectors. The Board has two lay members as required by the Apprenticeships, Skills, Children and Learning Act 2009.

Each Board partner retains their own existing line of accountability for safeguarding.

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are;

- ☐ To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and

- ☐ To ensure the effectiveness of what is done by each such person or body for that purpose. Regulation 5 of the Local Safeguarding Children Board's Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

- ☐ Developing policies and procedures for safeguarding and promoting the welfare of children, including policies and procedures in relation to:

    - The action to be taken where there are concerns about a child's safety or welfare including thresholds for intervention.
    - Training of persons who work with children or in services affecting the safety and welfare of children.
    - Recruitment and supervision of persons who work with children.
    - Investigation of allegations concerning persons who work with children.
    - Safety and welfare of children who are privately fostered.
    - Co-operation with neighbouring children's services authorities and their Board partners.

- ☐ 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.

- ☐ 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.

- ☐ Participating in the planning of services for children in the area of the authority.

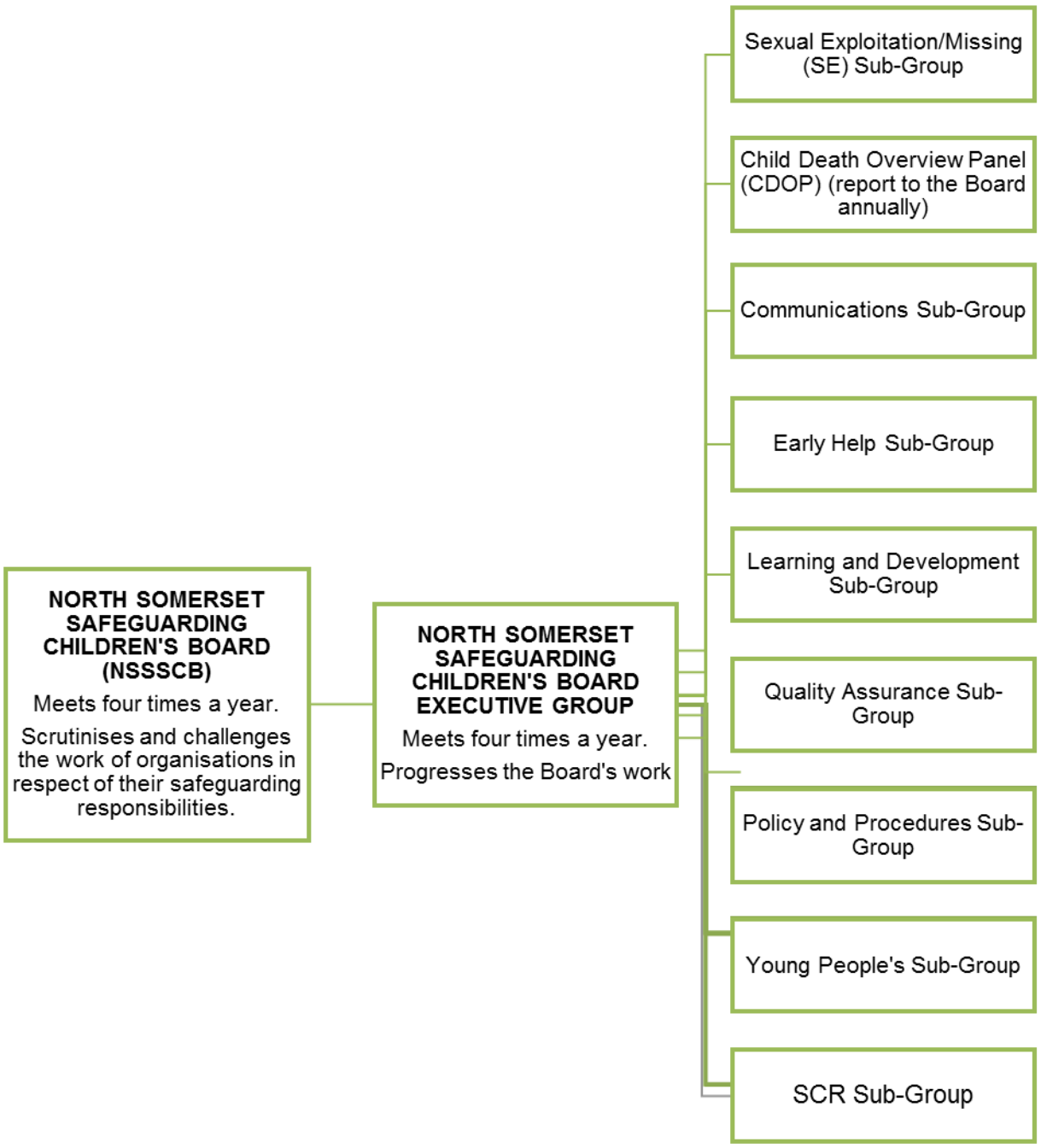
- ☐ Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Structure of North Somerset Safeguarding Children Board (NSSCB):

Working Together 2015 highlights the importance of partner agencies and their role in implementing effective safeguarding practice. While LSCBs do not have the power to direct other organisations, they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding. In North Somerset our Board partners include:

- ☐ Local Authority
- ☐ Avon and Somerset Police
- ☐ Health
- ☐ National Probation Service and local Community Rehabilitation Company (CRC)
- ☐ Education (including schools)
- ☐ Voluntary sector
- ☐ CAFCASS
- ☐ Border Agency

We also work with other partners such as Adult Safeguarding, Fire and Rescue Service and the Ambulance Service.


NORTH SOMERSET SAFEGUARDING CHILDREN'S BOARD (NSSSCB)
Meets four times a year.
Scrutinises and challenges the work of organisations in respect of their safeguarding responsibilities.
NORTH SOMERSET SAFEGUARDING CHILDREN'S BOARD EXECUTIVE GROUP
Meets four times a year.
Progresses the Board's work
Sexual Exploitation/Missing (SE) Sub-Group
Child Death Overview Panel (CDOP) (report to the Board annually)
Communications Sub-Group
Early Help Sub-Group
Learning and Development Sub-Group
Quality Assurance Sub-Group
Policy and Procedures Sub-Group
Young People's Sub-Group
SCR Sub-Group

3 – LOCAL DEMOGRAPHICS

The population of North Somerset is 209,994 (2015).

This section reviews trends and progress with safeguarding children with high levels of vulnerability. This includes children who need to be supported by a child protection plan and those who need to be in the care of the local authority to keep them safe.

Children with a child protection plan

At the end of March 2017 there were 150 children subject to a child protection plan across North Somerset. Compared with the previous years, this is a slight increase in numbers. Of the children subject of a child protection plan, neglect accounted for the most significant group.

Work is being undertaken to understand these trends and review practice where required.

Children in care

At the end of March 2017, 226 children were in care across North Somerset. The numbers of children in care have slightly increased since this time last year. Individual children have regular reviews which are chaired by Independent Reviewing Officers (IROs) to ensure their needs are met.

Please see appendix 6 which seeks to give an overview of activity within children's social care throughout 2016/17.

Data is provided for each of the areas shown in the attached diagram (appendix 6). Where possible, demographic data including disability, gender and ethnicity has been included, as has historical data.

As can been seen from appendix 6, overall the numbers of contact to Children's Social Care has fallen since the summer of 2014.

Over the course of a year, the number and rate of domestic abuse contacts has remained fairly steady in North Somerset despite variances (sometimes quite large) on a month by month basis.

4 – MAIN ACHIEVEMENTS OF THE BOARD

- Development of the LSCB Co-ordinator post.
- The work of the Board has been informed by clear agreed priorities and underpinned by an up to date and well-structured Business Plan.
- We have raised the profile of the North Somerset LSCB by widely disseminating LSCB Newsletters.

- Revised Terms of Reference for each Sub-group of the Board.
- Development of a Memorandum of Understanding for the Board.
- Risk register implemented and updated regularly to provide regular progress on identified concerns.
- SCR guidelines have been produced.
- The development of our Serious Case Review (SCR) Sub-group to ensure that a panel is held to consider all potential SCRs, and that recommendations from SCRs, domestic homicide reviews and Safeguarding Adults Reviews (SARs) are acted upon and regular progress reports are fed back to the Executive meetings and the Board meetings.
- A Neglect task and finish group has completed a Neglect Strategy, Practice Guidance, and toolkit.
- Our FGM policy and practice guidance was drawn up and distributed to staff within children and adult services.
- Our Learning & Development Sub-group now includes Safeguarding Adult Board Learning and Development. New Terms of Reference and training needs analysis adopted.
- Further progress in our response to Child Sexual Exploitation

    - Continued development of the Child Sexual Exploitation/Missing Sub-Group.
    - Terms of Reference and Membership from lead agencies.
    - Risk Assessments and CSE toolkit embedded in practice.
    - Multi-agency Missing meetings held monthly to track cases.
    - Training available through LSCB and well attended.

5 – EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS FOR CHILDREN AND YOUNG PEOPLE IN NORTH SOMERSET

This section of the report provides an assessment of the effectiveness and performance of local services. The categories and themes do not cover all the factors influencing the risk to children and young people within North Somerset, rather it maintains a focus on key local vulnerabilities and related themes. These are areas where the Board needs to provide scrutiny and seek assurance of the effectiveness of local inter-agency arrangements to protect children and young people.

Child Sexual Exploitation and Missing Children

During 2016-2017, progress has been made by working in partnership to further the collective understanding of the profile of CSE in North Somerset in order to inform our strategies to prevent, identify and tackle CSE effectively. The following is a summary set out against the elements of the overarching strategy.

Quarterly reporting arrangements have been established and undertaken for the mutual sharing and scrutiny of performance reports to the NCCSB.

We are required to report on numbers of children who have been missing from care each year and how we are addressing the issue. However, we also think it is important to include children who go missing from home. Children who go missing from home or care are at an increased risk of being sexually exploited, and regular missing episodes are a risk indicator that a child is at increased risk of sexual exploitation or possibly already being exploited. The Multi-agency Missing Group is well established and feeds in to the SE/Missing Sub-group of the LSCB, which reviews individual young people where there are concerns about going missing and/or CSE in order to seek reductions in risk and to improve outcomes working across all agencies.

CSE and Licensing

The CSE Sub-group co-opted a representative from North Somerset's Licensing Team to develop a coherent policy in relation to licensing issues and strengthening current arrangements. This is developing a consistent and effective approach to safeguarding in our licensing functions, particularly of taxi and private hire drivers. The approach includes three strands of work: intelligence, training and practices/procedures. The CSE Coordinator is a member of this group.

Training for taxi drivers in respect of CSE is ongoing. The focus of the training is on recognising abuse and neglect, communication, and how to report, with an underlying message that taxi drivers can often be effective as the "eyes and ears of the community."

Data on the number of people trained to date is currently being collated across North Somerset to provide an analysis of the progress made. This analysis will be contained within next year's NSSCB Annual Report, along with any further actions which are developed as a result of this important area of work.

Neglect

The need for this priority was based on national learning and local evidence which highlighted neglect as a recurring theme in serious case reviews and is known to be the most prevalent form of abuse for children who are subject to a child protection plan in North Somerset.

The NSSCB have developed a Neglect Strategy which sets out the vision, commitment and inter-agency approach to help promote the effectiveness of local arrangements to safeguard children from parental neglect.

Domestic Abuse

There is extensive evidence illustrating the harm caused to children and young people who live with domestic abuse. The Adoption and Children Act 2002 extended the definition of harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. The term 'living with domestic abuse' includes:

Children who are currently living where there are incidents of domestic abuse, or where there:

- is risk of domestic abuse, taking place
- Children seeing or hearing domestic abuse outside of their home
- Children witnessing the effects of domestic abuse on others.

The risks of harm to children who are exposed either directly or indirectly to domestic abuse are known to be significant but data in relation to the number of children affected by domestic abuse is difficult to capture; national statistics would suggest 1 in 5 children will be exposed to domestic abuse.

In 2016/17 29,690 domestic abuse flagged crimes and incidents were recorded across Avon and Somerset (17,235 crimes and 12,455 non-recordable incidents), with 3,495 of these in North Somerset (2,112 crimes and 1,383 non-recordable incidents).

Of the 17,235 domestic abuse flagged crimes recorded in Avon and Somerset, the gender of the victim was recorded in only 15,761 cases. Of these, 11,950 (75.8%) victims were female, and 3,811 (24.2%) were male. Because gender was not recorded for the remaining 1,474 domestic abuse flagged crimes, we cannot be certain of the gender split across all of the recorded crimes.

Of the 2,112 domestic abuse flagged crimes recorded in North Somerset, the gender of the victim was recorded in only 1,947 cases. Of these, 1,447 (74.3%) victims were female, and 500 (25.7%) were male. Because gender was not recorded for the remaining 165 domestic abuse flagged crimes, we cannot be certain of the gender split across all of the recorded crimes.

Disabled Children

Research and inspection indicate that nationally disabled children face an increased risk of abuse or neglect, yet they are underrepresented in the population of children in care, and in formal safeguarding systems. It is believed this is because there are greater barriers in identifying and responding to abused disabled children than for non-disabled children. During 2016/17 North Somerset had between 1 and 7 children with a disability at different points in the year who were the subjects of child protection plans and a rate of .23 per 10,000 to 1.85 p34 10,000 children. The difference demonstrates a potentially significant under-representation of disabled children for North Somerset.

This is an area of work of which the NSSCB has not had effective oversight prior to this report and, therefore, it is a priority area for the 2017 Business Plan.

5. 1 CHALLENGES

Now that Early Help arrangements have become embedded, the LSCB will need to build an improved understanding of the effectiveness of early help assessments and interventions. We will want to be assured that the provision of early help is being delivered in a timely way and that the LSCB and our partners can evidence the difference for children, particularly those who are most vulnerable, in making sure they receive the help they need before things escalate to child protection.

While awaiting the outcome of the national review of Child Death Overview Panels (CDOP), the Board need to ensure that we are fulfilling our requirement in this area and support the CDOP Coordinator in this.

The Board needs to improve its communication and raise its profile with the public by developing and launching its own website.

Collecting meaningful data from some Board partners continues to prove to be challenging. Some progress has been made but the varying ways and timescales in which different partners collect, collate and analyse data do not easily show collective progress. This is very much work in progress.

A further area of data collection which we need to improve on is the collection of and analysis of information from missing children return interviews.

6 – SUB-GROUPS

6.1 COMMUNICATIONS SUB GROUP (JOINT WITH ADULTS)

Report provided by Co-Chair Anne Ray-Rowley (Senior Safeguarding Adults Officer, North Somerset Council)

During 2016/17 the Communications and Publicity sub-group has struggled with low attendance and had temporary chair-person cover. Due to unforeseen circumstances there were no sub-group meetings between July 2016 and February 2017. At the end of the reporting period a new chair was appointed and we expect attendance to grow and consistency of attendance to increase.

The core purpose of the group is to:

- Communicate factual information about safeguarding of adults and children and the policies associated to these audiences.
- Promote and raise awareness of on-going work in this area to tackle abuse and also to highlight good practice.
- Ensure we raise the profile of different types of abuse, the signs of abuse and to
- Encourage people to act on this in accordance with safeguarding adults and children's policy.

The following has been achieved within the past year:

A TV Advert was created and distributed to various health, social care and community services.

We have developed an annual events calendar which prioritised campaigns the sub-group would publicise. The calendar was developed in consultation with both the SCB and SAB to ensure that awareness was raised on relevant high profile topics.

Awareness articles were published in the North Somerset Life, which is distributed to all households across the geographical area.

Work in progress / further development:

Membership of the sub-group to include representation from the Marketing and Communications team, Housing department and a lay person representative.

For this year's Stop Adult Abuse Week we will work closely with our neighbouring Local Authorities (Bath & North East Somerset, Bristol, Somerset and South Gloucestershire) on the campaign. This will be the first time we have collaborated with other local authority partners on this campaign. The pack will be distributed to various health, social care and community services.

We will be exploring taking over, refreshing and maintaining the Safeguarding Board Website for Adults and Children.

As a group we be taking over and further developing the joint NSSCB/NSSAB Newsletter. We will be distributing it quarterly to all partner agencies. The aim is to keep everyone informed and to raise the profile of the safeguarding boards.

We will continue to develop awareness raising of safeguarding with hard to reach groups.

We will continue expanding membership on the sub-group to include representation from mental health and learning disabilities services.

6.2 EARLY HELP SUB-GROUP

Report provided by Co-Chair, Sadie Hall (Service Leader, Children and Families, North Somerset Council)

What did we do and why?

North Somerset's Early Help approach fits clearly with what Research in Practice recommends as an effective way of delivering and sustaining Early Help when budgets are limited. Our approach to delivering Early Help was also acknowledged by Ofsted as an effective model, with inspectors stating that 'Early-help services in North Somerset are a key strength.' North Somerset Early-help professionals were seen as 'skilled and successfully supporting families for whom domestic abuse, parental mental ill health and substance misuse issues feature, through the provision of both intensive and universal early-help interventions. Black and minority ethnic families and travelling communities have been particularly successfully engaged in early-help and targeted services.'

Early Help is recognised as everyone's responsibility in North Somerset, and Early Help interventions are provided through Universal Services within North Somerset by multi-agency partners.

The Early Help Triage system is in place to support agencies to navigate Early Help and High Impact Families (HIF) cases. Our current work is building on this and will be incorporated into a new 'One Front Door' approach over the next 12 months. In the longer term this will increase the number of families offered Early Help in North Somerset, by diverting those families that need earlier support appropriately into Early Help. The triage continues to include professionals such as the Early Help Adviser, High Impact Families Manager, Children's Centre Leader and a representative from Health. The High Impact Families programme has aligned to Early Help and this has strengthened our overall approach. .

The Early Help Triage Team continues to work closely with Children's Social Care to identify an Early Help Coordinator for each case, where appropriate, to provide Early Help intervention when a case has not met the Children's Social Care Threshold. This threshold was seen by Ofsted as well embedded, clearly understood and consistently applied across the partnership, and the role of the Triage Team has contributed to this.

We are also working to share information more effectively to support delivery of Early Help. The project to link our Early Help Module (EHM) to LCS (the Children's Social Care Case Management System) as one 'single database' has been implemented.

We continue to see a rise in the number of Early Help episodes recorded by schools and for children and their families at primary and secondary school ages. The improved take up of schools recording their Early Help in the EHM contributes to identifying and providing interventions to children and their families where neglect, domestic abuse and sexual exploitation and missing episodes are issues of concern.

Training has been updated to ensure we incorporate information and provide clear guidance on the identification of and impact of neglect indicators. The training also looks at the cumulative effect of neglect and emotional harm.

A Management Information Dashboard has been developed to provide a much clearer picture of Early Help in North Somerset, presenting information on open episodes with an assessment, plan and Team Around the Family meeting, and those without. This Dashboard will ensure North Somerset and the NSSCB are better able to track and monitor Early Help provision and quality across North Somerset agencies and service providers. It will help us identify which agencies are engaged with Early Help, and where we need to work harder to promote the approach across the partnership.

Early Help is successfully coordinated and delivered through the Children's Centre offer. This is being developed from a 0-5 service into a family Hub model for 0–25 year olds and will build on the success of Early Help coordination and Think Family as the family hub model develops in North Somerset.

How have we made a difference for children and young people?

We have increased the number of children who are receiving coordinated Early Help recorded on EHM. We have supported agencies to provide good quality support and Early Help services. We have ensured children and families who are in need of support and do not reach the Threshold of Children's Social care, receive help and support from universal services through the identification of an Early Help Coordinator.

Views of children/young people/parents and carers.

We need to better understand the views of parents and carers and to better track outcomes for all families who have benefitted from Early Help and understand the impact of the early help offer in meeting the needs of children and families.

What have we learned and what do we need to do better?

The number of referrals to North Somerset Children's Services Referral and Assessment Team which are accompanied by an Early Help Assessment continues to be low. Our aim is that all children consistently receive early help regardless of where they live, where they attend school or whatever their age. Triage and the One Front Door approach will help to support this outcome. Data shows an improvement in the primary and secondary school age children being provided with coordinated early help and we will continue to build on this. We know that we need to systematically evaluate the impact of the early-help offer on families.

The consistency and quality of Early Help assessments and plans needs to be improved. We know good quality Early Help is happening but the work is not always

recorded on the system and where it is recorded the quality of assessments and plans remain variable.

The EHM system is still viewed as an additional administrative burden by some agencies who are not regularly using a recording system, and it is seen as complex and difficult to use especially by school partners. The different recording of EH and HIF has added to confusion. A system review will align and simplify the processes and workflow. We are reinvigorating the role of the super user to ensure agencies have internal EHM system expertise and support available for users. We are developing the role with our partner agencies such as health.

6.3 LEARNING AND DEVELOPMENT SUB-GROUP

Report provided by Co-Chairs Naomi Grace (Safeguarding in Education Officer, North Somerset Council) and Louise Lynch (Integrated Working Support and Development Officer, North Somerset Council)

NEGLECT

What did we do and why?

Single Agency and multi-agency Learning events held for in depth understanding of the issues highlighted by SCR 'Holly' for professionals closely involved.

We have aimed to disseminate the learning from the 'Holly' across all courses to reach as wide an audience as possible.

From Sept 2016:

- Basic awareness courses revised to incorporate key learning from Serious Case review Holly.
- Advanced Course –re-written using a neglect chronology throughout the day - focus on strategies to analyse impact on children of neglectful care giving.
- Neglect Conference attended by 140 professionals from different agencies for launch of the Neglect Tool kit on 29th June.

What have we learned?

The importance of the tool kit to assist in the identification of neglect

The need to have a comprehensive approach to disseminating learning from Serious Case reviews

Anecdotal evidence that practitioners like having a toolkit

How have we made a difference for children and young people?

Impact as yet to be determined

Views of children/young people/parents and carers.

We have used National 'voices' in our training to reflect the lived experience of neglected children

What do we need to do better?

Communicate the messages using as many different platforms as possible within a timely manner to ensure key messages are not lost or missed.

Work more effectively with the Communications sub group to have prepared messages to support and build upon the learning from our training courses across the whole multi-agency workforce.

Determine the impact training has had on practice and the impact on children's experiences.

Utilize a wider range of learning and development activities.

EARLY HELP (CSE)

What did we do and why?
We have revised the training on CSE originally provided by Barnados and identified which courses would best support practitioners working at the Early Help stage (Working with parents course). A flow chart detailing our findings has been published.

EARLY HELP (Neglect)

What did we do and why?
Written and disseminated Early Help guidance for Early Help practitioners at Neglect Conference.

Early intervention in neglect is a key focus of our skills and practice course.

EARLY HELP (skills and practice)

What did we do and why?
We provided bespoke training to all Midwives, completed over four sessions.

Three skills and practice courses were delivered for skill development in running TAF meetings and having difficult conversations.

Bespoke sessions for schools and Early Years have been offered.

What have we learned?
Anecdotal evidence from training that there is commitment to provide interventions, but using a shared data system which is perceived as complex or burdensome creates barriers in people's minds which then undermines the level of co-ordinated multi-agency programmes of support for families.

How have we made a difference for children and young people?
Impact as yet to be determined.

Views of children/young people/parents and carers.
Children's voice represented through use of quotes in training.

What do we need to do better?
Continue to work with Early Help sub group to ensure training supports messages and strategy.

Determine the impact training has had on practice and impact for children.

Utilize wider range of learning and development activities.

DOMESTIC ABUSE

What did we do and why?

We have this as a standing item on the joint Adult and Children's group so that we can discuss the wider issue of Domestic abuse including Modern Slavery, FGM, Forced Marriage and so-called Honour Base violence.
New course 'Domestic Abuse - working with families and adults affected by Domestic Abuse' that is attended by both children's and adult's workforce.

New legislation on coercion embedded in courses.

New course on Domestic Abuse and the Impact on children being devised.

Audit of Domestic Abuse training shows that single agency basic awareness is available to all groups.

Incorporated messages from Domestic homicide reviews into our courses.

What have we learned?

Domestic abuse presents an increasingly complicated picture.

Recent audits show a need for cumulative harm to be better expressed and therefore impact on children to be better explored and explained at referral stage.

How have we made a difference for children and young people?

Impact as yet to be determined.

Views of children/young people/parents and carers.

We use the voice of local children within training – obtained from group work with children affected by Domestic Abuse.

What do we need to do better?

Determine the impact training has had on practice and impact for children.

Utilize wider range of learning and development activities.

SE/MISSING

What did we do and why?

Standing agenda item on joint training subgroups to ensure that training covers wide needs as possible.

The Learning and Development team have attended all 'train the trainer' courses run by Barnardos and we now have a pool of trainers to cover all CSE courses.

New programme of CSE training developed and published, including flow chart to help people pick the right course for their needs.

Missing training provided to all relevant professionals.

Safeguarding and SE training provided to taxi drivers (attending training will be a condition of license renewal) and ongoing rolling programme in place.

What have we learned?

It is challenging to combine training on child and adult sexual exploitation because of the different approaches to protecting adults and children.

The message of disruption still needs to be stronger with local evidence.

How have we made a difference for children and young people?

Impact as yet to be determined.

Views of children/young people/parents and carers.

We have used video clips in training of young people speaking about their experiences.

What do we need to do better?

Determine the impact training has had on practice and impact for children.

Utilize wider range of learning and development activities.

General

We need to improve the rate of completion of our four month evaluations, in order to better evidence the impact of training in the longer term.

We have successfully built professional challenge into the way we design our courses.

We have had consistently high satisfaction rates for all our training courses.
We have promoted multi-agency attendance on the advanced course through locating the training at the hospital.

We have trained close to 1000 people over this year.

We have continued to offer a full programme of training that has been responsive to local needs as they have arisen.

We have implemented a new training needs analysis pro-forma for new course requests. This enables training transfer to be identified at the outset and to look at the most effective model for communicating new messages.

6.5 POLICY AND PROCEDURES SUB-GROUP (JOINT WITH ADULTS)

Report provided by Co-Chair James Wright (Safeguarding Adults Manager, North Somerset Council)

This year has been a time of great change for the Policy Procedures & Standards sub-group with two significant changes. The role of the group has been redefined.

From March 2017 the group has focused specifically on matters of Policy and Procedure, with the responsibility for standards handed over to the newly formed

Quality Assurance Sub-Group which met for the first time in March 2017.
Furthermore the policies and procedures work of both North Somerset's Children's

and Adults Boards is now carried out jointly through the one joint Policy & Procedures Sub Group for Adults & Children.

Despite some initial reservations prior to the inception of the joint group, partners have contributed enthusiastically with lively and engaging debate around the more diverse mandate.

With reference to adult policies and procedures, there have been several successes throughout the year for the group, there has been improvement in performance around the involvement of advocacy now that data collection is better defined.

Several major policies have also been influenced, scrutinised and subsequently signed off following the partnership scrutiny offered by the group. These have included;

- FGM Policy, Guidance and Flowchart
- Neglect Strategy and Toolkit
- Updated Joint Policy for Adult Safeguarding (Joint across the Bristol North Somerset, Somerset and South Gloucestershire)
- Sexual Exploitation Strategy
- Domestic Violence Process (Flowchart)

The Policy & Procedures Sub-Group also contributed to the successful development of the local Domestic Violence strategy.

Information sharing and early warning signs have also been a priority for the group who have distributed 'monitoring forms' across our partners, providing an opportunity for partners to share with the local authority, information of concern around service providers which may not reach the threshold of a 'safeguarding concern'.

Early in 2017 a working group was established from the Sub-Group to specifically work on the development of several specific pre-existing polices with the aim of achieving a more partnership/multi-agency agreement. Although out of scope of the relevant period, this work proved very successful and we are grateful to our partners for their contributions and enthusiasm, particularly to North Somerset Clinical Commissioning Group who played a critical role in this successful work.

Overall the redefined focus specifically upon policy and procedure, combined with genuine examples of partnership working have served to make the last 12 months incredibly productive and provide a platform for continued successful development into the future.

6.6 QUALITY ASSURANCE SUB-GROUP

Report provided by Co-Chair Jackie Milton (Service Leader, North Somerset Council)

DOMESTIC ABUSE

What did we do and why?

Completed audit of children experiencing domestic abuse to inform the LSCB on impact of agency activity and views of front line staff across agencies.

What have we learned?
Not all schools had a clear process for considering Domestic Abuse (DA) alerts that do not reach threshold for Children's Social Care involvement.

Domestic abuse is not routinely considered within adolescent relationships.

There are no services working with perpetrators.

The impact of Toxic Trio training is not evident in the workforce, suggesting that this needs updating.

SEXUAL EXPLOITATION AND MISSING

What did we do and why?
Completed audit of children identified as at risk of child sexual exploitation to inform the LSCB on impact of agency activity and views of front line staff across agencies.

What have we learned?
When professionals record on their own systems, support is uncoordinated and each professional does not have a complete picture of what is happening for the child.

EARLY HELP

What did we do and why?
Completed audit of children receiving support at an Early Help Level to inform the LSCB on impact of agency activity and views of front line staff across agencies.

NEGLECT

What did we do and why?
Preparing an audit of children experiencing neglect to inform the LSCB on impact of agency activity and views of front line staff across agencies.

How have we made a difference for children and young people?
By the use of joint case audits we have identified priorities for improving practice. By including the views of front line practitioners we have identified strengths and areas for improvement which will increase the knowledge and skills of the workforce as a whole.

Views of children/young people/parents and carers:
We have made it a requirement that all audits contain the views of children and young people. We intend to explore how we might directly collect their views in future.

What do we need to do better?
A key objective for the Quality Assurance (QA) subgroup is to provide information to the LSCB on the effectiveness of what is done by member agencies for the purposes of safeguarding and promoting the welfare of children. This is dependent upon member agencies commitment to responding to the audit requests.
There have been challenges within education and primary healthcare in establishing a pathway to distribute the audits, and the subgroup needs to re-examine this process.

As a board we need to have a robust process in place to monitor how the recommendations are followed; the 'So what?' question.

6.7 SE/MISSING SUB GROUP (JOINT WITH ADULTS)

Report provided by Co-Chair Ruth Sutherland (CSE/Missing Coordinator, North Somerset Council)

What we do and why?

We are a multi-agency group made up of professionals from Social Care, Health, Business intelligence, Training, Licensing, Adult Safeguarding, Police, Probation, Youth Offending, Education, Housing and third sector support services. The group has grown in number, and the frequency of attendance has improved over the past six months, with a positive and enthusiastic approach from members, improving the joined up and seamless working across all agencies.

We continue to work together to raise awareness of SE across North Somerset so we are confident children, young people and vulnerable adults are safe and, those at risk, or who are being targeted, are identified early and promptly so that abuse can be prevented, and perpetrators disrupted and prosecuted.

As a Sub-group we have oversight of children who go missing, and ensure processes are in place to ensure all children who have been missing are offered a return home interview.

Our work feeds into North Somerset Safeguarding Board's Business Plan. As a sub group we have recently updated and refined our action plan to show smarter objectives. The SE and Missing children's multi-agency strategies have both been updated and are being implemented.

Members of the SE/Missing Sub-group also sit on other sub groups including Policy & Procedures and Communications.

There is a strategic commitment across all agencies who have an improved knowledge and understanding of Sexual Exploitation

What have we learned?

Not all exploitation is sexual, criminal exploitation is becoming apparent in vulnerable young people who can be exploited by drug dealers. We need to gather information to look at what is happening in North Somerset, so together agencies are able to put robust procedures in place to address this.

Mental health in children and young people has been identified in cases where children go missing. As a sub-group we want to know more. We need to find a process that gives us an overview of the reasons why children go missing, and need to gain more information on our return home interview forms. This would enable us to capture data, so that we can identify specific reasons why children are 'missing' and respond by tailoring our services to these emerging needs.

We know that workers are proactive in identifying CSE and perpetrators, and that intelligence sharing with the Police is good. Cases are referred promptly to the West of England CSE network meeting so the disruption of perpetrators is timely.

We know the reporting of SE in vulnerable adults is very low. There are great challenges in developing joint or mirrored procedures across adults and children. The sub-group have been trying to identify a specific risk assessment tool for this, as there seem to be few currently available tools which are able to identify and assess risk of SE in vulnerable adults. The risk assessment tool we use for children is not transferable, this is an area being developed within Adults Safeguarding too. We need to better understand the differences between sexual exploitation in children and in adults and need to be able to clearly identify the synergies and differences, and look at the transition process of a child who is at risk of CSE as they approach adulthood.

The manager of the Disabled Children's Team joined the sub-group in August. This will help look at what bespoke tools we need to support our most vulnerable children, who have been identified as at risk of sexual exploitation. We also want to look at improving the process of how these children then go through transition from Children's to Adult Services. Members have made links with the National Working Group to get some help with this.

Missing episodes have increased significantly over the past twelve months (as can be seen in the chart – Appendix 3)

A multi-agency meeting to address concerns around the increased reported episodes of Missing children has been set up by the Police. The new lead for the Neighbourhood and Directorate will lead on this. The meeting will specifically look at addressing the following:

- Reducing demand (halve the number by 2018 as we currently have on average 25 reports a day)
- Information Sharing
- Working with partners
- Early Intervention
- Working with charities and 3rd sector

We have learnt that human trafficking is not only about young people coming in from overseas, but internal trafficking of UK nationals, within the UK being taken from town to town and street to street. This is something we need to raise awareness about to agencies in North Somerset. The sub-group has invited a new member from UNSEEN, a charity who work with survivors of human trafficking and modern slavery. They will be able to assist the group with taking this forward.

Online abuse is also increasingly prevalent. The sub-group are writing guidance for practitioners to show how to respond to a 'Sexting' incident.

There has also been a presentation to the designated safeguarding leads of schools of the video 'Kayleigh's love story' to raise awareness of the dangers of online abuse.

Our data shows that Sexual Exploitation risk assessments are being completed and reviewed more frequently. Increasing from 14 during April 15/ March 16 to 80 during April 16/March 17. The difference in these numbers may also be down to the way we are now recording the data in our system. We still need to improve the way we record all Sexual Exploitation Risk Assessment Frameworks (SERAFs), ensuring all paper forms are input to the system and form part of the data that we can report on.

There are CSE public awareness days being arranged by the Police, the Sub- group have been asked to support the Police with these days. The four days will be held across North Somerset and anticipated to be in September and October. There has also been a leaflet designed specifically for parents by the Police about the risks of grooming and CSE.

What we need to do better?

We have identified our taxi drivers as a valuable source of information who work within the night time economy, and by promoting and celebrating their involvement with us we are able to offer training to all taxi drivers to raise their awareness about CSE and safeguarding. They will then be aware of the processes that are in place and be confident in reporting anything they may see or hear that concerns them, with our sole aim to be able to gather information that we don't have, and protect even more children and vulnerable adults.

Next we need to roll out similar training to other night time economy staff in our Hotels, Pubs, Clubs and Eateries. A member from the Licensing team has joined the sub-group, so we have better links to help us take this forward over the coming year. The sub-group is also in the early stages of arranging to meet with faith groups and voluntary services across North Somerset, to explore similar awareness raising about sexual exploitation.

We need to have a better understanding of those who are 'Missing' and to be able to identify push and pull factors, as to why children go missing, prevent any further episodes, and ensure the information we are gathering on our return interviews are succinct, and reflects the information we need. By listening to the voice of the child, we can learn from them what needs to be put in place to keep them safe, and manage the risks. By offering good quality, purposeful interviews the information and intelligence gathered will identify any links between agencies. This will mean we will have a better understanding about sexual exploitation in North Somerset enabling us to know what resources we need and where.

How have we made a difference for children and young people?

There have been a number of prosecutions related to CSE across North Somerset.

BASE were commissioned to do two things for North Somerset:

- To deliver support to victims of CSE and;
- Train the workforce on CSE so the response improves.

As a result of this service 17 children in North Somerset have been supported and 170 professionals trained on CSE, 17 of whom have been trained in Train the Trainer and who are now cascading the training to their own workforce. The other courses were; Working with parents and CSE,: Working with CSE,: Skills and Practice, and Raising Awareness of CSE.

Young people have also delivered training to Police staff on what they would want from the Police responses to CSE. This mainly focussed on the need for children to know and trust the individual officers, who listen well and who prepare the children for the type of questions that the Police need to ask.

We have also improved our early help when responding to children at risk of CSE, though we recognise the potential for further improvement. . This is something that the sub-group is addressing by having a specific lead in each agency overseeing completed low level SERAFs. This will ensure even those identified with a low risk of

CSE are overseen, can be discussed, that 'Early Help' options can be put in place and the case escalated if necessary. The Sub- group and Safeguarding Board will then have knowledge of how many SERAFs are being completed, the level of risk and outcomes.

There has also been a system put in place so that the designated nurse for Children Looked After is notified of any SERAFs being completed. There is also now a process to notify the designated nurse of all the Looked after Children being placed in North Somerset by other local authorities, so that she is aware they are in our area and health checks are completed in time.

Members of the sub-group have also arranged a presentation at the Young Person's Housing Providers forum. The Housing providers have supported accommodation for young people from the ages of 16 to 25. These young people are often vulnerable, with many having experienced homelessness. This will raise awareness about sexual exploitation, the reporting of young people who go missing, criminal exploitation and how these risks are increased where children are homeless or in unstable accommodation. It will give a greater understanding of existing safeguarding processes and procedures that are in place to keep all children up to the age of 18 safe.

6.8 YOUNG PEOPLE'S SUB-GROUP

Report provided by Lewis Smallwood Co-Chair

What we did and why

We focused our efforts mainly on engaging as best we could with local schools to sustainably grow the group. This involved several meetings to plan a growth strategy, and to create letters to send to schools which resulted in us engaging Clevedon, Backwell, St. Katherine's, and Gordano School.

With a sustainable structure in place, we completed a poster to advertise the LSCB and to raise awareness about the board. This acted as a resource for young people and members of the public to find out what the LSCB does.

We performed exercises to reflect on what safeguarding means for young people – this information was used by the board and across sub-groups in order to make the resources more appropriate and relevant.

For example, we looked at the design, content, and language used on the new website being developed and we proposed improvements which would make the site more accessible from the perspectives of young people. We identified that signposting to resources for particular problems may be more appropriate for young people, as this would enable them to get help easily if they are unsure how they can obtain it.

We also contributed to the development of strategies and the vision of the board at their annual event. This supported the development of priorities that matter to young people and ensured that their voices were heard in all board activity. This feedback on priorities came from a survey which was sent out within schools, so young people's voices were received and acted upon.

Alongside this, the subgroup had several discussions considering anti-bullying measures and policies within schools and we made an agenda to try and

demonstrate best practice. The aim here was to set a benchmark for excellence and offer other schools the opportunity to learn from each other's examples of excellence.

What we have learnt.
As a group of young people, we have learnt that it is important for us to present to the board on concerns affecting us such as online safety and anti-bullying, as this will lead to us *influencing* the board's vision and outcomes which is important to develop goals and aims.

Our group priorities have been derived from what we have learnt are problems within schools, therefore we feel our involvement with the board has helped them to learn about our needs and feedback.

How we perceive to have made a difference for children and young people in North Somerset.
We feel that we effectively met our aims of bringing the young person's voice to the board, and tackling the issue surrounding the accessibility of resources which the board provide.

From the perspectives of young people, we feel that reflecting on the language and text used in the resources which the board are providing, we have made the board's resources more accessible to young people. This is because we reviewed how they are communicated to us and adjusted them accordingly to make them simple and understandable.

What we could do better.
As a group of young people, we feel that we could do better to enhance internet safety resources and contribute to policy development. We think this would help the board, and subsequently young people, as making the board aware of internet safety factors and common online malpractice seen in schools by young people, could be of use to the board in terms of educating member groups to put responses into practice. This is because we felt that focusing efforts through schools would be an effective method of early help in many areas, and it could prevent more serious safeguarding matters in later life.

6.9 SERIOUS CASE REVIEW SUB-GROUP

Report provided by Jo Baker, Service Leader for Strategic Safeguarding and Quality Assurance, North Somerset Council

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires the NSSCB to undertake reviews of serious cases in specified circumstances.

A serious case is one where:

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

The decision to undertake either a Serious Case Review (SCR) or Learning Review follows a referral and recommendation to the NSSCB Chair who makes the ultimate decision.

We completed a re-assessment of the process used for SCRs; exploring different processes followed from receipt of a SCR referral through to publication, in particular a partnership learning model/ methodology.

A SCR Sub-group has been developed in order to review Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews, and to ensure that learning is embedded and cascaded to Adult and Children's services. The group has representatives from both Adult and Children's services, as learning needs to be disseminated across both service areas. The Sub-group has met to draw up terms of reference and agree membership.

Each SCR or Learning Review has a panel set up to oversee the review and ensure that the learning is adopted as soon as themes begin to emerge.

One previous SCR, 'Holly', and its subsequent action plan was developed and pursued by the Board and is currently being monitored by the group. This is a case of child neglect. The process has had a strong emphasis on practitioner events and learning. Multi-agency learning was identified using practitioner events, such as around information sharing, early intervention, and assessing risk. It also identified learning around escalation and neglect resources.

Through monitoring and reviewing, the sub-group has brought together four main areas of learning:

- Assessment of neglect
- Interface between early intervention and statutory intervention
- Interpretation of procedures
- The child's lived experience

The following information provides examples of how the learning from the SCR has helped to strengthen local safeguarding children arrangements and frontline practice with children, young people and their families:

- Communication has been shared and audits undertaken by North Somerset Clinical Commissioning Group (CCG) to help ensure GPs are aware of the need to share information in relation to signs of neglect, and predisposing risk factors that may affect parenting capacity.

- Health visiting services practitioners have been reminded of the importance of routinely reporting evidence of neglect or risk of harm. This is now embedded within local workforce, development and training pathways.

- Children's Services threshold document has been revised to strengthen child protection and children in need information sharing processes. A Neglect Strategy and tool kit has been developed with guidance as to pathways of intervention, and training programmes to accompany this guide has been established.

Publication

The Board has been mindful of the impact on the children and family members of publication of the SCR. As with all SCRs, preparation for the publication is discussed

with the respective parties and carefully planned, the safety and welfare of the child has to be of the paramount concern.

Current SCR
During 2017 one independent SCR has been commissioned. A systems methodology is being used. Once this has been completed the recommendations will be tracked through the sub-group. Regular reports will then be reported to the Executive and Board.

A programme of work will be in place to implement the SCR recommendations (due in December). Key learning points will be extracted from the completed SCR and a programme of dissemination and learning events will be rolled out in 2018.

7 – LAY MEMBERS

Board Members: Anna and Pam

What do we do? Why?
Both Anna and Pam are experienced Lay members of the LSCB having been members for several years.

Both are residents of North Somerset and share a passion for and commitment to making an active contribution to the safeguarding of children within North Somerset and the wider community.

How have we made a difference for children?
Anna say's "I have been a member of the Board for a few years and it took a little time at first to understand the purpose of my attendance at the Board meetings. I think that as a lay member you can bring your everyday knowledge into the Board. I have had input as an RNLI Educator for water safety and this has been taken up by members of the Board which has been very positive. The Ofsted report was positive in respect of our attendance at the Board meetings. I think it is important for lay members to be part of these Boards to bring an outsiders perspective and ideas."

What have we learned?
Learning continues to grow through attendance at and contribution to the Board Meetings and Development Days.

One of the benefits of having lay members is that they have brought with them experiences of working with voluntary groups within the communities of North Somerset such as the RNLI and the Guides. This has enabled safeguarding messages to be taken into those bodies and for board members and sub-groups to be better aware of how safeguarding is prioritised within the voluntary sector.

What do we need to do better?
Expanding Safeguarding messages beyond RNLI and Guides to children and young people within other voluntary sector groups particularly those with disabilities.

Lay member to become a representative on the joint Communications and Publicity Sub-group.

8 – SAFEGUARDING IN EDUCATION

Report provided by Naomi Grace, Safeguarding in Education Officer, North Somerset Council

NEGLECT

What did we do and why?
Specific Single agency schools training currently includes Safeguarding in education Basic awareness (3 hours) and Safeguarding in Education Refresher (90 minutes).

Teaching and all other support staff (along with governors) have access to many specialist courses within the multi-agency forum.

What have we learned?
The importance of the running the 'Holly' SCR themes through both of these course highlighting the neglect element.

Signposting schools staff to the multi-agency learning forum to attend specialist courses is key.

Raising awareness of the neglect tool kit to assist in the identification of neglect.

How have we made a difference for children and young people?
Impact as yet to be determined.

Views of children/young people/parents and carers.
The 'Holly' SCR reflects on parental behaviours which contextualise the subsequent neglect.

What do we need to do better?
Continue to utilise the 'Noticeboard' platform of regular electronic bulletins to effectively communicate key messages to school staff with regards to training and training contents.

Find a comprehensive method to determine the impact training has had on practice and impact for children.

EARLY HELP

What did we do and why?
EARLY HELP: CSE
Both of the Safeguarding in Education courses cover CSE in some depth

All schools have access to the newly revised Barnardo's training on CSE.

EARLY HELP: Neglect
Both of the Safeguarding in Education courses cover Neglect in some depth. Early intervention in neglect key focus of skills and practice course.

Reminders of the continuum of need and the early help pathway is covered.

What have we learned?
More advertising needs to be done to raise the awareness of these courses available to schools via the multi-agency forum.

The new Safeguarding Children's Board website must be utilised once up and running to keep closer contact with schools.

How have we made a difference for children and young people?
Impact as yet to be determined. Agencies are more aware that they must act on emerging issues without drift or delay as per training. Some schools in particular are using the NSC early help system, others are using their own, however there are systems in place in order to flag up needs of children which require early intervention.

Views of children/young people/parents and carers.
Children's voice is represented through use of quotes in training.

What do we need to do better?
Continue to work with Early Help team coordinator to ensure training supports messages and strategy.

Determine the impact training has had on practice and impact for children.
Utilize wider range of learning and development activities.

DOMESTIC ABUSE

What did we do and why?
Is not covered in either of the Safeguarding in education basic awareness courses – however – this is covered in the multi-agency forum as a specialist subject.

New course 'Domestic Abuse – the impact on children' have been written and will be launched in October.

What have we learned?
Recent audits show need for cumulative harm to be better expressed and therefore impact on children to be better explored and explained at referral stage

How have we made a difference for children and young people?
Impact as yet to be determined. A suitable method of measuring impact has not been drawn up yet – this will happen when I have sufficient Learning and development sub group membership. I am building a new team which will work on impact on learning on our workforces. Once we have established this, we will know if the trained workforce are effective enough to support the children and young people.

Views of children/young people/parents and carers.
Use the voice of local children within training – obtained from group work with children affected by Domestic Abuse.

What do we need to do better?
Determine the impact training has had on practice and impact for children.
Communicate the importance of schools attendance of these new courses.

SEXUAL EXPLOITATION AND MISSING

What did we do and why?

This is not covered in either of the safeguarding in education courses – however, they are specialist topics which are available to all staff in the multi-agency forum.

What have we learned?

Due to the limited time in the courses run only for schools, the focus is and has always been on providing a basic awareness of safeguarding with the view that delegates will then move into the multi-agency arena to further their knowledge and understanding.

How have we made a difference for children and young people?

As yet to be determined. The CSE courses we have been offering in the multi agency forum have been under attended. We will be launching a CSE initiative with the courses being aimed specifically at Primary workforces, secondary workforces and adults in the next year.

Views of children/young people/parents and carers.

Use video clips in training of young people speaking about their experiences

What do we need to do better?

Determine the impact training has had on practice and impact for children. Communicate effectively the need for the step-up in knowledge of specialist subjects which can be accessed via the multi-agency training forum.

It is a challenge for the Safeguarding in Education lead to demonstrate the longer-term impact of training, and we need to improve the rate of completion of four-month evaluations of our courses.

We have successfully built professional challenge into the way we design our courses by way of highlighting expectations and accountability of all delegates.

There is a consistently high satisfaction rates for both of the training courses.

Schools are always encouraged, advised and directed to the multi-agency training forum to further their training.

9 – SAFEGUARDING IN HEALTH

Health Partners report to North Somerset Safeguarding Children's Board on progress against board priorities for 2016/7 *Susan Masters, Associate Director of Nursing and Quality (Safeguarding), BNSSG CCG*

9.1 NORTH SOMERSET COMMUNITY PARTNERSHIP

Report provided by Jos Grimwood, Head of Safeguarding / Named Nurse for Child Protection, NSCP

NEGLECT

This has formed a significant focus for NSCP following the Serious Case Review "Holly". NSCP Safeguarding Team and Health Visitors were key contributors to the learning process associated with the review. In response to the findings NSCP:

We developed a robust action plan which was tracked via our Safeguarding Forum. Key elements of the plan formed the basis of our annual safeguarding work plan. We collaborated with the multi-agency Neglect Working Group to identify, modify and pilot an appropriate neglect assessment tool for practice. We also reviewed and re-wrote our "No Access" policy to reflect the much wider principles of "Child Not Seen" in line with CQC (2016) expectation.

Our Head of Safeguarding developed a bespoke training package with respect to the SCR and neglect. This was attended by 79% of the children's work force and aimed to build confidence and competence with assessing and evaluating neglect. This was done via using "Holly" as a practice example for reviewing and refreshing experience of a using range of tools appropriate for practice.

Improving the quality of referrals to Children's Social Care with respect to Neglect cases is paramount. Developing and deploying in practice a best practice example of what a good referral looks like.

Improving information sharing with GP practices with respect to children at risk. A "practice note" form has been developed which practitioners complete and share with practices via nhs.net when they have concerns about a child that do not meet statutory child protection thresholds.

Amended our Think Family Safeguarding training package to reflect learning from the SCR.

Work for 2017 – 2018:

To continue to embed the neglect tool kit in both safeguarding supervision and clinical practice with families.

Audit use and impact of the tool kit on practice.

Audit use of the Child Not Seen Policy.

Collaborate with the Children's Service Lead to develop a process for obtaining the views of families and children for service improvement.

SEXUAL EXPLOITATION AND MISSING

During the year, NSCP has actively contributed to a range of activities aimed at strengthening sexual exploitation awareness and identification. Such work includes:

- 70% of Health Visitors have attended Level 2 training with 100% of School Nurses having attended Level 3 training Child Sex Exploitation Training

- Sexual Exploitation is a training theme in our single agency Think Family training and is linked to grooming and Modern Day Slavery messages.

- Active representation and participation in the work of the Missing Group by a named Safeguarding Supervisor (Fiona Gilbert) Fiona has been identified by the NSCP Safeguarding Team to co-ordinate all sexual exploitation awareness raising activities / events across the business.

- Fiona has attended a number of external conferences and has completed the Train the Trainer sexual exploitation event.

- Professional Development Forum event with respect to CSE with awareness raising and information sharing regarding Avon and Somerset Police information, North Somerset Survivors Pathway and sexualised behaviours in children.

NSCP have updated our internal guidance for staff which is linked to the North Somerset Sexual Exploitation Strategy. The Head of Safeguarding has actively contributed to the development of the latter strategy. She is also a regular contributor to the Sexual Exploitation sub group.

Contribution to the multi-agency child sexual exploitation audit under taken by the Quality Assurance Sub Group.

Completion of a single agency Child Sexual Exploitation audit. The latter led to improvements in the way in which information is shared between No Worries! Sexual service and the School Health Nurse Services
Use of Spotting the Signs made the mandatory assessment for No Worries / Sexual Health Services. Guidance re use of SERAF and requirement for a copy of all SERAFs completed to be forwarded to the Safeguarding Team and an incident form completed.

Three referrals were made regarding Child Sex Exploitation.

Work for 2017 – 2018:

To refresh Child Sexual Exploitation training across Children's Service staff.
Audit use of Spotting the Signs / SERAF use and adherence to expected process.

DOMESTIC ABUSE

Domestic abuse processes are well embedded with NSCP. Within the year work has been undertaken with respect to raising awareness and reporting within the adult clinical teams. To ensure that domestic abuse maintains a high profile within NSCP business the following activity has been supported:

- Head of Safeguarding / Child Protection Supervisor attend and contribute to the Domestic Abuse Strategy Group

- NSCP attends and actively contributes to the bi-monthly MARAC meetings.

- NSCP has extended the way in which it contributes to the sharing of information with the MARAC by agreeing to be the link for GP information. This has been a significant undertaking and ensures that this key element is now represented within the safety plans developed within the meetings.

- Additional administrative resource has been allocated by the North Somerset CCG to promote this work.

The Safeguarding Team have identified two team members who have assumed responsibility for progressing domestic abuse awareness and reporting across the business. This is shared by a Child Protection Supervisor, Sharon Doran and the Safeguarding Adult Lead, Helen Barrett. The latter is helping to embed a Think Family culture across the business with respect to domestic abuse understanding.

The domestic abuse leads have undertaken a number of thematic workshops aimed at the adult clinical staff group. This aimed to raise the awareness of domestic abuse and confidence to report it to NSCP proactively contributed to the domestic abuse audit undertaken by the Quality Assurance Sub Group.

Work for 2017–2018:

Work with partners with progress work aimed at improving communication with young children who may have experienced domestic abuse.

9.2 WESTON AREA HEALTH TRUST

Report provided by Judith Steele, Interim Named Nurse

NEGLECT

Attention has been focussed on Neglect in the trust, following case review 'Holly'. We have:

- Incorporated learning into supervision and training to update staff and enhance understanding of the complex nature of neglect.
- Disseminated learning events information to Trust for staff to consider attending to offer opportunities for abuse-specific learning.
- Reviewed neglect resources on Intranet to ensure Trust-wide access to resources

Grand Round events bi-monthly for all Trust staff but targeting medical staff, for case-based learning on relevant issues.
Additional Paediatric service provision, strengthening through:

Training and supervision
Level 3 for all Specialist Community Children's Services (SCCS), and lead for each area and adult physicians on hospital site where 16-18 year olds are admitted or treated. Compliance for this training is currently below expectation so an action plan is in place.

Safeguarding is part of the doctors (Acute paediatricians, Community paediatricians and CAMHS) meeting and SCCS clinical governance meeting which gives an opportunity for team supervision. There is also a separate Emergency Department and Seashore Centre safeguarding meeting attended by safeguarding team.

Child protection grand rounds have been introduced since 2016 as this benefits specialties like orthopaedics, sexual health clinics, radiology, ED and all specialities in the hospital.

Complex cases have been handled. Consultants discuss cases for peer supervision at BNSSG consultants meeting and seek advice as needed.

Follow up of some of sexual abuse cases take place at Weston Area Health Trust (WAHT). If for initial examinations, in case of clinical urgency where no slots are available at Bristol, joint examination between doctors, paediatricians and a consultant from Unity clinic takes place at WAHT.

Children Looked After. Improved results and compliant with timeliness of seeing children. Current data shows 100% compliance with Children Looked After Medicals.

Child death is managed appropriately with a multi-agency team approach and we provide a rapid response to child death. Our Process is completed alongside the Child death Review.

What have we learned?

- Neglect may be easy to recognise but hard to resolve.
- Measuring change remains challenging, particularly in acute services.
- Midwives are adept at recognising neglectful situations but Midwives have few planned universal contacts with Mothers, in which to review impact of any planned multi-agency interventions
- Ongoing discussions required with relevant services such as Midwifery, to develop ways to embed the process within the Trust.

How have we made a difference for children and young people?

- Seeking consent to request services has become more normal practice and appears to be well-embedded
- Inter-agency communication has been formalised in Primary Care to ensure greater opportunities to share information and concerns
- Concerns for neglect in families are brought to Named Nurse to discuss, in order to consider actions.

Views of children/young people/parents and carers.

- Family and friends system improved
- Community Services' involvement and engagement are sustained, with some hard to engage families
- Plans are in development within Trust to develop increased supervision opportunities in Trust Community Services, following a trial of ad hoc availability sessions set up on Community Services site.

What do we need to do better?

- Training compliance
- Early Help activity as above
- Strengthening Paediatric input as above.

EARLY HELP

Training is underway for Midwifery to ensure all Community Midwives understand the process and can use the process in practice
Specialist Community Paediatric Services have received training so that they understand the process.

How have we made a difference for children and young people?

Some Early Help referrals have been made but these are not case-tracked.
Acute Trust professionals have requested support from Children's Centres to manage the ongoing involvement with families, particularly with Maternity cases.

Families identified in need of Early Help are also signposted directly to agencies to seek help as independently as possible to enhance empowerment.

Views of children/young people/parents and carers.

- Early Help process is about gathering the views of children/young people and carers throughout the process.
- Consent is a sign of being prepared to work with services and agencies. Engagement is the main evidence of ability and willingness to work with agencies and professionals to make change.

What do we need to do better?

- Ensuring that all Trust services are aware of the Early Help Strategy and process
- Ongoing discussions required with relevant services such as Midwifery, to develop ways to embed the process within the Trust
- Paediatric input as above is being strengthened as above.

DOMESTIC ABUSE

- Close working relationship in Trust between adult and children safeguarding professionals to ensure children's interests considered when any domestic abuse case was identified.
- Contact other agencies with involvement to share information as soon as possible after identifying domestic abuse affecting household.
- Providing information to MARAC.
- Sharing information from Police with Maternity Services as swiftly as possible to enhance risk assessments.
- Ensured Trust-wide dissemination of training opportunities, including adult in-house training
- Grand Round events bi-monthly for all Trust staff but targeting medical staff, for case-based learning on relevant issues.

What have we learned?

- Reinforced learning about domestic abuse – knowledge of impact of domestic abuse on victims and children.
- Our systems and processes are suitable to the identification of, and offers of help to, victims but no certainty all victims are identified through Trust service contacts.

How have we made a difference for children and young people?

- Once parent/carer/sibling victims are identified, the risk situation is shared with other relevant professionals, services offered to the victim, assessments offered (SAFELIVES RIC) and relevant referrals made.
- Unknown outcomes following identification of child victims in household but aware of suitable systems in place to assess in Community
- Training and supervision for Community Specialist Paediatricians is a priority to enhance services to children.

Views of children/young people/parents and carers.

- Friends and family reviews are in place.
- No means of accessing views/voices of children beyond Acute Trust contact with victim, but perceived risks of long-term harm, through research knowledge, are reduced.

What do we need to do better?

- Identification of adult victims throughout Acute Trust services.
- Considering asking the question at safe and significant times such as admissions and discharges.
- Recognition of risk and use of Young person Safelives RIC within Acute Trust services and Community Paediatric services at suitable contacts such as assessments and reviews of interventions.

SE/MISSING

- Ensured any child of concern is flagged to relevant departments – particularly sexual health service and emergency department
- Shared any and all resources with relevant departments
- Disseminated any and all training opportunities across Trust, as well as to specific departments as above bullet point
- Contributed as relevant to any information-sharing with other agencies
- Grand Round events bi-monthly for all Trust staff but targeting medical staff, for case-based learning on relevant issues.

What have we learned?

- Children and young people may be hard to identify and hard to reach, particularly if involved or likely to be involved in exploitation
- Systems and processes are in place and can be responsive once a risk victim is identified.

How have we made a difference for children and young people?

- Reviewing all systems and processes internally to ensure the Trust responds to risk and acts appropriately
- Training and advice are available to ensure Trust staff have knowledge and skills Resources are accessible to all Trust staff via Intranet.

Views of children/young people/parents and carers.

- Friends and family test in place
- Specific services such as Unity and CAMHS seek feedback from families and young people throughout course of therapy/interventions.

What do we need to do better?

- Risk assessment of higher risk groups to gain clearest voice of child possible
- Paediatric service input being strengthened as above.

9.3 AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP TRUS

Report provided by Danielle Rowan, Named Professional for Safeguarding Children

The Trust has appointed a Named Professional for Safeguarding Children covering the wider Bristol, North Somerset and South Gloucestershire (BNSSG) area. They will share the outcomes of SCRs, Section 11 Audits and JTAIs with AWP staff.

There is a Single point of Contact in AWP for the requests for Conference reports from Children's Social Care (CSC) and for referrals made by AWP staff to CSC. Any reports or referrals received by the team are then quality assured by the Safeguarding team.

Safeguarding children is a standing agenda item in supervision supported by the Trust's safeguarding supervision tool.

AWP has provided operational senior practitioners to attend MARAC on a consistent basis in 2016/2017. They provide AWP information and provide clinical advice on non-AWP cases re mental health issues.

What have we learned?

The Associate Director for Statutory Delivery now has oversight of all requests for DHRs, the findings from DHRs will now be monitored through the Quality Improvement Programmes (QIPS).

The Trust annual safeguarding survey indicated increased awareness in identifying and responding to children at risk of Female Genital Mutilation (FGM) and CSE.

The AWP staff survey 2015/16 identified that there was some confusion about services available to individuals who do not meet MARAC threshold. This will be incorporated into guidance and team development sessions.

How have we made a difference for children and young people?

- Staff are encouraged to consider the lived experience of all children in the family.
- There has been a review of the level 3 training and Trust practice guidance to build upon CSE guidance, the staff survey suggests staff feel more confident in spotting the signs and how to act.
- Delivering and recording regular supervision to all staff, including safeguarding supervision.
- Updating Trust safeguarding children assessment tools and guidance for practitioners.
- Developing and extending access to Health s136 suites for children of all ages.
- Delivering extended safeguarding training on domestic abuse and Prevent to practitioners.
- Introducing a system to quality assure child protection conference reports and referrals
- All new staff must complete an e-learning module on Safeguarding within the trust.
- There has been increased contact to the Trust Safeguarding Children and Young People Team for safeguarding consultations and advice.

Views of children/young people/parents and carers.

AWP staff are encouraged to incorporate parent and child views in their referrals to Early Help, Child in Need and Child protection referrals/reports.

Establishing the Single Point of Contact within the safeguarding team has allowed for reports and referrals to be quality assured. This process further strengthens promotion of Think Family and better equips staff in actively establishing the views of children and families.

What do we need to do better?

All CSC conference reports, initial and review should be requested through to the AWP safeguarding team. There has been a decrease in requests for conference reports in the financial year 2016-2017, with only requests for North Somerset and often requests are not received far enough in advance for AWP practitioners to complete a report within the allotted timescale prior to conference. An internal audit regarding this issue features in the work plan for 2017/2018.

AWP standard target for safeguarding training is 90% to accommodate new starters and leavers; this is currently at 94% for level 1, 87% level 2 and 62% for level 3. The locality is monitoring Safeguarding Training rates with individual teams to ensure that staff are booked on to the next available training dates. Access to local authority training is being promoted and teams requested to inform AWP learning and development of attendance for recording. This has also been added to the risk register with corporate services developing a proposed recovery plan.

There has not been representation of a Safeguarding Specialist at a local level; however from Quarter 4 2016 /17 a Named Professional for Safeguarding Children was appointed to be an integrated aspect of local governance.

There will be greater visibility of the team for frontline practitioners and there will be provision of bespoke team development sessions which will provide increased support to teams.

The Trust's Safeguarding Children Team will develop Trust modular safeguarding guidance to build upon guidance sections relating to FGM and children living with domestic abuse.

10 – AVON AND SOMERSET CONSTABULARY

Report provided by Simon Eames, Policy, Support & Review Officer, Avon and Somerset Constabulary

Statutory responsibilities

To provide professional policing services, working with partner agencies, including services to and for children and young people, in order to keep them safe from harm and where necessary prevent their offending or reoffending. This includes working to prevent children from becoming the victims of crime, investigating crimes against children, bringing perpetrators to justice and managing offenders, and includes the Statutory Duties under Section 11 of the Children Act 2004.

Achievements during 2016-2017 *(including training and awareness raising activity)*

We now have in excess of 180 officers who have undertaken the Specialist Child Abuse Investigator's Development Programme (SCAIDP) and further officers will complete this over the next 6-9 months.

We have delivered dedicated team training to those officers who deal with child protection cases, specifically in ABE interviewing skills, child cognitive development and the purpose of local safeguarding children boards.

We contributed to an improved partnership understanding of the nature and extent of Child Sexual Exploitation across Avon & Somerset through the preparation of problem profiles by the five LSCBs.

Having led a successful partnership bid for Home Office Innovation Funding, the resulting two year West of England CSE Victim Identification and Support Service delivered from 01/04/2015 to 28/02/2017:

- direct specialist support for 305 children in Avon & Somerset in relation to their sexual exploitation
- training to 3,141 members of the children's workforce across Avon & Somerset.

The number of children identified as having been affected by CSE rose markedly during the life of the service, providing evidence of the heightened awareness across the children's workforce.

Describe how you raise awareness of safeguarding in your agency

Child abuse and safeguarding features from the most strategic communications, such as through the Force Strategic Threat Assessment and the Force Control Strategy, with Child Sexual Exploitation & Abuse being one of the five Strategic Priorities, through to communications at an operational and tactical level.

At a strategic level, the Constabulary Management Board, chaired by the Chief Constable, considers vulnerability on a bi-monthly basis. The discussion is informed by a paper prepared following consideration of the most significant issues by the Safeguarding Theme Leads Group. This Group is chaired by the Chief Superintendent, Head of Investigations, and is comprised of vulnerability thematic leads responsible for driving improvement across their respective vulnerability theme. Themes include Child Abuse, Child Sexual Exploitation, Female Genital Mutilation, Honour Based Violence and Forced Marriage, Domestic Abuse, Modern Slavery and Hate Crime.

The Constabulary introduced a new Operating Framework on 3 April 2017. Communications with staff and officers in the lead up to the change, and subsequently, have emphasised how the need to achieve vulnerability and safeguarding objectives was an important factor in developing the new Operating Framework. The new Neighbourhood & Partnerships Directorate will enable Neighbourhood officers to work more closely and effectively with Lighthouse & Safeguarding to protect the most vulnerable and manage the most harmful offenders, whilst the new Investigations Directorate has been organised so as to maintain the focus on child protection and vulnerability across the spectrum of crime, with one of the three Detective Superintendents being aligned to Crimes Against Children.

Training, awareness raising and communication actions, common to a number of vulnerability themes, can result from discussion at the Safeguarding Theme Leads Group, whilst bespoke actions can also be commissioned by thematic leads. For example, internal awareness raising of CSE is linked to our external awareness

raising campaigns, using the Force intranet, the Weekly Bulletin and the Chief's blog to provide stories and articles and links to the Force website, social media and media websites. External campaigns promoted internally included CSE Awareness Day 2016, International Missing Children's Day 2016, BBC Radio Bristol Missing Week, and the programme of regional CSE awareness campaigns, involving partners across local authorities, health and other police forces.

An induction process is in place for all staff who have contact with children. Basic training (covering familiarisation with child protection policies, how to recognise signs of abuse and neglect, how to respond to concerns, and e-safety awareness) is provided through a Safeguarding Children e-learning package as part of the induction process. 3,604 relevant officers and staff have completed the Safeguarding Children e-learning module.

Comprehensive Child Abuse and CSE training is provided for all new officers as part of their initial police training, including familiarisation with safeguarding policy and procedures. Training provision regarding the initial response to rape and sexual assault, which reflects child safeguarding and procedures, and the inclusion of a first response element through the Initial Police Learning and Development Programme (IPLDP), means that all new recruits arrive at their first operational posting with an appropriate awareness of child protection issues in relation to sexual assault (including CSE, modern slavery and chronic intrafamilial abuse). We now have in excess of 180 officers who have undertaken the SCAIDP programme. Awareness has also been raised through Investigation team development days. Our Safeguarding Coordination Units have delivered awareness training to front-line staff and Investigations teams regarding the support they can provide and the importance of considering safeguarding in all cases involving children.

Challenges

Working with five upper-tier local authorities, each with their own thresholds and differing approaches, meeting the expectations of five LSCBs, each with their own infrastructure of sub-groups and associated demands, in a context of declining budgets we need to do more to improve our ability to work effectively with our partners to protect children, for example working patterns of our Investigations teams aren't always conducive to working with partners increasing demand through rising numbers of reported child protection crimes, in a context of declining budgets - we need to further increase the numbers of officers who are trained to deal with such cases and ensure we have sufficient trained supervisors to support those officers.

What difference has your achievements made to children, young people, parents / carers?

- More children have been safeguarded and protected from harm or from further harm;
- Children have been listened to more effectively to better understand how they have been affected by the circumstances of the case;
- More perpetrators of child abuse have been brought to justice.

Objectives for 2017/18:

Avon & Somerset Constabulary's objectives 2017/18 for the protection of children are:

- respond to Organisational Learning & Inspection findings emerging from Serious Case Reviews/ Inspections/ Audits to improve service delivery;
- address our processes so we provide the best service for children, by appropriate recording, response and partnership working;

- ensure the ‘voice of the child’ is recognised in every policing interaction when children are present or could be affected;
- support staff involved in the investigation of Child Abuse;
- ensure our resources and ways of working sufficiently address the demand.

This is in the context of the Constabulary’s aims, in partnership with other agencies, to:

- prevent children from becoming victims of child abuse
- where children do become victims, ensure they are recognised as such, are protected from further harm, and are given the support they need to help them remain safe and to deal with the physical, emotional and psychological consequences of the abuse
- bring perpetrators of child abuse to justice and prevent them reoffending through robust offender management.

11 – BARNARDOS

Report provided by Duncan Stanway, Assistant Director, Barnardos

What did we do and why?

BASE (Barnardo’s Against Sexual Exploitation) has been commissioned by North Somerset Council and Police & Crime Commissioner to provide direct support to children who have been the victims of child sexual exploitation (CSE). In the last year, we worked with 17 children from North Somerset, all of whom had direct experience of sexual exploitation. Our work aimed to support these young people to understand the abuse they were going through and, through better support from us and other agencies, help them exit abusive situations. This work then has gone on to help these young people recover from the impact the abuse has had on them.

In addition, we have trained staff who work with children and young people about CSE. The training has aimed to help them identify when children have been groomed and are being exploited and to respond better. We also ran Train the Trainer courses so that organisations across North Somerset increased their own understanding and skills in helping children affected by CSE.

What have we learned?

That we need to be part of a multi-agency approach to tackle CSE. We have seen an increased number of referrals from Social Workers, which is positive. This means we are more likely in north Somerset to know about children who experience ongoing and high level CSE. However, we all need to make sure that children at risk of CSE have good responses which protect them.

How have we made a difference for children and young people?

We always set goals for our work, with young people having a big say in what the goals they want to work towards. Of the 17 children we worked with, 16 achieved positive change in 5 of the goals that we agreed with them. The most commonly achieved goals were that 15 children reduced the time they spend with risky individuals; 15 children said they are more aware of their rights and those of others; and 14 children are more able to describe what they will do to stay safe when in risky situations. In addition, many of the 17 young people reported improvements in their sexual health, reduced substance misuse, improvements at school / college / work and feeling more settled where they live.

From the training we delivered, many professionals said they felt more confident and know better how to respond when they are worried about CSE.

Views of children/young people/parents and carers.

Young people from North Somerset have been part of our CSE Participation Group, for young people across Avon & Somerset. They have played part in training senior Police officers in how the Police can get the best from interviews when young people are understandably very anxious and have trained Social Work managers in what their teams should do. Young people have also contributed to a consultation of what they want from the new CSE support service that North Somerset Council and the Police & Crime Commissioner are commissioning.

On an individual level, all of the 17 young people have had a large say in shaping the work that they and their BASE worker discussed and what goals they should work on together.

What do we need to do better?

When there is not enough evidence of crimes being committed, so Police action is not likely, we need to make sure that children still feel that adults believe them and will continue to support them – just because we cannot take a case to court, does not mean that children's lives have not been scarred by CSE.

Barnardo's needs to work more closely with other organisations who work with young people in North Somerset to help them get better at identifying and supporting children who have experienced CSE."

BASE were commissioned to do 2 things:

1. Deliver support to victims of CSE.
2. Train the workforce on CSE so the response improves.

We worked with 17 children and trained 170 professionals, 17 of whom we trained in Train the Trainer CSE. The other courses were Working with Parents and CSE; Working with CSE: Skills and Practice; and Raising Awareness of CSE.

How have we made a difference for children and young people?

See **Appendix 4** for:

- Good practice Case Study
- Practice to be developed Case Study
- Impact Data

Young people have delivered training to Police staff on what they want from Police responses to CSE. This mainly focused on need for children to know / trust individual officers who listen well and who prepare them for the type of questions that they need to ask.

Referrals from North Somerset's Children Social Care teams have increased and are now in line with other LA's across Avon and Somerset.

What do we need to do better?

Early Help responses to children at risk of CSE.

12 – CAFCASS

Report provided by Victoria Penaliggon, Service Manager, CAFCASS

What did we do and why? See Appendix 5 for CAFCASS data.

Key performance indicators for the wider service area are consistently achieved for Care cases allocated within one working day, private and public law cases allocated promptly and reports filed to court ordered dates. This demonstrates a timely service and compliance with court ordered time frames for children's assessments.

In a period of increased demand across the wider service area we have maintained low staff sickness and high employment with use of agency staff at less than 5%, this with a slight increase in staffing and a stable work force has enabled high quality service delivery in a period of increased demand.

What have we learned?

Length of care proceedings has been the subject of an audit via the Family Justice Board to explore reasons for cases running over 26 weeks, learning from this has been fed back to the authorities. Within proceedings Guardians work closely with the Children's solicitor to avoid delay.

Child protection referrals work has been done with the private law family court advisors to improve quality of referrals to ensure all possible information is shared and the risk and child impact are clear. This is a recent initiative and will be followed up through the next quarter to ensure quality of referrals is to a high standard to enable the LA to respond quickly.

EPO applications are higher in North Somerset than nationally (40 percent North Somerset, against 6 percent nationally).

How have we made a difference for children and young people?

Providing a timely service in public and private law cases that includes direct work with children to bring their voice into the court proceedings. To ensure this happens to best possible standard for the children we work with our Quality Assurance and Impact Framework was revised in 2017 to include 'child impact analysis'. This includes audit of files for the quality of direct work, quality of analysis of the child's experience, evidence of children being enabled to make choices where appropriate and good quality child impact analysis included in reports.

Views of children/young people/parents and carers.

Our work includes enabling children to write a letter to the judge or to meet with the judge in some cases. We have explored the use of children's orders (parallel order to the adult version written to be accessible to children and help the adults explain the outcome of proceedings) and letters to children at the close of the case to leave a lasting record with them of the court decision.

What do we need to do better?

- Further work with North Somerset to review emergency applications in public law.
- Ongoing work in the local team to improve the quality of child protection referrals.
- Increase the use of Children's orders and, where appropriate, letters to children either to share with them at the end of a case or for their life story record.
-

13 – NATIONAL PROBATION SERVICE NORTH SOMERSET

Report provided by Liz Spencer, Head of the National Probation Service, LDU Somerset Cluster South West South Central Division, National Offender Management Service

The National Probation Service was formed on 2nd June 2014. Our Local Delivery Unit is the Somerset Cluster, made up of Bath and North East Somerset, Somerset and North Somerset. The managers which covered those areas in 2015 - 2016 are:

- Bath and North East Somerset: Kevin Day
- Somerset - Bridgwater: Angela Powell
- Somerset – Yeovil: Claire Evans
- Somerset – Taunton: James Knight
- North Somerset: Andy Harris and Gemma Willcox/Emma White.

Glogan House – Approved Premises is part of the National Probation Service and these premises are in Bridgwater. The manager there is Kerensa Holgate, and the Assistant Chief Officer responsible is Mark Benden.

NPS - Youth Offending Service. Liz Spencer is a Board member of all three Local Authority's Youth Offending Service Management Boards, and Chairs the Youth Offending Service Board in North Somerset. NPS Probation Officers work in all three teams.

Multi Agency Public Protection Arrangements - the MAPPA Unit for the whole Avon and Somerset Area is based at Avon and Somerset Constabulary Police Headquarters. The MAPPA Coordinator is David Miners, who works at Police HQ. This post is two thirds Police funded and one third Probation funded, but sits within the NPS line management structure. MAPPA meetings are held in each local authority area, with a local panel and is co-Chaired by Police and NPS.

The Avon and Somerset MAPPA Annual Report is published every year in October, by the Office for National Statistics, containing the statistics for all the MAPPA (violent and sexual) offenders managed in this police force area.

Liz Spencer is the co-chair of the Avon and Somerset MAPPA Strategic Management Board on behalf of the NPS.

Outline of Agency Function:

The Role of the National Probation Service is to supervise High Risk of Harm offenders and MAPPA offenders, provide advice and reports to the courts, deliver the Victim Contact service to the victims of serious sexual and violent offenders, provide Approved Premises, provide the Probation staff within Public Sector prisons. We have our Safeguarding duties to Children and to Adults, and provide attendance at MARACs in relation to our nominated cases. We are also represented on the Local Criminal Justice Board, the Transforming Summary Justice Board and all other statutory partnerships.

Achievements:

We have successfully recruited Probation Officers and Administrative staff to work in our locations and have implemented a new operating model which provides consistency of service and resources across the country. We have provided information relating to the particular resource requirements for the NPS in providing a service within remote and rural communities. We are still recruiting for more Probation Officers and Administrative staff, and are receiving applications, although there is a national shortage of Probation Officers.

Three members of staff have been successful in completing the qualification to become a Probation Officer and they are all working in the area.

We will be able to continue to provide NPS Probation Officers to the Youth Offending Service. We have changed our configuration to provide 1½ Probation Officers for Somerset, 1 for North Somerset and will be providing a part time Probation Officer for Bath.

Mandatory training in Safeguarding has been carried out.

We continue to improve our performance in relation to our timeliness of recalls, provision of Parole Reports and risk escalation of cases from the Community Rehabilitation Companies.

We continue to place the highest priority on our public protection work, and protecting past and potential victims.

An Avon and Somerset wide Reducing Reoffending Board is being set up and NPS are represented.

We have held a well-received seminar jointly with the University of the West of England discussing research on Child Sexual Abuse images over the Internet to inform our practice.

We continue to develop our learning as a result of Serious Case Reviews and audits and make sure that the information is regularly shared with staff.
Our NPS Probation Officers are providing representation to the Child Sexual Exploitation Sub Groups of the Safeguarding Children Boards.

Challenges:

Maintaining our 100% attendance at all the Partnership Boards will be a challenge given our likely level of resources in the future. We are also unable to support all the sub groups of the Board, although we do prioritise different elements in different areas according to the priorities in those areas.

We will also need to work even more closely with our partners on information sharing and communication, to ensure that information is shared both ways to enable us to deliver our objectives successfully.

New Strategies have been issued to share with partners in relation to MARACs, Domestic Homicide Reviews, Community Safety Partnerships and Youth Offending Service.

What difference have we made to children, young people, and parents/carers?

We have been pro-active in liaising with and informing Children's Services about potential risks to children and areas of need. We have also liaised to ensure that Children's Services are aware of our involvement and that we have informed about new information or offences. We have participated in Conferences and Working Together to meet the needs of children in the best interests of children. For the critical few of the children who pose the highest risk we have supported the MAPPA process.

We continue to carry out our role by working with high risk of harm sexual and violent offenders in order to reduce the harm they may create and to prevent future victims. We do this by working closely with the Police, the Prison Service and partner agencies.

The National Probation Service provides the Victim Contact Service for victims of serious sexual and violent crime and this service is available to children, their parents and to adults.

Objectives:

Our objectives are set nationally for the NPS, but locally we hope to be able to improve our recording of safeguarding referrals in order to track and record the outcomes, receipt of outcome letters, and produce management information. We are trying to increase the identification of care leavers in our services and make sure they are flagged correctly and linked to the appropriate services. There are also area wide MAPPA Audits to which the standing members including Children's Services standing members, will be invited.

We have implemented the further national guidance as the National Probation Service work on consistency in safeguarding continues via a nationally led group.

The NPS overall commitment to the Safeguarding of children in this area remains a significant and high priority.

14 – CHILD DEATH OVERVIEW PANEL

The following Executive Summary has been taken from the West of England Child Death Overview Panel Annual Report (April 2016 – March 2017). The full report can be downloaded from the LSCB website Annual Report section: **Other Partner Organisations Annual Reports: WOE CDOP Annual Report**

http://northsomersetlscb.org.uk.mediatopiaprojects.co.uk/children-safeguarding-board/safeguarding-children-board/annual-report-and-business-plan

EXECUTIVE SUMMARY

The processes to be followed when a child dies are currently outlined within Working Together to Safeguard Children 2015: Chapter 5 Child Death Review Processes[1].

1 HM Government Department for Education (June 2013)

Crude death rates for the individual authorities across the West of England range from to 3.70 per 10,000 children aged under 18. There is some variation between authorities with Bristol having the highest rate. This is likely to be due to multiple reasons e.g. social, economic and cultural.

Data related to Child Death Notifications:

557 child deaths were notified to the West of England Child Death Enquiries Office between 1st April 2012 and 31st March 2017.

Between 2012 and 2017, 261/557 (47%) of children were not residents of Bristol, North Somerset, South Gloucestershire or Bath and North East Somerset (BANES). The great majority of these children were receiving specialist medical care in Bristol Children's Hospital or St Michaels Hospital (NICU).
Over the 5 year period, 82% died in hospitals, 10% in the parental home or in a relative's home, 6% in hospices and 2% in other locations.

Between 2012 and 2017, 70% of deaths occurred during the first year of life, 11% of deaths were of children ages 1-4, and rates then decrease in mid-childhood but are higher in ages 15-17 with 7% of deaths. Deaths in 1-4 year olds showed a continued decrease over the 5 year period.

76% of deaths notified in the last 5 years were children expected to die and 24% of deaths in children aged0-17 years were unexpected; 30% remaining unexplained after a full investigation and the local case review meeting. 34% of deaths due to perinatal complications (mostly extreme prematurity), and 28% children with chromosomal, genetic or congenital conditions. Acquired natural causes account for 21% and external causes, encompassing deliberate injury, suicide and trauma, accounted for 9%.

Between 2012 and 2017, 44% of children had a post-mortem examination and of these 69% had a Coroner's post mortem and the rest had a hospital post mortem Data from cases reviewed by the Child Death Overview Panel:

The West of England CDOP reviewed 356 cases in detail between 1st April 2012 and 31st March 2017. There is an inevitable time-lag between notification of the child's death to discussion at CDOP but 100% of the cases requiring review from 2012/13 and 2013/14 have now been reviewed.

The most common mode of death is following the active withholding, withdrawal or limitation of life-sustaining treatment, which occurred in41% of cases.

16% of children reviewed have another disability. In 76% of those the disability was felt to have contributed to the ill-health, death or vulnerability in the child.

In 98.3% of cases, factors intrinsic to the child (i.e. the underlying medical or surgical problem) provided a complete and sufficient explanation for the death. In 1% factors in service provision provided a complete and sufficient explanation for the death, and in one case issues with parenting capacity provided a complete explanation.

Factors that may have contributed to the vulnerability, ill-health or death were identified in the family in 29%, related to parenting capacity in 11% and in service provision in 28%. Parental smoking was classed as contributory in 8.4% of

deaths, emotional, behavioural or mental health issues in 3.6% alcohol or substance abuse in 3.9%, housing issues in 2.8% and domestic violence in 3.6%. It should be highlighted that positive parenting was noted in many cases.

CDOP identified 'modifiable factors' in 32%. Modifiable factors are defined as 'one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths'. Current national data shows this is higher than the national average and the average from the South West. This may be due to the open scrutiny with which this panel seeks opportunities to learn from every case reviewed and the fact that factors considered to be modifiable may not be considered modifiable by other panels.

Family bereavement follow-up was documented in 95% of cases, with hospital or specialist paediatrics providing this in 43% of cases, primary care in 14% and hospice/community nursing in 19%. In 3% the offer of follow-up had been declined, and no information was available in 2% including whether families had accessed national or local non-statutory bereavement support, information about which is routinely provided through the child death review process.

Focus on deaths of children with life-limiting conditions

Between 1st April 2012 and 31st March 2017, deaths of children with life limiting conditions (LLC) accounted for 21% of child deaths.
In 71.6% an end of life (EOL) plan was in place when the child died. 73% died in the family's location of choice. Most died from natural progression of the underlying disease. 50% had a named EOL care coordinator. In the last 3 years 33/52 (63.5%) had a symptom management plan in place.

Service improvement issues:

Some service improvement actions were taken as a direct result of discussion at the local child death review meeting and in some cases exceptional practice was commended.
Important issues highlighted by CDOP were disseminated through the constituent agencies and the chairs of the Local Safeguarding Children Boards.

Issues noted at CDOP led to specific actions in some cases:

i. Exploring how to ensure safe sleeping advice is given to fathers as well as mothers
ii. Improved information sharing when a Serious Case Review is being carried out
iii. Improving the availability of specialist reports when children are seen in other health settings
iv. Ensuring discussion with social care in cases of concealed pregnancy
v. Explore whether road design processes take into account proximity of cyclists
vi. Explore remit of NHS 111 in providing resuscitation advice.

Themes

Certain themes have emerged from reviewing children's deaths in the West of England this year.

A number of deaths from Group A streptococcal infection were noted and although not necessarily modifiable individually these are important for Public Health strategy and future research opportunities.

The Panel has been aware of some inequalities of health provision across the areas within Wets of England, and this year noted cases illustrating a difference in provision of pre- hospital care and in staff experience in managing paediatric resuscitation situations.

Choice of place of End of Life care is sometimes limited by the lack of availability of community based palliative care.

Coordination of hospital care for those with complex medical needs.

There has been no formal support for parents in the next pregnancy after a sudden unexpected death in infancy although CDOP have now been able to support a pilot Care of the Next Infant programme.

Achievements and Future Priorities

RCPCH State of Child Heath 2017 report draws attention to higher child mortality rates in the UK compared to similar European countries, and sets out a strategy in response to this.

The Children and Social Work Act 2017 paves the way for changes to the Child Death and CDOP processes, and Bristol continues to be seen nationally as an example of good practice.

Maintaining the quality of local Child Death Review meetings, and engagement of professionals in the process. CDOP has a role in ensuring families' questions are addressed and that appropriate bereavement support is offered.

Sharing data with partner agencies through presentations and reports and in some cases, data requests.

15 – PRIVATE FOSTERING

Report provided by Jenny Slee, Adoption and Permanence Team Leader, North Somerset Council

What did we do and why?

This report gives an overview of activities in relation to Privately Fostered children in North Somerset from 1st April 2016 to the North Somerset Safeguarding Children Board (NSSCB) meeting on 14th March 2017. The report details how North Somerset has complied with its duties and functions in relation to Private Fostering and includes how the welfare of privately fostered children has been satisfactorily safeguarded and promoted over the past 12 months. The report also outlines the activities which have been undertaken to promote local awareness of the notification requirements regarding children who are living in Private Fostering arrangements.

Current arrangements for the regulation of Private Fostering originate from concern following the tragic death of Victoria Climbié in 2000. Victoria was abused and killed as a privately fostered child in a private arrangement made by her parents with her Great Aunt. The Regulations for Private Fostering were codified in the Children Act 2004. Following this, the Children (Private Arrangement for Fostering) Regulations 2005 set out the duties of local authorities in their arrangements for private fostering

and statutory National Minimum Standards for Private Fostering were published in 2005.

Private Fostering is defined by The Children (Private Arrangements for Fostering) Regulations 2005 as an arrangement made for the care of a child or young person under the age ofc16 (under 18 if disabled) by someone other than a parent or close relative (close relatives are parents, step-parents, siblings, siblings of a parent and grandparents) for 28 days or more in the carer's home. This could be an arrangement by mutual agreement between parents and the carers or a situation where a child or young person has left home against their parent's wishes and is living with a friend and the friend's family. In a private fostering arrangement, the parent retains parental responsibility for the child or young person.

Private Fostering arrangements are diverse. However, examples of arrangements which are private fostering include:

- Children and young people sent from abroad to stay with another family, usually to improve their educational opportunities;
- Teenagers who, having broken ties with their parents, are staying in short term arrangements with friends or other non-relatives, sometimes known as 'sofa-surfing';
- Children of prisoners placed with distant relatives;
- Language students living with host families;
- Trafficked children and young people.

A child or young person who is Looked After or placed in any residential home, hospital or school is excluded from the definition.

In practice, where it is unclear whether a care arrangement for a child or young person is or is not a private fostering arrangement, discussion takes place with the North Somerset Council Designated Manager for Private Fostering. The Designated Manager may seek legal advice as to whether the arrangement does or does not fall within the statutory definition of private fostering. Learning from this process is then shared as relevant.

The primary responsibility of the local authority is to safeguard and promote the welfare of these children and young people by:

- Meeting the duty to promote public awareness of the requirement to notify the local authority of private fostering arrangements and, therefore, to reduce the number of 'unknown' private fostering arrangements;
- Responding to notifications and assessing the private fostering arrangements
- Meeting the duty to support private fostering arrangements.

This responsibility is underpinned by the Replacement Children Act 1989 Guidance Private Fostering; Children Act 2004 (Section 44 amends Section 67 in the 1989 Act); the Children (Private Arrangements for Fostering) Regulations 2005 and the National Minimum Standards for Private Fostering 2005.

The Designated Manager for Private Fostering is a requirement of the National Minimum Standards. The role of the Designated Manager is defined as 'the person within the local authority with expertise in private fostering, whom social workers can contact for advice'. At the time of writing this Report, the Designated Manager for Private Fostering is Amanda Braund, Service Leader, Resource Service.

What have we learned?

We have learnt that frequent raising of awareness is essential to ensure staff and the community are fully appraised of our systems in connection with private fostering. Early notification from the referral and assessment team to the Adoption and Permanence team is critical to ensure timely intervention, therefore we have learnt that the team leaders of these teams need to ensure a timely reporting system is in place.

Numbers of identified Privately Fostered children are low and, despite awareness raising, are likely to continue to be low. Nevertheless, as Private Fostering is a statutory requirement, significant work has been undertaken over the past year to review, update and develop the way in which North Somerset Council discharges its duties and functions in relation to Private Fostering. Learning from the cases and from Private national data and the Ofsted Thematic Report has informed the local offer and over the next twelve months it is anticipated that performance should significantly improve to this small but vulnerable group of children and young people.

How have we made a difference for children and young people?

A particularly useful focus of awareness raising activity has been a link from the Adoption and Permanence team allocated to each of the community family teams (North, South and East and the Disabled Children's Team). Raising awareness has continued and all teams have been visited within Support and Safeguarding to ensure their knowledge is up to date.

A 'learning lunch' facilitated by the Principal Social Worker has provided an opportunity to discuss with social care staff the policy and procedures involved in Private Fostering.

This focus on raising the awareness of professionals in particular was informed by the findings of the Ofsted Thematic Report which found that even well-funded media 'campaigns' by Local Authorities had limited impact, noting:

There is little evidence that 'awareness-raising' campaigns have any impact on self-referrals by the public, although strategies can help to raise awareness among professionals.

All the Private Fostering requests were referred by the referral and assessment team and were subsequently allocated to the community family teams appropriately
The Ofsted Thematic report noted that they identified that best practice by a Local Authority should include identification and analysis of referral 'routes' and reasons for Private Fostering.

Within the period of 2016-17 North Somerset Council returned that it had complied with the requirement that a visit be undertaken within seven working days of Notification. Within this period there were four notifications of Private Fostering arrangements with one chid returning home to the birth family, another the carer requested it should end, another ended because the child reached 16 and the fourth placement ended because the carer was not suitable.

Views of children young people and carers

Private foster carers and parents of privately fostered children receive advice and support to assist them to meet the needs of privately fostered children; privately

fostered children are able to access information and support when required so that their welfare is safeguarded and promoted.

Children in private foster care will receive regular visits from an allocated social worker (in the CFT) in order to safeguard and promote their welfare. While the private fostering assessment is being completed, visits must be made every 2 weeks. When the assessment has been completed, visits must be made at least every 6 weeks during the first year of the arrangement and thereafter every 12 weeks. On each visit the social worker will speak to the child alone and will give the child information and support in accordance with his or her individual needs.

All visits and contact with the child / carers must be recorded on LCS.

The local authority provides such advice and support to private foster carers and prospective private foster carers as appears to the authority to be needed.

Social workers should provide private foster carers with information on the advice that is available from both Children's Services and other agencies.

Where there is a need for support that cannot be met by other agencies then consideration should be given about providing support under section 17 of the Children Act 1989.

When it is appropriate, private foster carers will be given access to the training offered to foster carers in North Somerset. Specific training will be developed for private foster carers, if required and if it is appropriate.

Carers should be facilitated to access community-based resources.

Where appropriate, and with the carer's agreement, referrals will be made to other agencies.

The local authority provides advice and support to the parents of children who are privately fostered within their area as appears to the authority to be needed.

The workers may be required to offer advice and guidance to parents on a number of issues. This may include advice and guidance regarding the placement of their child, should the private fostering placement be deemed as unsuitable by the local authority.

A parent can reasonably request a visit from the worker involved in the monitoring of their child's care.

A parent should be kept informed of changes to any existing arrangements and of the outcome of reviews. Parents should be invited to the annual review of their child's placement.

Children who are privately fostered are able to access information and support when required so that their welfare is safeguarded and promoted. Privately fostered children are enabled to participate in decisions about their lives.

All privately fostered children must be given the name and contact details of their allocated CFT social worker. The child should be seen alone at each visit, and be given the opportunity to discuss any issue with the worker that they need to.

A privately fostered child should be given access to a range of universal support services, and to specialist services if required. The worker should co-ordinate these support services with the consent of the child.

What we need to do better

Attempt to increase the number of new notifications through improved identification of Private Fostering arrangements through targeting of services for example schools, Health Centres and Health visitors.

Visit social work teams to ensure they have up to date knowledge of procedures and suggest each team identifies a private fostering lead/champion to ensure Private Fostering retains a high profile.

Place the Guide for Professionals on the fostering website.

Discuss Private Fostering at the Strategic 'Where Children Live' sub-group to identify good practice and improvements needed.

Use the 'Learning lunch' forum chaired by the Principal Social worker to increase awareness.

Update practice procedures.

Research other private fostering regional groups.

Draw up a separate Statement of Purpose for Private Fostering, currently a statement is contained in the fostering Statement of Purpose. The aim of the Statement of Purpose is to ensure awareness of North Somerset Council's duties and functions in relation to private fostering and the ways in which they will be carried out. The document will aim to provide a clear guide in relation to private fostering for professionals, wider agencies and members of the public. The statement to be reviewed through the NSSCB and to be available on the NSSCB website.

Continue to promote local understanding and awareness of private fostering and to improve how we meet the needs of the children and young people concerned. This to include using audit to review our own performance and to identify where improvements need to be made.

Ensure the Private Fostering leaflet and information can be available in every language by using the Language Line.

As part of the Single Assessment, consideration must be given to the overall development needs of a disabled child who is privately fostered and the additional support that may be required. This will be done in conjunction with the Disabled Children's Team and with appropriate services.

Introduce an Independent review process to ensure children in Private Foster Care arrangements are safeguarded and progressing well.

The NSSCB will be sent out a Newsletter to all professionals outlining their expectation around professionals knowing their responsibility around notification.

16 – DESIGNATED OFFICER FOR ALLEGATIONS (DOFA) FORMERLY KNOWN AS LADO

The following Executive Summary has been taken from the Designated Officer for Allegations against Professionals, Volunteers and Foster Carers (annual report March 2016 – April 2017). The full report can be downloaded from the LSCB website Annual Report section: **Other Partner Organisations Annual Reports: DOfA**

http://northsomersetlscb.org.uk.mediatopiaprojects.co.uk/children-safeguarding-board/safeguarding-children-board/annual-report-and-business-plan

EXECUTIVE SUMMARY

This report sets out the key findings from North Somerset's Designated Officer for Allegations (DOfA), formerly LADO, and activity using both data analysis and commentary since April 2016 – March 2017.

Referrals to the (DOfA) service have continued their upward trend and in the 2016 - 2017 reporting year there were a total of 84 referrals and 82 enquiries in North Somerset an overall total of 166.

In December 2016 a new DOfA was appointed on a part time basis to fulfil the requirements of this critical role.

17 – CONCLUSION

It has been a very busy year for the LSCB. This report demonstrates that safeguarding activity is progressing and that the North Somerset LSCB has clear agreement on the strategic priorities achieved and what actions need to be taken forward over the coming year. The LSCB is aware of, and working to fulfil, its statutory functions under Working Together to Safeguard Children 2015.

The Sub-group reports and Agency reports demonstrate that members are consistently participating towards the same goals in partnership and within their individual agencies.

We do, however, have areas where further development is required. These are detailed in the below section.

The publication of the Children and Social Work Act 2017 and the proposed changes to LSCB structures will have a significant influence on the work of the Board over the next reporting period.

This and our focus on responding positively and proactively to Ofsted's inspection recommendations will provide us with a challenging period ahead, and a renewed need to ensure that all partners are working together effectively, sharing information and seeking common outcomes. Whilst we wait for a confirmed enactment date of the new legislation we must ensure that the existing statutory guidance provided by "Working Together to Safeguard Children 2015" is adhered to.

18 – NEXT STEPS

This section reviews what needs to happen next to ensure continuing improvement.

We discuss the Board's plans moving forward; 'Next Steps', which will inform next year's business plan.

Business Planning

It is expected that the new two-year business planning approach will address identified priorities more effectively by balancing short-term and long-term priorities through a work-stream planning approach. The Business Plan 2017-19 is available in Appendix 1 and contains work streams and priorities for year 1. Priorities for the following years will be added after the annual appraisal of the Board's effectiveness.

The plan sets out the future focus of the NSSCB, providing a series of outcomes, milestones and measures which will support providing evidence of progress and impact.

Serious Case Reviews

A programme of work will be in place to implement the independent Serious Case Review (SCR) recommendations (due in December). Key learning points will be extracted from the completed SCRs and a programme of dissemination and learning events will be rolled out in 2018.

Quality Assurance

In order to fulfil its governance and accountability duties, the NSSCB relies on an effective quality assurance process to generate evidence for effective scrutiny and challenge. We need to establish a culture of partners not only sharing information from performance management systems but also being committed to collecting information in the absence of systems. This means that agencies ensure that significant data is collected for the NSSCB dataset. This is work in progress.

Performance Monitoring

All Board members must be committed to developing its performance monitoring system to operate effectively. The plan is that the Board takes a phased approach with the initial focus being on developing robust Board governance arrangements. The NSSCB has reviewed the Board infrastructure and made changes to the sub-group arrangements, to more effectively drive forward policy, practice and learning and development priorities. For example, the Multi-Agency Sexual Exploitation Sub-Group comes under the management of the NSSCB to oversee the implementation of the SE Strategy and Action Plan. The NSSCB is developing a quality assurance process model, which draws on single agencies' performance management systems.

Data and Performance Information

Children's Services key performance indicators relating to safeguarding, child protection and early help are currently monitored by the NSSCB Executive Group. The next steps are for all partners to report their data to the Board on a quarterly

basis. This will enable us to challenge appropriately and satisfy ourselves in relation to the effectiveness of all services being delivered in North Somerset to support children and young people and ensure their safety and wellbeing.

The Board must begin a robust programme that will monitor, quality assure and evaluate the quality of services within North Somerset.

We need to develop a more effective multi-agency dataset which is to be used to routinely scrutinise operational partners' performance, and challenge and audit where necessary.

Our quality assurance process will aim to develop an understanding of the quality of multi-agency practice and the child's journey.

Overview and Single Agency Activity

As a board we need to analyse how effective services are in North Somerset at keeping children and young people safe and what the impact of our work has been in terms of improving outcomes for children and young people. All partner agencies will be asked to present their respective annual reports to the NSSCB.

As set out in Working Together to Safeguard Children (2015), our objectives are to coordinate and ensure the effectiveness of safeguarding arrangements in the local area.

Leadership, Challenge and Learning

We need to agree a new approach for 2017-2018 which will be more focused on our specific role and remit in ensuring the welfare of children is safeguarded and protected. Our three overarching principles will be: Leadership, Challenge and Learning.

The Board must be committed to an approach where the Independent Chair leads the safeguarding agenda, challenges the work of partner agencies and, as a board, learns lessons, embeds good practice and is continually influenced by the views of children and young people.

Partners will be asked to provide examples and evidence of work where leadership, challenge and learning has taken place and led to changes in practice and will ultimately improve outcomes. By supporting our partners in these areas we can work together to really make a difference for the children and young people of North Somerset.

Sub-Groups

There will be an appraisal of multi-agency sub-group activities in relation to the NSSCB Business Plan objectives. The appraisal will refer to aspects of NSSCB effectiveness that relate to outcome-based accountability principles; these are about providing assurance to the Board based on evidence of impact and change as a result of NSSCB activities. The information is to be provided by each sub-group chair and presented by sub-group area of responsibility.

A review of the activity reports submitted by the chair of each sub-group will provide evidence that they have operated effectively; objectives were delivered as planned.

Development of new processes to increase the efficiency of support to the NSSCB. This will ensure that work is carried out more effectively and efficiently resulting in clearer Sub-Group reports presented to the Board and clearly defining where there are gaps that need to be challenged.

Learning and Improvement

A key part of the work of the NSSCB is to ensure that its activities are making an impact on safeguarding practice. This commitment to development and improvement is to be clearly set out in its learning and improvement framework which will drive and monitor improvement. We will continue to develop case audits, reviews, learning and training evaluations and data analysis. Measuring the impact of learning and development activities such as training courses, workshops and courses is one of the key areas the NSSCB will be working on. The updated learning and improvement framework to detail the mechanisms for measuring impact of learning.

The NSSCB to scrutinise and challenge the level of safeguarding training provision across agencies. This will also be supported by the findings of the Section 11 audits.

New guidance to be developed on the safeguarding training levels and learning outcomes that can be expected from each level of training.

Working with the Safeguarding Adults Board to ensure that cross-cutting themes such as domestic abuse and mental health are dealt with holistically i.e. as a whole family approach.

Further work is needed in relation to feedback processes from children and young people and understanding the views of professionals of what practice is like on the front-line.

Engagement with and Participation of Children and Young People

For the Business Plan going forward, the NSSCB wishes to develop a broader understanding of what local young people and children are saying about feeling safe in North Somerset, and their experience of services.

A key role for the NSSCB is to maintain an understanding and have oversight of how children and young people are involved in the decisions that affect their lives. The Board will begin to identify lines of enquiry and forge links to other boards and sub-groups.

As a priority, the NSSCB will seek to secure the necessary evidence to assure itself of the quality and effectiveness of participation and engagement of children and young people in planning, reviews and decision making. The NSSCB will play a key role in challenging all partners in their delivery of strategies to strengthen voice and influence, and it will promote voice and influence as central element for safeguarding children and young people.

Wood Review and Children and Social Work Act 2017

The Department for Education (DfE) commissioned a review of the role and functions of Local Safeguarding Children Boards, led by Alan Wood – the national 'Wood Review'. The Government's response to the Wood Review indicates a change in thinking regarding the future of LSCBs and proposes new arrangements. The anticipated changes in arrangements will be linked to the provisions of the Children and Social Work Bill enacted through legislation 2017. Those changes are:

- A new statutory framework, which will set out clear requirements, but give local partners the freedom to decide how they operate to improve outcomes for children;
- The 3 key partners (local authorities, the police and the health) will be required to make and publish plans showing how they will work together to safeguard and promote the welfare of children in the local area;
- All local organisations involved in the protection of children will be expected to cooperate with the new multi-agency arrangements;
- LSCBs will lose their statutory status and local areas will be able to choose whether they retain their LSCB, or a version of it, to deliver the requirements of the statutory framework.

The review has also advocated the discontinuation of complex serious case reviews in favour of an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. Local learning reviews are still being advocated.

Legislation and statutory guidance will be published to underpin the new framework Publication of the revised version of the statutory guidance 'Working Together' is awaited. It is currently available for consultation up until December 2017 with a view to publication early in 2018. It will then be possible for discussions to take place about the requirements of the statutory framework and the most appropriate way for these requirements to be delivered locally, to include a debate about whether North Somerset retains its safeguarding children board or moves towards an alternative model.

APPENDICES

Appendix 1 Business Plan

The NSSCB is responsible for:

- co-ordinating what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established;
- ensuring the effectiveness of what is done by each such person or body for that purpose.
- promoting greater understanding of the need to safeguard children and promote their welfare.

This Business plan is produced in consultation with all NSSCB partners and describes our priorities as a Board over the next year. Business priorities are taken from: the NSSCB workshop, performance questions arising from data and additional priorities arising from key national and local issues.

Overarching Principles: Leadership, Challenge and Learning.

Our Strategic intent:

- Strategies and action plans for the priority areas developed and implemented;
- Prevalence of priority area abuse known and understood;
- Priority areas audited as part of planned audit schedule and quality of partners engagement and interventions analysed to evidence impact and outcomes for children and young people;
- Preventative interventions are promoted through targeted awareness raising sessions and communications on the priority areas, including to the wider community.

Our key priorities:	**Key themes for 2017/18:**
Early Intervention	Challenge and holding each other to account
Neglect	Voice/participation of children and young people
Sexual Exploitation/Missing	Better joined up working between sub-groups
Domestic Abuse	Multi-agency involvement in Early Help

	Identifying and promoting a learning culture
	Learning from audits

Priority: Early Help, Pathways, Thresholds
A significant focus on prevention
Understand the Early Intervention arrangement, structure and process.

Outcome for children: Emerging problems and potential unmet needs are identified so that children and families receive the right support at the right time.

Objective	By When	Lead	Outcome	Actions
NSSCB to understand the effectiveness of Early Intervention	June '18	Early Help Sub-group Quality Assurance Sub-group Independent Chair Board members	NSSCB receive analysis and data in relation to the Quality Assurance Framework for the Early Help Service. This will enable the Board to evaluate effectiveness and operation in practice.	Early Help Sub-group chair to present report to March '18 Board with data and analysis of the effectiveness and impact of Early Intervention. Early Help Sub-Group to enable completed assessments by partner agencies to be attached in the Early Help Module to address duplication. Data Dashboard to ensure NSSCB is able to track and monitor progress of Early Help provision and quality across North Somerset agencies and service providers.
NSSCB to ensure children and families views and experiences of early help intervention and support influences service delivery.	September '18	Early Help Sub-group Quality Assurance Sub-group	NSSCB seeks the views of children and families about their experiences of services. This will contribute to measuring the impact and effectiveness of early intervention and support.	Early Help conference to focus on Transitions using the experiences of families to engage schools in Early Help. Families will be invited as stakeholders to the conference. New family hubs to improve access for families to Early Help. Gathering feedback on

Objective	By When	Lead	Outcome	Actions
				families understanding of Early Help and capacity to gain children and family views to be built into the development of family hubs. Early Help sub-group to devise a questionnaire to seek feedback from children, young people and families around their views and their experiences of early help intervention.
NSSCB to make sure thresholds & referrals between early help and statutory child protection work are appropriate, understood and are operating effectively to meet a range of needs in different communities.	September '18	Early Help Sub-group Quality Assurance Sub-group Independent Chair P&P Sub-group	Increase number of families offered Early Help in North Somerset and reduce number of NFA Referral and Assessment Team. NSSCB challenges across the Partnership and gains assurance that policies and procedures concerning thresholds are reviewed and maintained, to ensure children receive the right service at the right time.	New 'front door'. Triage acts as an interim measure. Early Help to be represented on One Front Door Project board. Audit to be undertaken between early help and R&A around thresholds. Report and analysis to be presented to March '18 Board.
Ensure services provide appropriate and high quality early help and intervention, consistent application of thresholds between preventative, targeted and specialist services	December '18	Early Help Sub-group	NSSCB to capitalise on high level of engagement of Early Help within 0-5 services and grow Early Help using Transitions into primary and secondary education.	All agencies and service providers set out their Early Help offer to families and this information is made available to families via the NSSCB website. Early Help Conference to focus on ensuring Transition of families receiving Early Help

Objective	By When	Lead	Outcome	Actions
		Quality Assurance Sub-group Independent Chair Board members Learning and Development Sub-group		within children centres and 0-5 services into primary school settings. Step up and Step Down between Early Help and Children's Social Care should enable families to receive more consistent and flexible support from relevant agencies. Use of Dashboard. Use of New Front door pilot. A multi-agency audit of early help services around consistency of thresholds. Report and findings to be presented to Board in March '18. Inter-agency safeguarding courses for managers and safeguarding leads to be revised to better address application of threshold in decision making. Changes to training to improve the use of the Threshold in decision make.
Identify any gaps or duplication.	December '17	Independent Chair Board Members Early Help Sub-Group	There are no gaps or duplication.	Data Dashboard to ensure NSSCB is able to track and monitor progress of Early Help provision and quality across North Somerset agencies and service providers.
Audits: Priority 1: Early Help, Pathways, Threshold	December '17	Quality Assurance Sub-group		Audit report to be presented to December '17 Board. Review audit actions.

Priority: Neglect
We are focusing on Neglect because it is one of the highest categories for children and young people in North Somerset on a Child Protection Plan.
Outcome for children: Children in households where neglect is a feature are helped and, when necessary, protected.

Objective	By when	Lead	Outcome	Actions
NSSCB to develop and implement a Multi-Agency Neglect Strategy & Action Plan.	December '17	NSSCB Short Life Working Group (to be agreed) P&P Sub-group	NSSCB has in place a multi-agency Neglect Strategy which sets out the strategic aims and objectives	Health agencies to collaborate with the roll out of neglect toolkit Learning from SCR with subject of serious neglect to be cascaded and discussed with all NS safeguarding leads for health. Update: Neglect Strategy and Action Plan drawn up March '17. Neglect toolkit launched at Neglect Conference in June '17. Evaluation of implementation and progress of the use of the toolkit to be provided by each partner agency to the June '18 board. Each partner agency to provide an update.
NSSCB to understand the numbers of children for whom neglect is a feature, the prevalence of parental factors and the effectiveness of the safeguarding system in reducing neglect. Identify a range of indicators to identify the prevalence of neglect in North Somerset and to measure progress in tackling this;	June '18	Early Help Sub-group Quality Assurance Sub-group	NSSCB dataset includes information on the numbers of children experiencing neglect at each level of the continuum of need. This will support the NSSCB to understand the prevalence of all children receiving services for child neglect. NSSCB Quality Assurance Sub-group provides analysis and scrutinises data in relation to the impact of adverse parental factors which supports their understanding of the impact	Neglect data to become part of Early Help dashboard. Analysis of data to be presented to June '18 Board to include information on children and young people experiencing neglect at each level of the continuum. Report and analysis to be presented to June '18 Board. This will allow a period of time to test the use of the Neglect Tool kit.

Objective	By when	Lead	Outcome	Actions
			and extent of these factors in relation to child neglect. Partner agencies contribute to the NSSCB Annual Report and provide a narrative on activity undertaken by their agency to tackle child neglect and the impact of it.	
NSSCB Neglect training offer to be delivered and evaluated.	December '17	Learning and Development Sub-group	Learning & Development Sub-group receive analysis and evaluation of the impact of training in improving the quality of professional practice and of the experiences of children.	Update: Training courses are using neglect cases as the basis of learning to heighten awareness indirectly. Update: Neglect tool kit launched at Neglect conference in June. Level 3 safeguarding training includes identifying and responding to Neglect. Learning and Development Chair to provide an update to December '17 Board re Level 3 Safeguarding training uptake and evaluation.
The particular vulnerabilities of families experiencing mental health difficulties, domestic abuse, or who are impacted by the misuse of substances/alcohol, to be understood by the workforce Ensure that the issue of neglect receives due prominence in assessment, prevention and intervention work alongside issues of adult mental health and substance misuse.	September '18	Learning and Development Sub-group Early Help Sub-group Learning and Development Sub-group Quality Assurance Sub-group All Board Members	Learning & Development Sub-group review & receive evaluation of safeguarding training (including Disguised Compliance).	Update: Health Briefing paper on findings from triennial review of serious case reviews cascaded to NS Health Leads for safeguarding Update: Toxic Trio course revised to include cumulative effects of harm taken from 'Pathways to Harm.' by Jan 2017. Think Family Lead to join Sub-group. L&D sub-group chair to provide an update to the March '18 Board re the evaluation on safeguarding training.

Objective	By when	Lead	Outcome	Actions
		NSSAB		QA sub-group to include within their audit prominence of neglect within assessments. Provide an update to March ’18 Board.
NSSCB to understand, and challenge, the effectiveness of interventions in reducing the impact of neglect.	November ‘17 and on-going.	Quality Assurance Sub-group Independent Chair Board	Multi-agency case audit identifies how multi-agency support, at all levels of the continuum of need, leads to a reduction in risk/ need associated with neglect. Where parents are not engaging with plans or outcomes for children are not improving, professionals are observed to be making consistent challenges. NSSCB challenges the effectiveness of multi-agency working and interventions to tackle neglect.	QA sub-group to undertake review audits to measure effectiveness and outcome at June ’18 Board. Voice and participation of children, young people and families to be ascertained around the effectiveness of interventions in reducing the impact of neglect. Board to plan a themed multi-agency audit. December ’17 Board.

Objective	By when	Lead	Outcome	Actions
A coordinated response. Improve early identification and the effectiveness of the professional response (at all tiers of need) to child neglect. Develop and implement systems and practices which improve the early identification and the effectiveness of the professional response.	September '18	Early Help Sub-group All Board Members P&P Sub-group All Board Members		Update: "Difficult" conversations is now incorporated in level 3 safeguarding training. L&D Chair to provide an update to the Board regarding Level 3 Safeguarding Training uptake and evaluation. December '17 Update: Neglect toolkit launched, which will help in the early identification of neglect and to measure the effectiveness of the professional response. Each partner agency to provide the Board with a summary of their progress. Each partner agency to provide an update to March '18 Board.
Audits: Priority 2: Neglect	December '17	Quality Assurance Sub-group		Audit planned on Neglect. Presentation to December '17 Board to include the above.

Priority: Sexual Exploitation/Missing

Identify the extent of sexual exploitation towards children and tackle it across all agencies to protect children.
Pay particular attention to work with those who go missing from care, home and education.
Outcome for children: Children and young people in North Somerset are protected from sexual exploitation.

Objective	By when	Lead	Outcome	Actions
NSSCB to develop and implement a Multi-Agency SE Strategy & Action Plan.	June '16 (Achieved)	SE/Missing Sub-group P&P Sub-group	NSSCB has in place a multi-agency SE Strategy which sets out the strategic aims and objectives of North Somerset's approach to tackling SE.	Update: The final update of the SE Strategy was signed-off at the Board in June '16 and is available on the LSCB website. A Missing Protocol has been drawn up and is available on the LSCB website.
		SE/Missing Sub-group Early Help Sub-group Independent Chair Comms Sub-group P&P Sub-group	Prevent & Early Identification of SE Protect & Pursue Work plans that ensure delivery of objectives relating to; □ Strategic commitment across all agencies □ Identification - improve awareness, understanding & recognition □ Prevention - Communication □ Protection - Improve effectiveness of interventions – Support for victims and families □ Disruption - Improve the prosecution of perpetrators. NSSCB dataset includes relevant data; numbers of children at all	Update: NS CCG made a successful bid to NHS England for a senior health practitioner for CSE/SE across all health agencies in North Somerset and Somerset. Post commences on 3.10.16. Update: NSCCG have facilitated GP safeguarding leads have receiving specialist CSE training from Barnardo's Update: NSCCG head of safeguarding participates in West of England regional CSE network meetings, looking at perpetrator disruption Health agencies are engaged with SE subgroup Each partner agency to provide the March '18 Board with an analysis of the

Objective	By when	Lead	Outcome	Actions
Continue to establish an understanding of the known prevalence and nature of child exploitation in North Somerset NSSCB to know the numbers of children who are victims of SE and the effectiveness of its strategy to reduce it.	On-going	SE/Missing Sub-group Police All Board Members Safer & Stronger Communities	levels of the continuum who are victims of SE & vulnerable groups. Partner agencies contribute to the NSSCB Annual Report and provide a narrative on activity undertaken by their agency to tackle SE.	implementation of the SE Guidance and strategy to highlight impact. Police to provide Board with an update re disruption (prosecution of perpetrators). December '17 Board
NSSCB to collect child sexual abuse data NSSCB to scrutinise the quality of safeguarding work through audit and consultation.	September '16 (Achieved) June '18	Quality Assurance Sub-group Independent Chair All Board Members	Audit measures practice and impact, not just process. There is evidence that; the child's history informs risk assessment, each relevant child in the family is considered in their own right, the level of risk is understood from the child's perspective and there is a clear shared understanding of risk between agencies.	Update: QA Sub-group audit data presented to the Executive in July '16 and updated at the Board September '16. Each agency to provide the June '18 Board their respective data in relation to CSE and Missing. Review audit actions and recommendations at September Board.
NSSCB to support the workforce to understand, recognise and contribute to joined up working when children and young people have suffered sexual exploitation.	On-going through Executives and Boards	Learning and Development Sub-group SE/Missing Sub-group	NSSCB has learning and development opportunities that raises staff awareness and understanding of: □ the signs and symptoms of sexual exploitation □ how to respond to allegations of sexual exploitation	Update: Jan-March 2017 Train the Trainer courses accessed to ensure current level of training can continue to be delivered. Update: SE/Missing: Train the Trainer courses have commenced.

Objective	By when	Lead	Outcome	Actions
	June ‘18			SE/Missing sub-group to provide the Board in March ‘18 with an analysis of multi-agency working with those children and young people who have suffered SE.
NSSCB to make sure that strategic and operational responses to SE are informed by voices of children, who have experienced SE.	December ’17 and ongoing	SE/Missing Sub-group. Quality Assurance Sub-group Early Intervention Sub-group SE/Missing Sub-group	Victims of CSE or families of CSE victims are engaged and their perspective informs strategic and operational activity of NSSCB. Audits evaluate how the voices of children have informed, influenced, changed and impacted on the CSE activity of NSSCB. Children and young people’s views and experiences are used to inform and improve prevention and support service provision.	CSE Sub-group to provide the Board in March ’18 with an analysis of data in respect of the child’s voice in SERAFs. Sub-group to provide the Board with detail on regional use and completion of SERAF to look at consistency across the area. February ’18 Executive.
NSSCB to ensure children who are victims, or potential victims, of SE or children who go missing are provided with necessary and effective support and interventions.	December ‘17	SE/Missing Sub-group Board Quality Assurance Sub-group (through audit).	NSSCB reviews provision of support services so that Return Interviews and Support Services for children who go missing, are of good quality	To be reviewed through audit findings. SE/Missing sub-group to provide an update to the December ‘17 board on timeliness of return interviews and an analysis of those not completed within 72 hours.
Raising awareness re SE. Prepare an awareness campaign – to cover prevention and education	June ’16 (Achieved) and on-going Comms Sub-Group to update Board March ‘17	Comms Sub-group Safer & Stronger Communities SE/Missing Sub-group		Comms Sub-Group to roll out awareness campaigns within education. Update: Training delivered to the designated leads in schools within North Somerset. Update: TV adverts in different formats sent to different organisations in North Somerset.

Objective	By when	Lead	Outcome	Actions
	December '17			Update: A thunder clap has taken place on 8th May '17 to raise awareness around modern slavery. Update: Taxi drivers training has commenced. L&D sub-group to provide a report to December '17 Board on the evaluation of the taxi driver training to include impact and outcomes. Update: Presentation re SE to school safeguarding leads has taken place.
Identify learning and development needs across agencies and identify or commission training to address those needs	March '17 and on-going. December '17	Learning and Development Sub-group SE/Missing Coordinator		Update: Jan-March 2017 Train the trainer courses accessed to ensure current level of training can continue to be delivered. Update: Lunch and Learn sessions too place in September '16 re Sexual Exploitation Practice Guidance. L&D Sub-group to provide an update at December '17 Board on the evaluation of the SE training.
Be mindful and act on the links between missing children, vulnerabilities and exploitation, the 'missing children' priority will become incorporated into the focus of our SE Sub-group.	March '17 and on-going	SE/Missing Sub-group		Update: Monthly Multi-agency Missing meetings now take place. Partner agencies to provide the February '18 Executive with a brief on their respective workforce learning and development needs in relation to SE and Missing.

Objective	By when	Lead	Outcome	Actions
				SE/Missing Sub-group to provide the Board with any significant themes identified. At each Executive.
Develop a strategic response and identify emerging themes for children who go missing	December '17 December '17	SE/Missing Coordinator SE/Missing Sub-group P&P Sub-group	Missing Strategy and Action Plan	Update: SE Strategy signed-off by the Board June '16 and uploaded on the LSCB website. SE/Missing Sub-group to present a report to December '17 Board identifying emerging themes for children and young people who go missing.
Improve the coordination of information about children who are missing	June '16 (Achieved) March '18	SE/Missing Sub-group Police SE/Missing Coordinator Safer & Stronger Communities All agencies	Fortnightly 'Missing' multi-agency meeting to be held	Update: Multi-agency Missing meetings commenced April 2016. They are now held monthly to ensure full representation from all partner agencies. Return interviews to be completed. Monitor length of times taken to complete interviewed, to ensure contact is being made within 72 hours of being found. . SE/Missing sub-group to present to the December '17 Board a report that includes an analysis of timeliness of return interviews.
Priority 3 Sexual Exploitation/ Missing	June 2016	Quality Assurance Sub-Group	Audit complete	Update: Audit complete June 2016. Recommendations passed to Early Help, Learning and Development, CSE and Communication sub-groups

Objective	By when	Lead	Outcome	Actions
	March '18			March '18 Board to review the recommendations of the CSE audit. Each agency to participate.

Priority: Domestic Abuse
Outcome for children: Children in North Somerset who live in households where domestic abuse is a factor will be helped and protected

Objective	By when	Lead	Outcome	Actions
Set up a Task and finish group to: • Review current governance arrangements for Domestic Abuse to ensure they are adequate to significantly influence decisions for children Domestic Abuse Strategy in relation to safeguarding children and promoting welfare	December '17 March '18	Domestic Abuse Coordinator Domestic Abuse Task and Finish Group Principal Social Worker P&P Sub-group Domestic Abuse Coordinator MARAC Steering Group	Children who live in households where domestic abuse is a factor will be supported and protected by good quality practice This ensures a free flow of information at a strategic level. Assured that an effective Domestic Abuse Strategy is in place which safeguards children and young people in North Somerset.	Update: CCG and NSC co-commission the IRIS service which works with General practice to support victims and provide training to practice staff. Health agencies to participate in MARAC meetings. Update: Task and Finish Group – Service Leader Strategic Safeguarding & Quality Assurance, DA coordinator, Principal Social Worker, representative from education, representative from NS Community Partnership and Board Manager. Completed March '17. Update: strategy signed-off and uploaded to LSCB website. Each partner agency to provide the March '18 board with data around domestic abuse.

Objective	By when	Lead	Outcome	Actions
				Police to provide to March '18 Board data on call outs to domestic abuse incidents. Social Care to provide data on referrals relating to domestic abuse. March '18 Health to provide data on GP reports identifying domestic abuse. March '18
Review the current service offer to help children who either witness, are victims or are perpetrators of domestic abuse to ensure appropriate help is available – any identified unmet need to be fed into the Board to influence future commissioning decisions	September '18	Domestic Abuse Task and Finish Group Quality Assurance Sub-group Domestic Abuse Coordinator Safer & Stronger Communities	Children who live in households where domestic abuse is a factor will be well supported and protected through appropriate service provision	Partner agencies to provide a brief to June '18 Board on service provision for children and young people who live in households where domestic abuse features.
Implement a Multi-Agency Domestic Abuse and Safeguarding Children Policy that sets out the response expected from all agencies at differing levels of risk posed by domestic abuse.	March '17 March '18	Domestic Abuse Task and Finish Group Domestic Abuse Coordinator P&P Sub-group	Practitioners will understand the response expected for children where Domestic Abuse is a factor	Update: Domestic abuse strategy signed off and uploaded onto website. Partner agencies to provide a brief on the evaluation of practitioners' understanding around response to neglect. March '18 Board
Train staff and managers and cascade agreed risk assessment tool to all professionals so to aid a consistent understanding of how Domestic Abuse affects children.	January '17 (Achieved) March '18	Learning and Development Group Domestic Abuse Coordinator Comms Sub-group		Update: New course devised for January 2017 to meet this outcome and to improve safety planning. L&D Sub-group and DA Coordinator to provide update to March '18 Board.
The Training Officer will support the Domestic Abuse Coordinator in developing and	March '17 and on-going.	Learning and Development Sub-group		Update: Train the trainer course commissioned in November to deliver above course.

Objective	By when	Lead	Outcome	Actions
training staff to deliver domestic abuse training to support the roll out of the Strategy		Domestic Abuse Coordinator Principal Social Worker		L&D Sub-group and DA Coordinator to provide update to March ’18 Board.
NSSCB to ensure the workforce are skilled and equipped when identifying and working with families where domestic abuse is present by undertaking a training challenge event.	June ’17 and on-going.	Learning and Development Sub-group	The workforce will be skilled and equipped with identifying and working with families where domestic abuse features. Children and young people will be protected from domestic abuse.	L&D sub-group to present to December ‘17 Board an evaluation and impact of training. L&D Sub-group to provide June ’18 Board with evaluation of training.
Domestic Abuse Learning Event for NSSCB and NSSAB – ‘Think Family’	September ‘17	Learning and Development Sub-group Independent Chair		Update: Completed in October 2016. Think Family conference.
NSSCB will receive information and provide challenge in relation to the Strategy and evidence of impact in relation to improving outcomes for children and parents living with domestic abuse.	September ‘18	Domestic Abuse Coordinator Independent Chair		Partner agencies to present their respective data to the Board in Jun ‘18.
NSSCB will know the impact of the Domestic Abuse Strategy through robust performance reporting framework. NSSCB to develop an enhanced performance dataset to support NSSCB understanding of the prevalence and response to domestic abuse cases in North Somerset	December ‘18	Domestic Abuse Coordinator Quality Assurance Sub-group		To be reviewed at the February ’18 Executive. Board to agree format of Scorecard for reporting data. December ’17 Board..

Objective	By when	Lead	Outcome	Actions
				Update: Audit re DA completed March 2017. Findings presented to LSCB Executive members. Review of the recommendations of the audit at December '17 Board.

Priority: Governance, Quality Assurance and LSCB Scrutiny
We must challenge each other and seek evidence of the effectiveness of all that we do to keep children and young people safe in North Somerset
Outcome for children: Board business is coordinated and ensures the effectiveness of what is done by partner agencies.

Objective	By when	Accountability	Outcome	Actions
NSSCB Independent Chair should direct the work of the NSSCB and be effective in improving safeguarding services	March '17 and on-going.	Independent Chair	NSSCB has a multi-agency dataset that is both comprehensive and user-friendly, contributing to the Board's understanding of key safeguarding challenges. NSSCB has effective mechanisms for receiving analysis of data that enables NSSCB to; scrutinise, hypothesise, test, challenge and act to ensure delivery of more effective safeguarding services.	On the agenda at each Executive and Board meeting. Independent Chair to confirm dataset content at the December '17 Board.

Objective	By when	Accountability	Outcome	Actions
NSSCB Quality Assurance activity will direct the work of the NSSCB and be effective in improving safeguarding services	March '17 and on-going. December '17	Quality Assurance Sub-group Independent Chair All Board Members	Multi-agency Audit Forward Plan and thematic datasets are aligned, supporting the delivery of NSSCB priorities and highlighting deficit areas or weaknesses in existing systems and processes. Audits make recommendations for action leading to improvement LSCB has receipt, oversight and scrutiny of single agency child protection and safeguarding quality assurance activity. Learning and Improvement activity is embedded within services, single and multi-agency, across the partnership	Independent Chair to review recommendations of SE, Domestic Abuse and Early Help audits. December '17 Board. Neglect audit report to be feedback to Board in December '17.
NSSCB to improve the accessibility of safeguarding and child protection policies, procedures and expectations for working practices.	November '17 December '17	Independent Chair P&P Sub-group	Procedures are up to date, visible and accessible for frontline professionals and managers.	NSSCB's new website to go live November '17 Up-to-date P&P tracker sheet to be reviewed and monitored by the P&P Sub-group, Representative from the Disabled Children's Service to be co-opted into the P&P sub-group to ensure that all policies and procedures include the needs of disabled children. December '17
NSSCB will have a comprehensive understanding of key	On-going	Independent Chair	Development plans support an overarching analysis of key findings and lessons from NSSCB	Audit findings to be presented to Executive and Board.

Objective	By when	Accountability	Outcome	Actions
findings and lessons arising from audit and review and monitor agreed actions.		Quality Assurance Sub-group Board	activity. Agreed actions are monitored in terms of their • implementation • progress and • impact	Update: QA SE/Missing audit presented to July Executive and September Board. Independent Chair to lead a review of audit recommendations. December '17 Board.
NSSCB will build on its culture and confidence of self-challenge.	On-going	Independent Chair Board	NSSCB can demonstrate through its 'Challenge Log' cross agency challenge.	To be reviewed at each Executive. Independent Chair to update the Executive and Board any themes identified through the challenge log.
Develop a programme to review the learning and development needs of NSSCB members and systematically address these through annual appraisal	March '18	Independent Chair	Members of the Board are clear about their roles. Members are taking appropriate actions in their role on the NSSCB.	Independent Chair to plan a development session for Board Members. March '18 Update: Annual business planning event took place February '17. Independent Chair to review and refresh the Board's terms of reference.
Development sessions (as part of annual conference) to ensure that members are working together to scrutinise and challenge local arrangements for safeguarding children	March '17 March '18	Board	The Board is effective at challenging and scrutinising to protect and promote the welfare of children in North Somerset	Update: Annual business planning event took place February '17. Challenge workshop to be introduced as a follow-up to Section 11 findings and recommendations. March '18
Priority 5: Governance, Quality Assurance and scrutiny	December '17	Quality Assurance sub-group Board		Audit process to be agreed. Audit timetable to be agreed. New audit themes to be agreed at December '17 Board.
Safeguarding disabled children Review safeguarding procedures for disabled children	March '18	 Board		Representative from the Disabled Children's Service to be co-opted to P&P sub-group as above.

Objective	By when	Accountability	Outcome	Actions
Review LSCB safeguarding training course LSCB Audit of cases re disabled children Evaluate disability training – impact Ensure all revised procedures are uploaded to LSCB webpages		L&D Sub-group QA Sub-group L&D Sub-group		L&D Sub-group to provide a brief for the Board of their review of safeguarding training. March '18 Audit theme to be agreed at December '17 Board.

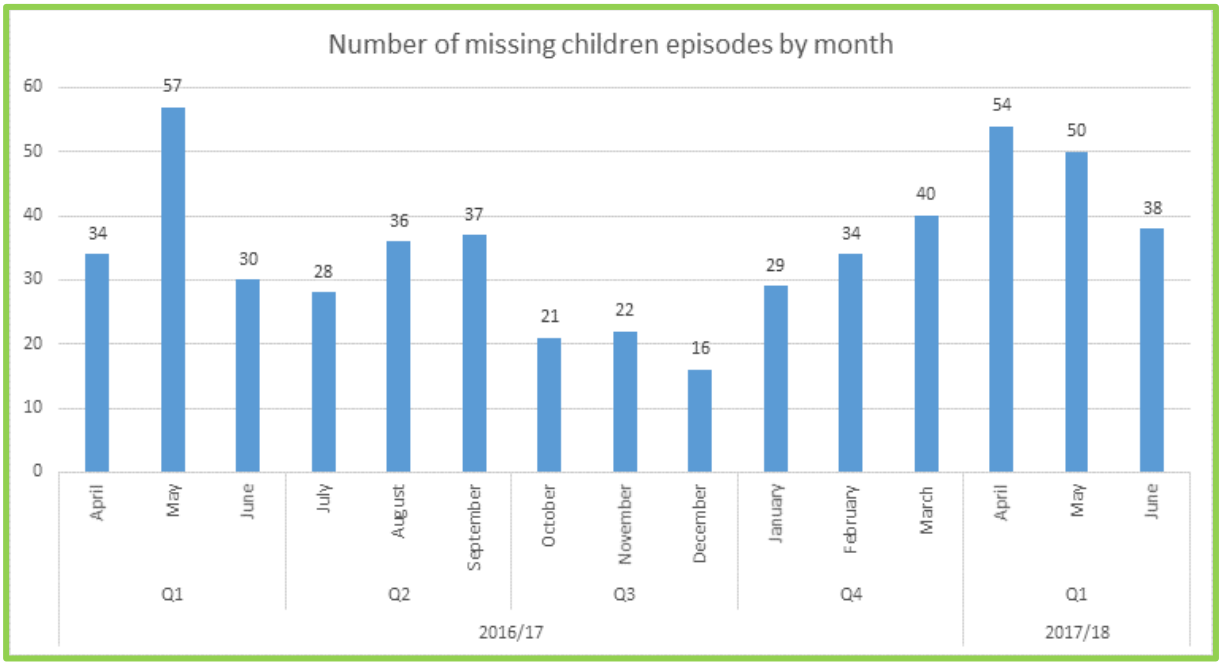
Appendix 2: Board Attendance chart

Organisation	Representative	June '16	Sep '16	Dec '16	March '17
Alliance	Andy Perry	A	√	√	No longer on Board
Avon Fire and Rescue (Correspondent Member only)	Mick Dixon/Neil Liddington	n/a	n/a	n/a	n/a
Avon & Somerset Police	Will White	√	√	Liz Hughes	Sarah Omell
AWP	Suzanne Howell	M. Dean	Jon Peyton	A	A
Barnados	Duncan Stanway	√	√	√	A
BGSW Probation	Peter Brandt	√	A	A	A
Border Force Agency	Jo Ware/Fiona Mcphail	A	A	A	√
CAFCASS	Victoria Penaliggon	A	√	√	A
Clevedon Academy	Rose Fox/Lee Dickinson	L. Dickinson	A	A	A
Clinical Commissioning Group	Jacqui Chidgey-Clark	A	Susan Masters	Susan Masters	A
Community Partnership	Mary Lewis	√	Jos Grimwood	Jos Grimwood	Jos Grimwood
Deputy Chair and Director of P&C (NSC)	Sheila Smith	√	√	√	√
Designated Doctor	Dr Richard Williams	√	√	√	√
Designated Nurse (CCG)	Susan Masters	√	√	√	A
Independent Chair	Tony Oliver	√	√	√	√

Organisation	Representative	June '16	Sep '16	Dec '16	March '17
Lay Member	Anna Curvan	√	√	√	A
Lay Member	Pam Pollard	√	√	Apols	Apols
Named Doctor	Dr Mike Pimm	√	√	A	A
Named Nurse for Child Protection (AWP)	Jon Peyton	√	√	A	A
Named Nurse for Child Protection (WAHT)	Lara Anderson/Judith Steele	√	√	A	√
Named Nurse Safeguarding Children (CP)	Jocelyn Grimwood	√		√	√
National Probation Service	Liz Spencer	√	√	Andy Harris	Andy Harris
NHS South South West	Nick Rudling	n/a	n/a	n/a	A
NSC: CSDAT	Jo Mercer	A	√	√	A
NSC: Learning & Development	Carolyn Hills	A	√	√	√
NSC: Principal Social worker	Shelley Caldwell		√	√	√
NSC: Safeguarding Quality Assurance	Jo Baker	√	A	A	√
NSC: Support & Safeguarding Adults	David Jones	√	√	A	√
NSC: Support & Safeguarding Children	Eifion Price	√	√	√	√
NSC: Youth Offending Team	Mike Rees/Howard Wilson	Howard Wilson	Howard Wilson	Howard Wilson	A
Participating Observer, Executive Member NSC	Cllr Colin Hall/ Cllr Jan Barber	A	√	√	√
Schools: St Francis Primary	Caroline Hostein	√	A	√	A

Organisation	Representative	June '16	Sep '16	Dec '16	March '17
Schools: Clevedon Academy	John Wells	√	√	A	A
Solicitor	Lorraine Sherman	A	√	√	√
South West Ambulance Service	Sarah Thompson	A	√	A	A
Sub Group: Communications	Anne Ray-Rowley	√	A	Anne Ray-Rowley	√
Sub Group: Early Help	Sadie Hall	√	A	A	√
Sub Group: Policy & Procedures	Jos Grimwood	√	√	√	√
Sub Group: SE/Missing (formerly CSE)	Ruth Sutherland	√	A	√	√
Sub Group: Training and Development	Carolyn Hills	A	√	√	√
Sub Group: Quality Assurance (formerly Monitoring and Evaluation)	Jackie Milton	√	A	A	√
Sub-Group: Young People	Sophia Tuplin/Lewis Smallwood	Lewis Smallwood	A	Shelley Caldwell	A
University Hospitals Bristol Foundation Trust	Sarah Winfield	√	A	A	√
VANS	Cara Macmahon/Paul Tompkins	Paul Tompkins	Paul Tompkins	Paul Tompkins	Paul Tompkins
Weston Area Health NHS Trust	Helen Richardson	Lara Anderson	Lara Anderson	A	Judith Steele
Young Person's Representative	Sophia Tuplin	A	A	Shelley Caldwell	A

Appendix 3 – Missing Children Episodes



Appendix 4 Barnardos

Number of young people who have had positive change in 5 or more objectives	Number of young people where there has been positive change in 3 or more objectives	Number of young people where that have had positive change in 1 or more objective
14	16	17

Number of young people who have not engaged with the service: 1

	Outcome	Number of YP where this is an identified need	Number of YP where there has been positive change	Number of YP where there has been no change	Number of YP where there has been negative change
Risk Indicators of CSE	Going missing	11	9	2	0
	Spending time with risky individuals	16	13	3	0
	Reduction in level of risk/harm	17	10	6	1
	Stable and secure accommodation	17	11	4	2

	Satisfactory school/college attendance	14	7	5	2
Knowledge and understanding of CSE	Improved carer's capacity to prevent abusive/harmful behaviours	17	8	4	5
	Increased knowledge of sexual health strategies	17	10	5	2
	Able to describe safety strategies	17	12	5	0
	Aware of own rights and those of others	17	13	3	1
	Able to identify abusive/exploitative behaviour	17	9	6	2
Health, Wellbeing and Safety	Improved mental health and wellbeing	17	10	6	1
	Increased ability to express feelings	17	11	5	1
	Reduced consumption of substance/alcohol	13	9	3	1
	Increased awareness and navigation of the legal system	17	8	5	2

Appendix 4 Barnardos

Good practice Case Study

We worked with a young person called M. BASE became involved with M in June 2016 following him being the victim of online grooming and child sexual exploitation.

When BASE first met M he was feeling very low, was not happy being educated in a specialist residential school (for children and young people with social, emotional and mental health needs), had a volatile relationship with his mother and was processing trying to make sense of the trauma he had experienced.

BASE used a relationship approach to build a positive, trusting working relationship with M and initially saw him every week. M moved to his father's and grandparent's house and was also moved schools back to mainstream.

BASE supported M around grooming and exploitation, safe disclosure, the criminal justice system, choice and control, self-esteem and future aspirations. M was able to identify and disclose to BASE during our work that someone was sending inappropriate messages and videos to him online which were then passed on to the police. M was also able to share this with his dad.

M has been able to talk about some of his needs and feelings at the time he was sexually exploited online and we have worked on increasing his self- esteem and feeling of belonging as they are very much protective factors for him. Dad and

grandparents are now monitoring his emotional wellbeing and supporting him with his ongoing needs.

M has started to rebuild the relationship with his mum and is taking this slowly and at his own pace. He has started to enjoy positive time with mum and siblings again.

M is completing his GCSE's this year, has made friends at school and has just applied for 2 college courses. I am now seeing M fortnightly and we are currently working towards closure.

Practice to be developed Case Study: *M is a 16 year old young person who has been supported by BASE since November 2015. When M was first referred it was due to concerns raised by her Dad that she was going out at night in cars with older males, drinking alcohol and using drugs. M had recently moved back to live with her Dad in North Somerset after living with her Mum in Wales for a short period where she reports she was allowed out at night and this was not challenged by her Mum. M has moved between her Mum and Dad's care regularly throughout her teenage years and has been excluded from multiple schools so has not had consistent parenting or education.*

M was initially reluctant to work with BASE as she felt that she was not at risk of CSE, however did agree to meet with me on some occasions. I used a relationship based approach to get to know M gradually and try to build a safe relationship and we were able to spend some sessions looking at healthy relationships, grooming, CSE and sexual health. M partook in this work at times, however told me that she was not at risk and these concerns did not apply to her. During our work however, M began to go missing more regularly, her school attendance was sporadic, concerns about her drug use was escalating and M did disclose some occasions where she felt unsafe or out of control when in the company of older males. M was able to recognise this as abuse, but felt that she would be able to prevent this the next time. M also showed signs of her mental health deteriorating and she struggled with anxiety and panic attacks.

With agreement from M and her Dad, I made a referral to social care for M, and this led to M being allocated a social worker. M was then also re-referred to CAMHS for support with her mental health and to the young person's drug service to support her to reduce and safely manage her drug and alcohol use. M did attend many of these appointments and Dad reported seeing some change in M's behaviour and recognition of dangers, however there was also a lack of consistency for the family as M had three different social workers in a year and these changes happened quickly and without time for any of the social workers to have an ending and handover to the new social worker with M.

Due to heightening concerns, an ICPC was held and it was the agreement of professionals that M should be made subject to safeguarding under the category of sexual abuse through CSE. Actions were agreed with regards to disrupting perpetrators and recommendations were made for Abduction Notices to be served in March, however after following this up with social care and the police regularly, it transpired that this had not been done and led to escalation from BASE's Children's Service Manager in April before this was achieved.

As M was becoming increasing isolated from school and sanctions were being implemented, M's Mum suggested that M move back to Wales and she would home school her. M agreed with this and Mum contacted M's school to inform them that

she would be withdrawing M with immediate effect. M then informed her Dad of the plan and moved out that week.

Following M's move to Wales, Social Care advised that they would be transferring the case to Monmouthshire Social Care and informed BASE that they had requested a transfer in meeting, due to her being on a Child Protection Plan, and BASE would be invited to this. After a period of no contact I followed this up with North Somerset Social Care and was informed that the plan had been ended by post as Monmouthshire had not accepted the meeting and the review Child Protection Conference was out of timescales for North Somerset. Following this, Monmouthshire accepted the case as a Child in Need case and advised they would visit the family. In a following conversation with M's Dad it appeared that he was not aware that the plan had been ended.

In the 4½ months M has been living in Wales she has not received any support from mental health services or drug and alcohol services and I believe has been visited by a social worker once. M has also reported that she is signed off sick due to a private therapist diagnosing her with anxiety and depression, so Mum is not providing any education to M and has not entered her for any of her exams. I have tried to support M whilst in Wales, however she has cancelled the majority of our visits, and Mum has not been willing to support these as she reports being busy with her work. I have been in regular contact with Social Care in Monmouthshire through telephone calls and email to inform them of my concerns that she is still at high risk of CSE, information from Dad that she is going out with older males at night, and not receiving any education however have not had a response from her current social worker. Following a recent conversation with M's Dad he informed me that the social worker told him that M's Mum told them that M is now living in North Somerset again so no longer had an open case with them. This is currently being questioned by BASE as to who should be supporting M to ensure she does not become hidden from professionals.

This case highlights the need for good communication between agencies to ensure actions are carried out, the challenges for families when they have a high turnover of workers and shows a clear breakdown in support when a young person moved authorities and safeguarding plans and support were not continued.

BASE were commissioned to do 2 things:
1. *Deliver support to victims of CSE.*
2. *Train the workforce on CSE so the response improves.*

We worked with 17 children and trained 170 professionals, 17 of whom we trained in Train the Trainer CSE. The other courses were Working with Parents and CSE; Working with CSE: Skills and Practice; and Raising Awareness of CSE.

Impact Data:

	Outcome	Number of YP where this is an identified need	Number of YP where there has been positive change	Number of YP where there has been no change	Number of YP where there has been negative change
Risk Indicators of CSE	Going missing	**11**	**9**	**2**	**0**
	Spending time with risky individuals	**16**	**13**	**3**	**0**
	Reduction in level of risk/harm	**17**	**10**	**6**	**1**
	Stable and secure accommodation	**17**	**11**	**4**	**2**
	Satisfactory school/college attendance	**14**	**7**	**5**	**2**
Knowledge and understanding of CSE	Improved carer's capacity to prevent abusive/harmful behaviours	**17**	**8**	**4**	**5**
	Increased knowledge of sexual health strategies	**17**	**10**	**5**	**2**
	Able to describe safety strategies	**17**	**12**	**5**	**0**
	Aware of own rights and those of others	**17**	**13**	**3**	**1**
	Able to identify abusive/exploitative behaviour	**17**	**9**	**6**	**2**
Health, Wellbeing and Safety	Improved mental health and wellbeing	**17**	**10**	**6**	**1**
	Increased ability to express feelings	**17**	**11**	**5**	**1**
	Reduced consumption of substance/alcohol	**13**	**9**	**3**	**1**
	Increased awareness and navigation of the legal system	**17**	**8**	**5**	**2**

Number of young people who have had positive change in 5 or more objectives	Number of young people where there has been positive change in 3 or more objectives	Number of young people where that have had positive change in 1 or more objective
14	**16**	**17**

Number of young people who have not engaged with the service: 1

Appendix 5 - CAFCASS

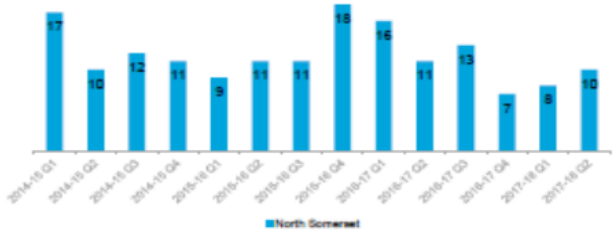
Summary of North Somerset LA Performance
Apr-17 - Sep-17

Please note that the latest quarter showing will be the last **complete** quarter.

Public Law

North Somerset Local Authority made 18 Care (s31) Applications between Apr-17 and Sep-17. This represented a -33% decrease from the previous year (-9 cases). Nationally, there was a -4% decrease (-329 cases) in in Care (s31) Applications in the same period.

Public Law Care Demand (North Somerset LA)



	2016-17				2017-18				YTD	
	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4	#	%
LA	16	11	13	7	8	10	-	-	-9	-33%
National	3,670	3,801	3,542	3,583	3,563	3,579	-	-	-329	-4%

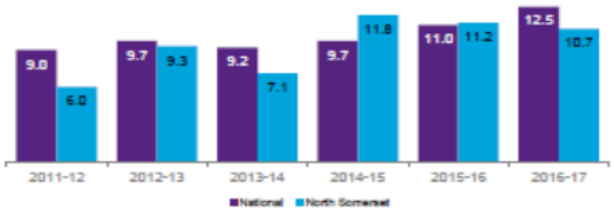
s31 Application duration for North Somerset LA was 37 weeks in 2017-18 Q2, longer than (4 weeks) in 2017-18 Q1. Nationally, the average duration was 31 weeks in 2017-18 Q2 shorter than (-1 weeks) the previous quarter.
This data is refreshed on a monthly basis and may differ from durations as noted in the Cafcass Heat Maps.

North Somerset LA Care (s31) Duration Data

	2016-17				2017-18			
	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
LA	20	27	27	37	33	37		
National	30	29	29	31	31	31		

In North Somerset, the rate of care applications per 10,000 children was 10.7 in 2016-17. This was a decrease on the previous year. The rate in North Somerset is lower than the national rate of 12.5 for 2016-17.

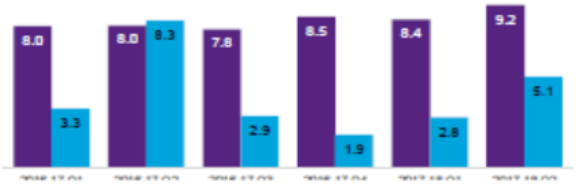
Care Applications per 10,000 Children (North Somerset LA v. National Average)



	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
LA	6	9.3	7.1	11.8	11.2	10.7
National	9	9.7	9.2	9.7	11	12.5

In the latest quarter (2017-18 Q2) a total of 103 Child referral checks were returned by North Somerset LA. On average, they were returned to Cafcass within 5.1 working days. Nationally, checks were returned in 9.2 working days on average.

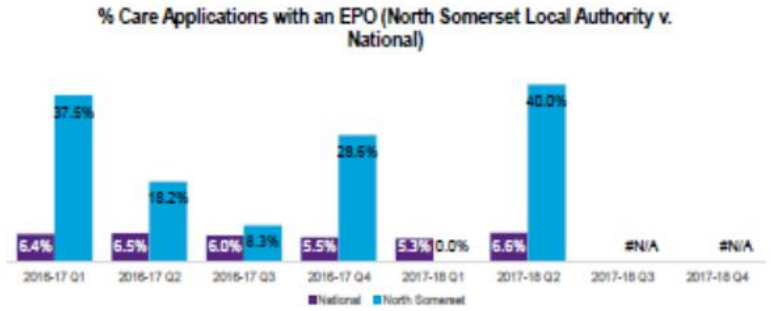
Average Working Days to Return Child Referral Checks (North Somerset LA v. National Average)



Total number of Child Referral Checks Returned (North Somerset LA)

	2016-17				2017-18			
	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
LA	3.3	8.3	2.9	1.9	2.8			
National	8.0	8.0	7.8	8.5	8.4			

In North Somerset, 40% of Care Applications have an EPO on them in the latest quarter (2017-18 Q2), for the same period Nationally, it was 6.6%.



	2016-17				2017-18			
	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	2017-18 Q1	2017-18 Q2	2017-18 Q3	2017-18 Q4
LA	37.5%	18.2%	8.3%	28.6%	0.0%	40.0%		
National	6.4%	6.5%	6.0%	5.5%	5.3%	6.6%		

DfE Data

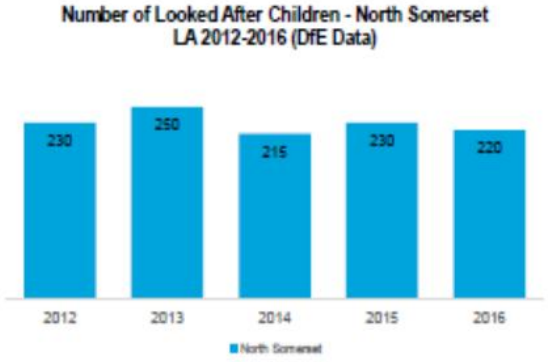
DfE makes annual data public in the September of each year, the below data is taken from publicly available information and has been aggregated to provide additional insight into the Local Authority in which you have inquired. More information on the calculation method(s) can be found on the DfE Statistics Website.

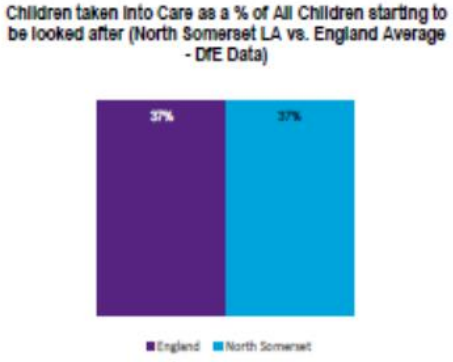
DfE data shows that in North Somerset LA there were 220 Looked After Children in 2016 this is a decrease on the figure published for the previous year of -4.3%. Nationally there was an increase of 1.4%.

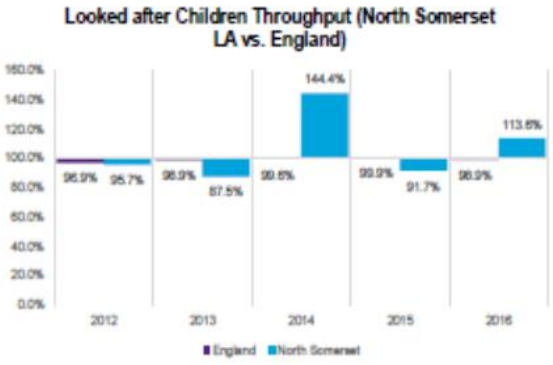
In 2016, 37% of children (as a % of looked after children) were taken into Care in North Somerset; The average for all of England was 37%.

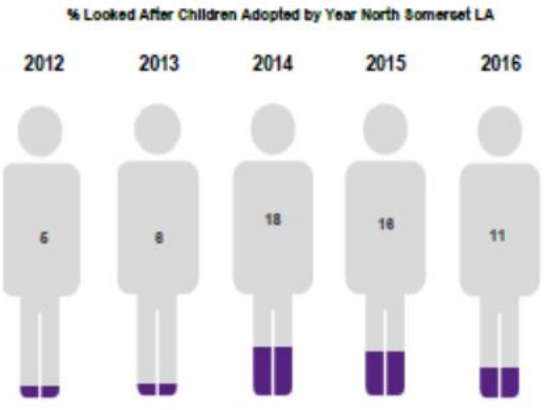
Throughput of children being looked after in North Somerset (children who ceased to be looked after, divided by children who started to be looked after in the year) was at 113.6%, for England, this figure was 98.9%.

As a percentage of all Looked after Children, 11% were adopted in North Somerset LA in 2016. The rate for the same period in England was 17%.









Appendix 6: NSSCB Performance Management Framework

The document North Somerset Safeguarding Children's Board Data Pack 2016/17 details the activity during this period. This can be downloaded from the LSCB website on the Annual Report section: **Other Partner Organisations Annual Reports: NSCCB Analysis.**

http://northsomersetlscb.org.uk.mediatopiaprojects.co.uk/children-safeguarding-board/safeguarding-children-board/annual-report-and-business-plan