Somerset Local Safeguarding Children Board

Annual Report 2013 – 2014

www.somersetlscb.org.uk

Foreword

This is the second annual report to be published since I was appointed as Independent Chair of Somerset Local Safeguarding Children Board (LSCB) in September 2012. It provides an assessment of the performance and effectiveness of local services in safeguarding and promoting the welfare of children in Somerset during 2013-2014, as well as giving an account of the activities, development and impact of the Board in meeting its statutory responsibilities. It sets out the areas in which the Board and its partners are facing particular challenges and identifies areas of weakness, the causes of those weaknesses and the action being taken to address them, as well as other proposals for action. The report includes lessons from inspections, audits and reviews undertaken within the reporting period and sets out priorities for the coming year. It is intended to be read by both professionals and members of the public.

As is usual in the world of safeguarding, the period has been characterised by significant changes to the political, strategic and operational context in which the LSCB operates, both within and beyond Somerset. What has remained consistent over the past year is the determination of all who are engaged with Somerset LSCB to make a positive difference; to continue to learn, develop and fulfil their responsibilities to the highest standard. Partner organisations have shown commitment and consistency in their contributions to the Board's work, as well as in their day to day delivery of safeguarding services.

What does not change is the need always to listen to what children and young people have to tell us about what is important to them, and the commitment and dedication of the children's workforce to their tremendously challenging task of safeguarding and promoting the welfare of children and young people.

Sally Halls
Independent Chair

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1 Introduction

1.1 This is the annual report and business plan for the Somerset Local Safeguarding Children Board. It covers the reporting period between April 2013 and March 2014 and evaluates the work and impact of the Board related to the identified priority areas of work for the period 2013 – 2015.

1.2 The Chair is required to publish an annual report; this is set out in statute and is most recently described in *Working Together to Safeguard Children* (2013).

1.3 The report has been authored by Sally Halls, Independent Chair with support from Matthew Turner, Service Manager – Safeguarding, who is the LSCB business manager.

1.4 It was presented in final version to the full Board in October 2014 and subsequently to the Chief Executive of the local authority, the Leader of the Council, the local Police and Crime Commissioner (PCC) and the chair of the Health and Wellbeing Board. It will also be presented to the Somerset Children's Trust.

1.5 The annual report is published on the LSCB website – www.somersetlscb.org.uk – and is disseminated to partner organisations electronically. Paper copies are not made available.

1.6 Any questions relating to the content, publication, sources or accessibility of the report should be addressed to:

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2 Executive Summary

2.1 The Local Safeguarding Children Board is a well-established multi-agency partnership working across Somerset. Section 14 of the Children Act 2004 sets out the statutory objectives of the Board: these are to coordinate what is done by the organisations represented on the Board for the purposes of safeguarding and promoting the welfare of children living in the area and to ensure the effectiveness of these arrangements.

2.2 The local context of child protection and safeguarding work is described in detail within this report. It considers the work of the LSCB in the widest organisational context and, more specifically, the work and impact of the subgroups in monitoring and challenging effectiveness whilst driving forward improvement in services, leading to better outcomes for children.

2.3 Governance and accountability arrangements for the Board are explained, attendance of partners at meetings is detailed, activity is described and there is evaluative commentary included in order to understand what difference the work and influence of the LSCB has made to outcomes for children and young people who are living in Somerset.

2.4 During the period covered by this report, there has been significant external challenge to the work of Somerset County Council and the LSCB in the form of the Ofsted inspection of the local authority arrangements for the protection of children, carried out in June and July 2013. The judgement of the inspection was that the overall effectiveness of the arrangements to protect children by Somerset County Council was inadequate. Led by the independent chair, the issues raised in this inspection, and the ensuing Improvement Notice, in addition to ongoing usual business, have led to significant activity within the LSCB in order to continue to develop and improve accountability and effectiveness. There have been further practical and structural changes as well, continuing to drive forward cultural change in order to make partners far more accountable for their actions, their role as agency representatives and as contributors to subgroups. Within Board meetings, the role of the LSCB has been made more explicit, with the development of a culture of positive challenge based around calling partners to account for their child protection and safeguarding activity and the provision of exception and assurance reports where required by the Board.

2.5 The LSCB carries out a range of review and audit work in order to assess the quality and effectiveness of safeguarding arrangements. All of these give rise to specific opportunities for learning about what best practice looks like within the multi and single agency context. A Serious Case Review was initiated in early 2014, reporting in May 2014 and there is learning arising from that work which is described in this report.

2.6 The performance and effectiveness of local services are described, challenged and assessed, noting areas which need improving and the action being taken to address them, together with other proposals for action. Progress with priorities is assessed.

2.7 In 2012, the LSCB identified a number of priority areas of work for the coming three year work plan cycle. They have been agreed by partners and are in addition to all aspects of core business that are the responsibility of the Board:

1) Strengthening core child protection activity

2) Early help, including child and adolescent mental health services

3) Safeguarding vulnerable adolescents

2.8 The LSCB also identified the following over-arching themes which support the effectiveness and quality of the child protection and safeguarding system:

- The child's voice – engagement and participation
- Effective training and supervision
- Cross agency working and information sharing
- Communication (including development of the LSCB website)

2.9 These are significant pieces of inter-related work that can only be achieved through the combined efforts of the LSCB partnership. The effectiveness of this work is potentially affected by complex re-organisational issues and changes in management and staffing.

3 Children in Somerset

3.1 Somerset is a large, mainly rural, county with an area of 3,452 square kilometres. The total population is approximately 535,000 people (amounting to 10% of the population of the south west region) and of these 108,609 (– about 20%) are children aged 0 to 17 years old (source ONS 2012 mid-year population estimates). The majority of people live in the main urban areas centred on the towns of Taunton, Bridgwater, Frome, Glastonbury and Yeovil. Somerset is considered to be the third most rural county in England, which presents particular challenges in terms of infrastructure, including in the context of safeguarding and child protection.

3.2 Somerset's population is predominantly of a white British ethnic origin although there are significant numbers of people from other ethnic groups, particularly from East European countries and Portugal. There are an estimated 733 Gypsy or Irish Traveller residents in Somerset, the second highest number of any local authority in the South West; just over a third are resident in Mendip. Overall, in 2011 the black and ethnic minority (BME) population of the county was estimated at 11,450 - approximately 2% of the total population. (Source – 2011 Census)

3.3 Deprivation levels remain relatively low. More recent figures are not yet available, but in 2010 there were estimated to be 14.9% of children living in poverty in Somerset. Whilst this is a reduction of 0.7% from the previous year, this still equates to one in every six children aged under 16. The national average for England is 21.1%

3.4 The number of children with a child protection plan has risen significantly. At the end of March 2014, there were 412 (317 in the previous year) children with child protection plans from 203 families (155) living in the county. This is approximately 37.9 (30) per 10,000 which is the same as the national rate for 2012/13. There were also 24 (25) children with a child protection plan from 19 (20) families who were temporarily living in Somerset at some time during the year. The duration of these stays varies greatly, from a few nights to a more protracted period.

3.5 Within this reporting period, 1.8% (1.4%) of child protection plans lasted for two years or more, with most lasting between six and twelve months. The figure of 1.4% at the time of the previous report followed a significant increase to 5.7% in the preceding year and so this represents a continued decrease compared with the national average for 2012-13 of 5.2%.

3.6 The majority of child protection plans (42.4%) that ended during the year lasted between six and twelve months. At the end of March 2014, in Somerset, children were subject of child protection plans for the following reasons:

- Emotional – 39.6% (48.4%)
- Neglect – 30.1% (28.6%)
- Physical – 5.1% (4.1%)
- Sexual – 4.4% (1.3%)
- Multiple – 20.8% (17.8%)

3.7 At the end of March 2014 there were 493 children in care, compared with 513 in the previous reporting period – a rate of 45.4 per 10,000 children compared with a 2012-13 national rate of 60. After a number of years of steady and continual rise in this figure, the population of children in care now appears to be levelling off.

3.8 Of particular significance for Somerset is the number of children in care placed in independent sector placements within Somerset by other local authorities. As of March 2014, there were 215 (179) such placements recorded. Whilst there is a requirement for the receiving local authority to be notified when such placements are made, it is recognised nationally as well as locally that this does not happen consistently. These children are likely to be the most complex and challenging to look after and this has an impact on all services for children within Somerset.

3.9 There were 15 (9) children notified during the year as being privately fostered. At the end of March 2014, there are three children known to be placed in private fostering arrangements. It is likely that there is significant under-reporting of this vulnerable group of children, some of whom may be attending one of the many independent schools in Somerset which provide day and boarding places for children who are normally resident both within and outside Somerset. It is not possible to ascertain this without approaching each school and asking. This has not been done to date.

3.10 As of March 2014, there were 242 (238) fostering households approved by Somerset County Council, providing approximately 373 (373) beds across all approval categories; four (five) local authority residential children's homes offering 15 (21) beds; plus three homes designed for children with disabilities, which provide long term and respite placements. Of Somerset children in care, 168 (139) were placed with independent providers (both fostering and residential placements), some within the county boundary and others outside.

3.11 In the year between April 2013 and March 2014, 53 (40) children were given permanence either in adoptive placements - 44 (30), or through Special Guardianship Orders – 9 (10).

4 The Local Safeguarding Children Board (LSCB)

4.1 The purpose and objectives of the LSCB are:

a) to coordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area; and
b) to ensure the effectiveness of what is done by each such person or body for those purposes.

4.2 Associated functions are set out in more detail in regulations. They include:

(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority;
(b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) Participating in the planning of services for children in the area of the authority; and
(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. This includes Serious Case Reviews (SCRs) and the Child Death Review process.

4.3 The role of the LSCB is to hold agencies to account by making clear where improvement is needed, whilst not being directly accountable for the operational work of partners nor having the power to direct other organisations. Each Board partner retains their own existing line of accountability for safeguarding.

4.4 Membership of the LSCB is prescribed, together with arrangements for governance and resourcing. LSCB members are senior managers who are able to:

- Speak for their agency;
- Hold their agency to account and challenge its practice;
- Make decisions about safeguarding as required and allocate resources;
- Ensure that safeguarding is given strategic priority within their own agency.

4.5 This is set out in detail in Chapter 3 of *Working Together to Safeguard Children* (HM Government, March 2013). More detail about Somerset's arrangements, including governance and accountability, membership and attendance, and funding are described in Appendix 4.

4.6 The 2013-14 LSCB core budget was £228k. A breakdown of this, showing contributors and expenditure, is included as Appendix 3.

4.7 In order to meet its objectives, the LSCB uses data and carries out a range of activities which includes:

- assessing the effectiveness of the help being provided to children and families, including early help;
- assessing whether LSCB partners are fulfilling their statutory obligations;
- quality assuring practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitoring and evaluating the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

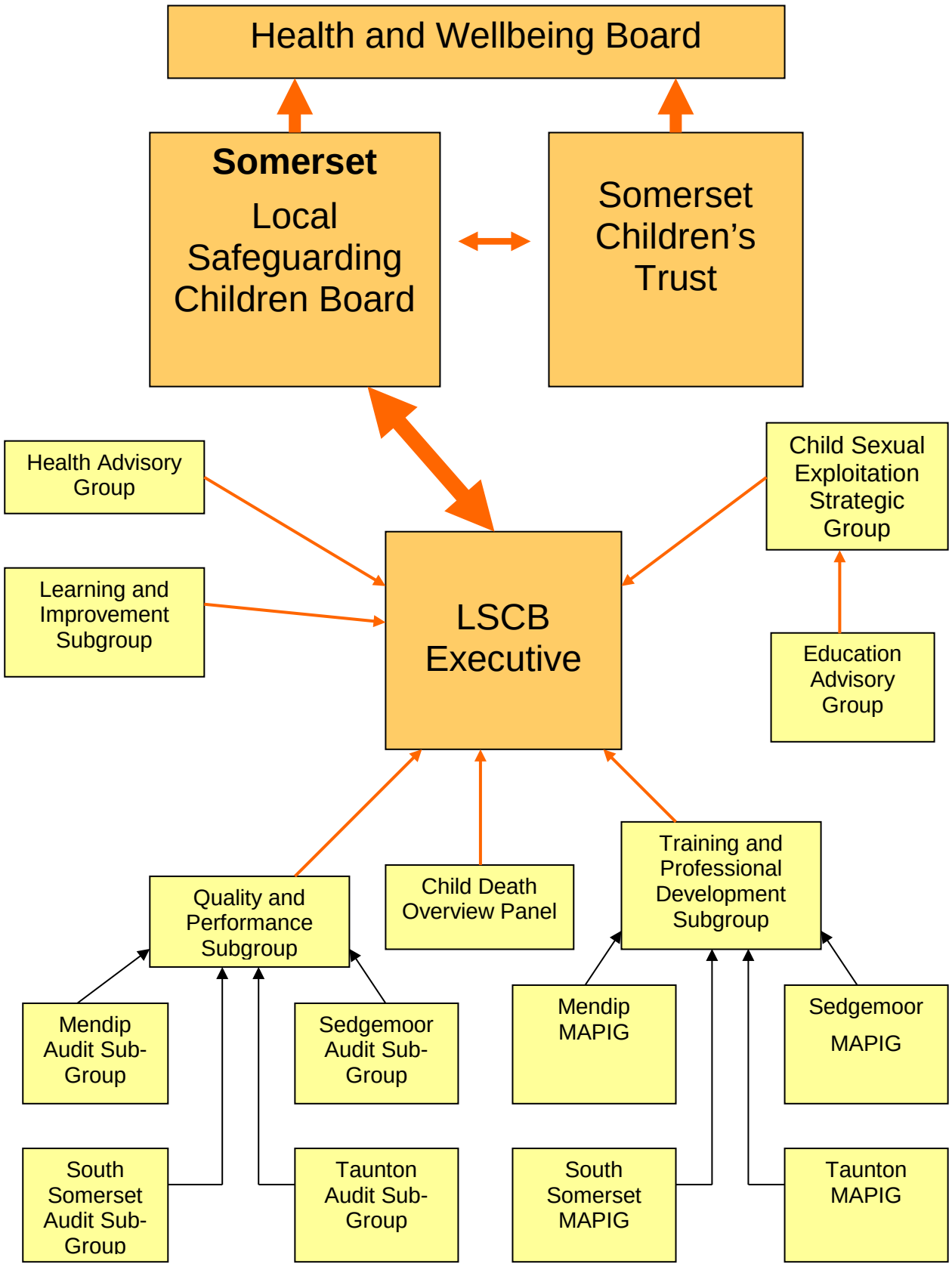
4.8 Much of the work of the LSCB is conducted through subgroups, and by its central support team. The Executive Group has the responsibility of monitoring and co-ordinating the work of the LSCB, agreeing and overseeing the strategic plan, and driving forward improvements in multi-agency safeguarding practice. Task and finish groups are convened as required in order to carry out specific pieces of work. These groups are well supported by LSCB members. Summaries of the work of the subgroups are in Appendix 5.

4.9 Assurance from partners about the appropriateness of safeguarding arrangements is sought and provided through annual reporting and other measures. This includes information about training, service accessibility and any information relating to external inspection and regulation. This allows the LSCB to challenge the arrangements, identify areas for improvement, monitor that work and then seek further assurance about sustained change.

4.10 The diagram on the following page shows the relationship between the LSCB, the Executive, the subgroups and the Children's Trust.

Somerset Local Safeguarding Children Board

Structure chart – 2013/14



5 The LSCB business plan 2013-14: progress

5.1 The LSCB set out its intentions for 2013-14 in a business plan which was published together with last year's annual report. The plan set out a number of areas of activity which were agreed following assessment of the effectiveness of the Board and its partners, and reflecting areas of weakness and challenge set out in last year's LSCB annual report. These were reviewed following publication of revised statutory guidance (*Working Together to Safeguard Children)* in March 2013. A risk register (Appendix 2) was developed to sit alongside the plan.

5.2 The business plan falls into two main sections:

i. Priority areas for improvement in services to and outcomes for children;

ii. Developing and strengthening the LSCB.

5.3 Priority areas for improvement in services to and outcomes for children

5.3.1 In the previous year (2012-13) LSCB members reviewed data and other information (including outcomes of inspections and other assessments) and determined three priority areas in which individual services and multi-agency working needed to be improved. These were reviewed and confirmed for 2013-14 and incorporated into the business plan:

1) Strengthening child protection practice and processes

2) Early intervention

3) Safeguarding vulnerable adolescents

5.3.2 A number of cross-cutting themes, which support the effectiveness and quality of the safeguarding system, were also identified as areas for additional work:

- The child's voice – promoting the engagement and participation of children and young people across partners, and with the LSCB and its work;
- Improving the quality and impact of multi-agency training and supervision;
- Promoting partnership working and information sharing;
- Improving communication about the LSCB and its work (including development of the LSCB website).

These themes are also reflected in the LSCB's Strategic Plan for 2014-17, which is included as Appendix 1.

5.4 Strengthening child protection practice and processes

5.4.1 This priority was chosen because the work of the Council's Children's Services had been assessed by Ofsted as inadequate, and children and young people were not being systematically protected from harm. Although Ofsted had focused on Children's Services, partners accepted that the poor result had implications also for multi-agency services.

5.4.2 LSCB members included the following within the scope of this area of work:

- Encouraging the co-location of services to improve the response to concerns about children;
- Improving engagement and participation of all agencies;
- Auditing practice in order to monitor and assess effectiveness of multi-agency strategy discussions and meetings;
- Ensuring appropriate application of the LSCB escalation process;
- Conducting QA activity of child protection practice and basic performance, using benchmarking from other authorities.

What has been done?

5.4.3 The South West Child Protection Procedures have been re-launched with improved accessibility and search functions to ensure that they are fit for purpose. There is work in hand to retender for the provision of regional on-line procedures.

5.4.4 Progress is being made towards establishing a Multi-agency safeguarding hub (MASH) in Somerset, with good cooperation evident between police, health and children's social care.

5.4.5 In response to a more consistent approach to assessment, the number of children who are the subject of a child protection plan has increased from 310 in 2012-13 to 412 in 2013-14. This brings the rate per 10,000 children from well below to slightly above the average rate amongst Somerset's 'statistical neighbours'.

5.4.6 Two large scale audits have been carried out following the Ofsted inspection, the outcomes of which were reported to and scrutinised by the LSCB and the Children's Improvement Board (CIB).

5.4.7 Reporting in December 2013, the first (independent) audit focused on more than 500 'Children in Need' cases held by Children's Social Care. These included cases held by the Disabled Children Team. The quality of work in approximately 12% was graded as Good or Outstanding, 58% as Adequate and 30% as Inadequate (or received no grading). The audit summarised the "direction of travel" as positive overall.

5.4.8 The second was led by Children's Social Care and looked at more than 450 child protection cases. Of these, approximately 13% were rated as Good or Outstanding, 42% were considered to be Adequate, and 43% were graded as Inadequate or were "ungraded". A number of recommendations for improvement were made.

5.4.9 More details of both audits are given in the section on Children's Social Care.

5.4.10 Ensuring regular and timely visiting to children who are the subject of child protection plans has received a great deal of attention. From an unacceptably low baseline, over recent months the percentage of visits taking place on time has generally been in excess of 90%. The service now has to focus more on ensuring that work carried out is of consistently high quality and results in improved outcomes for children.

5.4.11 The number of children who are subject of a child protection plan for a second or subsequent time has increased over the past year, suggesting that attention needs to be paid to 'step down' arrangements, ensuring that good plans are in place to continue to keep children safe once risk has diminished sufficiently to discharge a child protection plan.

5.4.12 Challenge to all partners about the importance of multi-agency pre-birth planning to ensure timely assessment of risk has led to improving multi-agency work with this vulnerable group, which will be further enhanced once the learning from the current serious case review has been incorporated into training and practice.

5.4.13 The LSCB continues to receive regular assurance and progress updates from Somerset County Council on progress in these areas, challenging the focus and pace of improvement as and when required. This has included scrutiny of the implementation of a number of closely related initiatives: the major reorganisation of the service; the development of an Early Help offer and the Common Assessment Framework; the threshold document indicating "step up" and "step down" arrangements; and the introduction of the Signs of Safety approach to child protection work.

5.4.14 Meanwhile, improved monitoring arrangements are being put into place to demonstrate more accurately the contribution of partners to core child protection processes. Audit activity carried out by the LSCB shows a number of areas where work is still required. These include:

- More active discussion and challenge at case conferences;
- Improving the quality of multi-agency child protection plans, including reassessing risk as required;
- Improving the contribution and/or attendance of GPs at case conferences;
- Ensuring consistency by the Police in carrying out PND checks to inform strategy discussions;
- Ensuring the availability, consistency and quality of safeguarding supervision across agencies.

What difference has been made?

5.4.15 There is an improving picture of quality and consistency, although this remains slow.

5.4.16 Across the partnership, there is still work to be done to demonstrate that the voice of the child has been sought, heard and responded to; and to be able to demonstrate more clearly the impact of safeguarding activity on outcomes for the child.

5.4.17 There is accessible, informed and consistent advice relating to safeguarding and child protection available to all organisations in Somerset, especially universal services including education settings. This is provided by a range of staff including the Service Manager – Safeguarding, the Safeguarding Education Advisor, and the LADO. The Child

Safe organisation, managed within the LSCB team, provides safeguarding advice, guidance and support to small community and voluntary groups, and assurance to parents.

5.4.18 The importance of multi-agency co-operation and understanding of roles, responsibilities and principles in child protection and safeguarding across all partner agencies has been reinforced through single and multi-agency training and other LSCB events, including the Annual Practitioners' Conference. This is evidenced through training attendance and course evaluation which will be further strengthened by gathering longitudinal evaluation regarding the impact on practice, including feedback from managers of delegates.

5.5 Early intervention

5.5.1 This priority was chosen as there was no strategy in place for ensuring families receive early help, services for families were poorly co-ordinated and multi-agency working was under-developed.

5.5.2 LSCB members included the following within the scope of this area of work:

- Promoting the development and implementation of an early help strategy for Somerset;
- Developing and publishing a threshold document to clarify and simplify access to a range of targeted and specialist services assisting staff across agencies to understand how systems work below and above the child protection threshold;
- Monitoring the use across agencies of the Common Assessment Framework (CAF), ensuring it is fit for purpose, and results in timely and effective help for children and their families;

- Integrating the Think Family and Troubled Families initiatives.

What has been done?

5.5.3 Led by Children's Social Care, partners have been engaged in:

- Revising the 'threshold document' to clarify access to services through from universal and early help to targeted and specialist services;
- Revising and re-launching the Common Assessment Framework (CAF) as the key means of assessing whether a child and family are in need of a multi-agency service;
- Developing an Early Help Strategy (available via the LSCB website);
- Reviewing and developing a range of early help provision, including Children's Centres, to ensure their availability and accessibility across the county;
- Engaging District Councils, who lead the work on Troubled Families, in order to improve alignment of services;
- Training a significant proportion of the children's workforce in the 'Signs of Safety' approach, with the aim of improving consistency of approach and language across agencies, and enhancing the engagement of parents and carers;

- Development of a single information sharing protocol to encompass all aspects of multi-agency working (Whilst developed as part of the work on early help, following challenge by the LSCB this is being developed to incorporate all multi-agency work relating to safeguarding, and will provide an update of the previous protocol).

What difference has been made?

5.5.4 This area remains under development, and there is too little evidence of impact as yet. Contacts have continued to increase, and the numbers of CAFs completed remain low, demonstrating poor partner engagement overall. However, a more robust and consistent response by the First Response Team has resulted in a recent reduction of referrals to Children's Social Care. The corresponding rise in re-referrals, however, to a rate higher than Somerset's comparators, suggests that the threshold is still not widely understood and consistently applied. Audit activity is planned to identify why the rate is increasing and what needs to be put in place to reverse this trend.

5.6 Safeguarding vulnerable adolescents

5.6.1 This priority was chosen in recognition that some young people in Somerset were not receiving the help and support they required; too many were missing from home or care and education; and outcomes for some young people who had left care were not good enough. This included the significant number of young people who had been placed in Somerset by other local authorities. This priority also incorporated the developing recognition nationally and locally of sexual exploitation of children, and the risks associated with the internet.

5.6.1 LSCB members included the following within the scope of this area of work:

- Completion of the review of care leaver services and applying lessons learned;
- Conducting action research into the issues of children and young people who go missing from home and care and those who are vulnerable to Child Sexual Exploitation (CSE) in order to inform development and delivery of services;
- Ensuring work links all relevant areas of risk into a cohesive plan leading to a reduction in incidence and a rise in prosecution of adult offenders;
- On-line child protection.

What has been done?

5.6.3 In the autumn of 2011, the LSCB signed up to support the Barnardo's campaign "Cut them free" which was about raising awareness of CSE. In autumn 2012 the LSCB began working directly with Barnardo's and the BASE project in Bristol to bring CSE more centrally into the 'Safeguarding Adolescents' work. This included further awareness raising and information sharing/scoping work across partners carried out by the Children's Society, working in conjunction with Barnardo's.

5.6.4 In January 2013, information was disseminated through the Safer Somerset partnership into District Councils about CSE and the role that the "hospitality, tourism and service sectors" play. In autumn 2013, the four area based MAPIGs took CSE as their theme; Barnardo's and the Children's Society presented sessions to approximately 120 people from across a range of agencies that raised awareness of CSE and used case studies to help delegates consider the issue.

5.6.5 The CSE Strategic Subgroup, which incorporates work related to on-line safety, missing children and other related areas of vulnerability, has now developed a CSE Strategy and there has been an initial implementation day that identified activities for the three themes: Prevent, Protect and Prosecute. The strategy describes the multi-agency response to CSE in Somerset under the three themed work areas, including awareness raising, training requirements and risk assessment methodology, leading to early

identification of children vulnerable to CSE and ensuring better outcomes for them. Partners have been asked to complete a self-assessment audit, and were challenged as required for a lack of return; this return is required in order to inform the implementation of the CSE strategy, identifying partners' learning needs as well as other developments.

5.6.6 All LSCB multi-agency training progression material has been reviewed to ensure strong, clear information is included about CSE, and information about CSE has been included in the last few LSCB newsletters and will continue to be so.

5.6.7 Four half day "basic awareness" CSE courses have been commissioned from Barnardo's. Course outcomes include making sure that delegates know what CSE is, how children's vulnerabilities contribute to the risk of CSE, what steps to take if CSE is suspected. These start in January 2015 and there will have been four by September in the four areas of the county. We anticipate that we may need to commission more.

5.6.8 A CSE multi-agency audit day is planned for the autumn, which will consider a number of cases where the young person has been identified as having experienced CSE or is assessed as being vulnerable to it.

5.6.9 The Annual Conference in December 2014 takes CSE as the theme (it is also worth noting that the conference in 2012 included content about CSE within the overall topic of Safeguarding Adolescents). Planned content includes a range of inputs from areas and organisations with significant relevant experience.

What difference has been made?

5.6.10 An immediate impact of the work so far has been an increase in the number of child exploitation crimes recorded by the police, which suggests an encouraging increase in awareness.

5.7 Developing and strengthening the LSCB

5.7.1 The LSCB was criticised by Ofsted in 2012 for being too 'comfortable'. This was described further in a subsequent *Inspection of local authority arrangements for the protection of children* (June/July 2013), when Ofsted commented that *the SSCB independent chair has been in role since autumn 2012. Prior to that time the Board appears to have been moribund, with a high level of passivity, little holding to account and a lack of focus.*

5.7.2 This was a clear and unequivocal challenge to the Board, and much work has been undertaken since then by all partners to improve the performance of the LSCB. It was therefore pleasing to note that Ofsted further commented that:

"Since then, there has been demonstrable improvement, with evidence of challenge, clear expectations of agencies and individual members and better engagement……Accountabilities between the DCS, the Council's Chief Executive, the Children's Trust, senior political leaders and Somerset Safeguarding Children Board (SSCB) and its independent Chair are clear, with appropriate formal and informal mechanisms applied to ensure reporting and holding to account. Politicians and senior leaders are committed to supporting the necessary improvement actions….Structures have been revised to provide a greater focus and case-level analyses have been

undertaken and reported on to enable lessons to be learnt. There is more use made of quality audits."

5.7.3 Nevertheless, there was still work to do in extending the impact of the changes beyond the Board itself: "*the impact of the changes is as yet largely evident in the Board itself, with significantly better participation by partner agencies, a streamlined sub-group structure and the introduction of multi-agency auditing of files from the different partners. Significant impact in driving improvements in child protection practice across the system is not yet apparent."*

5.7.4 With these comments in mind, the Board agreed further improvements to the structure of the wider LSCB, the introduction of a Board Constitution and the revision of the terms of reference of all the subgroups and advisory groups, all designed to support the drive for improved effectiveness. Partner representation has been reviewed and work continues to ensure that LSCB members are able to represent their agencies and help to take work forward in a meaningful and effective way.

5.7.5 In the process, Board culture has been changing to reflect a more challenging and rigorous approach. Whilst this is not greeted positively by all members, some of whom view the Board meetings as becoming more adversarial (evidenced through a recent survey for members of Board effectiveness), the Executive Group remains clear that this is, in fact, an indication of increasing effectiveness and indicates a reduction of the previous "comfortable" culture. It is important to sustain and further enhance this work in order to continue to improve effectiveness and impact.

Community (lay) members

5.7.6 The LSCB has actively worked to recruit community (lay) members. One has been appointed to date, and efforts are being made to recruit a second. The community members operate as full members of the LSCB, participating as appropriate on the Board itself and on relevant sub-groups. Their role is to provide a community voice at the LSCB, help to make links between the LSCB and community groups, support stronger public engagement in local child protection and safeguarding matters and an improved public understanding of safeguarding and the work of the LSCB generally.

Strengthening governance and accountability

5.7.7 The LSCB has developed a Constitution that articulates the roles and responsibilities of members who, in turn, are required to sign the constitution. Each Board member has a primary responsibility for delivering the objectives of the Board with a secondary role of representing their agency. They are expected to ensure that their agency fulfils their responsibilities for safeguarding and protecting children. Membership of the Board and its sub-groups has been revised and strengthened during the year to reflect changing requirements and circumstances.

5.7.8 Somerset has retained a Children's Trust and there is also a Health and Wellbeing Board in place. A formal protocol has been developed which sets out the relationship between the LSCB, the Children's Trust and the Health and Wellbeing Board. The document is available on the Children's Trust and LSCB websites. The independent chair is a participating observer of the Children's Trust and presents the LSCB annual report to

the Trust and the Health and Wellbeing Board (as well as the Police and Crime Commissioner and senior leaders across the Council and its partners).

5.7.9 Following the 2013 Ofsted inspection, there is now a Children's Improvement Board (CIB) in place within Somerset. The membership of this group includes the chair of the LSCB. Discussion between the LSCB Chair, the Chief Executive of the Local Authority, the Director of Children's Services and the DfE representative has clarified accountabilities and future direction of travel.

5.7.10 Areas for future focus in relation to governance include closer working with the Safeguarding Adult Board (SAB) and the Safer Somerset Partnership to ensure that common areas of interest and responsibility are developed appropriately and are mutually reinforcing (for example, the multi-agency response to domestic abuse, vulnerable adults who are parents, and the transition from Children's to Adult services for vulnerable individuals).

5.7.11 A further area of planned engagement is with the Local Family Justice Board, which co-ordinates and oversees the smooth running of the Family Justice system, in particular the embedding of new performance standards following the recent Family Justice reforms. Part of Somerset (Taunton) is among the worst performing in England in relation to the speedy conclusion of care proceedings.

Quality assurance

5.7.12 The Audit, Policy and Procedures subgroup has been reviewed and strengthened to become the Quality and Performance Subgroup. This subgroup oversees all quality assurance activity on behalf of the Board, including carrying out 'section 11' and practice audits and also co-ordinating the work of the area based Multi-agency Practice Improvement Groups (MAPIGs).

5.7.13 Within the local authority, a Quality Assurance and Independent Reviewing Unit has been established which will also encompass the LSCB business support and LADO functions. Together with the corporate performance team, this forms a critical component of the LSCB's capacity to carry out its QA role.

5.7.14 A multi-agency Quality Assurance Framework has been developed and agreed by the LSCB and will be critical in the drive for improvement. It is intended to be the single framework for performance across the various multi-agency partnerships, based on a common dataset. It is anticipated that the framework will, in time, replace the performance reporting arrangements currently operating for the Children's Improvement Board.

5.7.15 The QA framework incorporates the national requirements and prescribed local information set out in the Department for Education's LSCB Performance Framework requirements (published in 2012), together with multi-agency data which reflects the priority development areas in the LSCB business plan. The framework will be overseen and managed through the Quality and Performance Subgroup. From this group, accountability then runs to the LSCB Executive and full Board.

5.7.16 There have been regular reports made to the LSCB about the populations of children in care and those in receipt of child protection plans which provide age, ethnicity

and gender breakdowns. Within the work of the LSCB, this information is increasingly being used to inform work, and to challenge the performance of partners.

Learning and Improvement

5.7.17 A new Learning and Improvement Subgroup, which incorporates the functions of a Serious Case Review (SCR) panel, is now in place. This has developed a Learning and Improvement Framework for the LSCB and takes the lead in ensuring that learning derived from the Board's activities, as well as from national reviews, research, etc., is translated into practice. This sub-group works closely with the Board's Child Death Overview Panel (CDOP).

5.7.18 Details of the activity of both the Learning and Improvement subgroup and the Child Death Overview Panel can be found elsewhere in this report.

The child's voice

5.7.19 Ensuring that the "voice of the child" informs the overall work of the LSCB and specifically influences and informs the priority areas of work in a way that ensures the key messages are incorporated into all the work for which the LSCB is responsible remains a key aspiration, in which some progress has been made this year.

5.7.20 A small working group was convened to look at existing work across partners and identify "early" key messages. A first draft strategy has now been further developed and agreed through the LSCB Executive.

5.7.21 It is expected that the 2014-15 annual reports of the subgroups (and the assurance reports provided by main partners) will include a section on the impact of the voice of the child on service delivery and developments. These reports are provided to the LSCB Executive and included in the LSCB Annual Report which is provided for the full Board each year. It is also presented to other statutory partnerships and so through these accountability routes there will be additional assurance provided about understanding what children see as important in terms of safeguarding, and that partners have listened to them.

5.7.22 There is a range of LSCB activity that is able to assess the impact of this work, largely through the review of effectiveness of the subgroup work plans. This is supported by the various single agency audits that are carried out by partners and will be expected to consider the views of children. Multi-agency audit falling within the scope of the LSCB will also be expected to do this. Information about impact will be included in future LSCB Annual Reports.

5.7.23 Early indicators of the key messages and areas of concern likely to emerge include a number that are relevant to the LSCB:

- Reduction of bullying (including in school and on-line bullying);
- Safety in the community;
- Legal ages of activity ("At what age can I….");
- How to access confidential advice about matters of concern;
- Issues relating to risk taking behaviour such as drug use, self-harm and suicide.

Risk register

5.7.24 The LSCB has developed a Risk Register which is attached at Appendix 2. This is in its first version and is already been reviewed and developed. However, it does provide a framework within which to consider and evaluate the impact of some of the issues and challenges described above.

6 Performance and effectiveness of local arrangements

6.1 The LSCB assesses the effectiveness of local arrangements using a number of methods, which include the scrutiny of data, auditing aspects of practice and requesting assurance reports. It also challenges in relation to additional matters which it has reason to think need improvement.

6.2 Health services

6.2.1 NHS organisations are subject to the 'section 11' duties set out in Working Together 2013. Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

6.2.2 A wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children including: GPs, primary care professionals, paediatricians, nurses, health visitors, midwives, school nurses, those working in maternity, child and adolescent mental health, adult mental health, alcohol and drug services, unscheduled and emergency care settings and secondary and tertiary care.

6.2.3 The implementation of the Health and Social Care Bill has involved significant organisational change within the NHS. From 1 April 2013, all Primary Care Trusts in England were abolished as part of the NHS Reforms with the statutory responsibilities for commissioning local health services becoming the responsibility of the new Clinical Commissioning Groups. The implementation of the Health and Social Care Bill gave General Practitioners and other clinicians, the responsibility to commission health services on behalf of service users.

6.2.4 Specific roles and responsibilities for Clinical Commissioning Groups and other NHS statutory bodies in relation to safeguarding are outlined in "Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework", issued by NHS England in March 2013. In December 2012, the Somerset Clinical Commissioning Group demonstrated that it had met its safeguarding requirements, including accountability and leadership, and was one of three health-commissioning organisations in the South West to be authorised, ready to take over the statutory responsibility of commissioning health services for Somerset residents.

6.2.5 Somerset Clinical Commissioning Group, as a commissioner of provider services, has provided strong leadership to the safeguarding children agenda across the health community. The designated professionals and CCG executive lead for safeguarding are members of the LSCB and make a significant contribution to the work of the Board and its subgroups. The Health Advisory Group brings together professional across the health community to discuss matters relating to safeguarding, and acts as a conduit between the LSCB and health services.

6.2.6 Health and adult social care services in England are independently regulated by the Care Quality Commission (CQC), which ensures that the Essential Standards for quality and safety are met and in particular Outcome 7 *Safeguarding people who use services from abuse*. The CQC inspects how NHS providers are meeting this standard through the acute hospital, Community and mental health trust and primary care inspection

programmes. CQC also undertakes themed safeguarding inspections of the arrangements for safeguarding across a health community.

6.2.7 The LSCB regularly seeks assurance from health services about their safeguarding arrangements. In 2013-14 this took the form of an annual report from the Somerset Clinical Commissioning Group (CCG) to provide assurance that the CCG is fulfilling its statutory responsibilities as commissioners to ensure that the safety and welfare of children is paramount in all of the services commissioned from NHS Trusts and from Primary Care. It also provides an overview of the clinical governance arrangements in place for safeguarding children in all 3 NHS provider trusts and of the way in which NHS Trusts have discharged their duties in respect of section 11 of the Children Act 2004 during 2013/14.

6.2.8 This has been supplemented by more subject specific reports as and when required from the CCG, NHS England and the 3 provider trusts. A gap in respect of the SW Ambulance Trust is being addressed. Public Health now sits within the local authority, and will be separately assured.

6.2.9 The report presents a range of evidence concerning child protection activity, training, leadership and management, underpinned by good quality assurance work, such as auditing, across the CCG and provider trusts. Recommendations are made to achieve improvements in:

- serious incident reporting;
- safeguarding supervision, particularly in public health nursing and midwifery services;
- engagement with the CAF process and the early help strategy, particularly within maternity services for teenage parents and vulnerable women;
- review of processes for service user involvement and feedback to ensure the voice of the child is heard to inform service development and better outcomes for children and young people;
- ensuring contracts and service specifications reflect statutory safeguarding children requirements and additional safeguarding quality standards.

6.2.10 A range of recommendations apply to primary care, in respect of:

- training for GP child protection leads and GPs, supporting them to strength their engagement with safeguarding children processes;
- auditing safeguarding arrangements in General Practice, offering targeted support as appropriate;
- monitoring GP attendance at child protection conferences and quality assuring reports.

6.2.11 Following the presentation of the Allegation Management Annual Report, health services were challenged about the very low number of referrals made to the Local Authority Designated Officer (LADO), and asked to ensure that information and referral pathways were known to key staff.

6.2.12 Assurance has also been sought and provided by the CCG regarding paediatric duty cover required for emergency child protection matters at Weston-Super-Mare General Hospital (which receives patients from the north west corner of Somerset.

6.3 Somerset Partnership

6.3.1 It is pleasing to note Somerset Partnership's developments in improving services to looked after children, including enhancing the 'voice of the child'. For example, a clear pathway for statutory health assessments is now in place, with defined roles and responsibilities for the children looked after teams. Through consultation with the Somerset in Care Council, children looked after health leaflets have now been developed and are in use. An expression of interest has also been submitted to the Somerset in Care and Leaving Care Councils, to seek their opinion as to how review health assessments are delivered in the future, which will assist in the development of health services for children and young people who come into care, and also determine what personal health information young people leaving care might need in the transition into adulthood.

6.3.2 Somerset Partnership has very actively engaged with the review and re-launch of the CAF. Engagement in staff training is very high; participation in assessment and child protection processes is generally good and improving, despite increased volumes of activity overall (although the provision of reports to case conferences needs improving); and engagement with the LADO over allegations against staff has taken place.

6.3.3 An issue between Somerset Partnership and the Fire Service regarding data sharing and IT security was highlighted at the LSCB and resolved by a meeting between managers.

6.4 Taunton and Somerset NHS Foundation Trust

6.4.1 A 'new style' CQC inspection of the Trust took place in September 2013. The report describes the judgement of the quality of care at Musgrove Park Hospital. It is based on a combination of findings at the time of the inspection, information from the 'Intelligent Monitoring' system, and information given to the inspectors from patients, the public and other organisations. With regards to safeguarding children, the Trust was commended for training rates and staff knowledge. There was a notable absence of action points required for safeguarding, which can be seen as a positive reinforcement of the work of the safeguarding team.

6.4.2 Quality assurance activity at the Trust is systematic and embedded; the rate of engagement in training is high,

6.4.3 The significant rise in the request by Children's Social Care for examinations in respect of abuse and/or neglect – an indicator of the increased volumes right across the system – has led to a number of challenges in the system, which the Trust is considering how to best respond to.

6.4.4 The serious case review in progress involves Musgrove Park Hospital Maternity services, and concerns an infant who presented with injuries typical of the shaken – impact syndrome.

6.4.5 Following this, a review of midwifery safeguarding practice was undertaken within the Trust. The LSCB has been assured that there is a comprehensive action plan underway in Maternity Services pending the formal outcome of the SCR, which includes:

- a retrospective review of all current maternity records;
- a review of mandatory training sessions delivered to maternity staff, in accordance with the intercollegiate guidance;

- a review of supervision for midwives. The number of staff able to provide supervision will increase after further training has been provided;
- development of additional level 3 e-learning modules, specific to midwifery practice, which include content regarding female genital mutilation (FGM). Evidence of maintaining a competence level must be provided at the practitioner's annual appraisal to ensure that there is oversight of the effectiveness of safeguarding training.

6.4.6 A maternity specific safeguarding policy, linked to the Trust safeguarding policy, is now in place.

6.5 Yeovil District Hospital NHS Foundation Trust

6.5.1 The Trust has a programme of audit in place, and has worked to ensure that the voice of children is sought and responded to. The voice of the child is sought through the family and friends audit (a national audit) and a Trust *I Care* audit, which is done by a visiting independent patient representative. Children, young people, and their family members are encouraged to participate in these surveys, the results of which are peer reviewed fed back to ward staff to inform and influence services.

6.5.2 Whilst compliance with level 1 safeguarding training has always been good, engagement with levels 2 and 3 has been relatively poor. This has clearly been the focus of attention, with significant improvement noted between 2012 and 2014. There remains work to do in this area.

6.5.3 As with the other NHS Trusts, engagement in child protection activity has increased. The Trust has introduced and is embedding individual and group safeguarding supervision.

6.6 NHS England

6.6.1 Following the reorganisation of health commissioning and provision described above, responsibility for the commissioning for child and adolescent mental health services (CAMHS) is divided between NHS England, the CCG and the local authority. Tier 4 (inpatient) CAMHS services are commissioned by NHS England.

6.6.2 The local tier 4 provision in Somerset consisted of a single12-bedded facility which also provided a service to the other peninsula authorities. The unit had been experiencing an increasing number of challenges in delivering the inpatient service, including significant vacancies within the leadership team on the ward, sickness absence, a difficulty in recruiting registered nurses with CAMHS experience and an increasing number of young patients with highly complex needs, requiring 1:1 and 2:1 staff to patient support. The unit was closed temporarily in February 2013 whilst a redevelopment plan was considered. This decision was fully supported by the Specialised Commissioning Group and the CCG at the time. During April 2013 young people were discharged into the community with support or transferred to out of county placements.

6.6.3 When in-patient provision was needed, when appropriate and where possible young people have been cared for on general children's wards, and are supported by CAMHs staff on a 24 hour basis. Whilst this is not ideal it has meant that a number of Somerset young people requiring an inpatient service have not had to travel to units outside of the county. However, there were occasions where 17 year olds have been admitted to adult

mental health wards. The LSCB has monitored this closely, at one stage receiving a report on every occasion where this has taken place. On one occasion, this was escalated to a neighbouring LSCB in respect of a young care leaver from that area. Reports on progress with addressing this problem have been sought and provided to the LSCB at regular intervals. The decision has now been taken to redesign and invest in an Integrated Tier 4 CAMH Service which will include a generic 8-12 bedded inpatient unit and a new Tier 4 Intensive Outreach team to ensure there is capacity and flexibility to sustain the community service and to ensure that young people and their families receive the appropriate level of intervention they require. This is expected to be in place in late 2014.

6.7 Primary Care

6.7.1 The responsibility for delivery of safeguarding children training to General Practitioners (GPs) now sits with the Somerset Clinical Commissioning Group (CCG), and is delivered and supported by the CCG safeguarding children team. All GP practices have previously received Level 1 safeguarding children training. Within the first year of the CCG provided training, which has included delivering training sessions to almost 50% of General Practices, more than 170 GPs have received training. Training sessions have also included the participation of nurses and supporting practice staff. In addition, a training day for GP child protection leads was held in January 2014. Almost 60% of practices were represented, which included sessions on child sexual exploitation, signs of safety, fabricated illness and the Somerset multi-agency safeguarding hub.

6.7.2 The effectiveness of safeguarding children training for GPs will be measured through increased referrals to Children's Social Care and the level of enquires for advice to the Designated Professionals for Safeguarding Children.

6.7.3 Safeguarding children training continues to be available for independent providers, such as Dentists and Pharmacists. These services are now commissioned by NHS England. Where Dental practices have contacted the CCG Safeguarding team this year, in-house training sessions have been provided for practices. The South West Deanery continues to provide courses for dental practitioners each year, and continue to engage with the designated professionals to facilitate these sessions. Safeguarding children training for pharmacists is provided as part of the programme for provision of emergency contraception by pharmacists and sessions in partnership with Public Health have been scheduled for May 2014.

6.7.4 Discussion with regard to available support from the NHS England area team is on-going to review how to best provide continual training sessions for both independent providers and GPs.

6.7.5 Engagement of GPs in child protection processes such as case conferences remains an area for improvement, of which the CCG is aware.

6.7.6 Areas which will be monitored by the LSCB in the coming months include:

1) progress with the re-provision of Tier 4 CAMH services, together with Tier 3 outreach;
2) engagement of health services with CAF and early help arrangements;
3) participation of GPs and other primary health practitioners in child protection activity;
4) developing engagement with the CSE strategy.

6.8 Education and schools

6.8.1 Section 175 of the Education Act 2002 places a duty on local authorities (in relation to their education functions and governing bodies of maintained schools and further education institutions, which include sixth-form colleges) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school, or who are students under 18 years of age attending further education institutions. The same duty applies to independent schools (which include Academies and free schools) by virtue of regulations made under section 157 of the same Act. Details of what this means are set out in chapter 2 of *Working Together* 2013.

6.8.2 The LSCB seek evidence about the arrangements in Somerset through the provision of an annual assurance report, coordinated and presented by the local authority. This gives details about safeguarding arrangements in schools, pupil focused data such as attendance and behaviour, availability and use of training by designated safeguarding leads, and information about the support and guidance available to school staff (eg in relation to safe recruitment practice and management of allegations).

6.8.3 All maintained schools, academies, independent schools and Further Education colleges are required to complete an annual audit that culminates in an Annual Safeguarding Report to the Governing Body. The local authority monitors compliance. Over the past three years 89% of these Annual Safeguarding Reports have been received from the 302 schools, academies and FE colleges in Somerset. The LSCB has requested that the local authority provides an overview of the qualitative information within these audits, highlighting key themes, for future assurance reports.

6.8.4 In the *Inspection of local authority arrangements for the protection of children in Somerset* in June 2013, Ofsted found:

> *"The council's approach to children missing from education (CME) is well developed, with active identification and monitoring. Similarly the needs and potential vulnerabilities of children educated at home are well understood by the council, with an active approach to both educational and welfare issues."*

6.8.5 The establishing of an Education Advisory Group, incorporating the on-line protection group of the LSCB, is improving understanding, recognition and response to education related safeguarding issues across school and college settings in Somerset, ensuring the timely dissemination of information and engagement with partners about safeguarding.

6.8.6 In the past three academic years there have been 44 allegations of sexual abuse made against staff in Somerset schools. Of these, 13 staff were suspended and 8 were subject to disciplinary action. Six staff were permanently dismissed and six were charged by police. These figures are high when compared to authorities of a similar size. However, one independent school accounted for ten of these allegations.

6.8.7 The most recent (annual) audit of the safeguarding arrangements in a sample of schools, which included a review of safe recruitment and employment practices, concluded that the only area that warranted further attention was in relation to safe recruitment. Following this outcome, further guidance was issued to all schools and the auditors concluded that no further action is deemed necessary by the Local Authority. However, the small sample was challenged by the LSCB Executive, which has requested a wider audit be undertaken to provide additional assurance.

6.8.8 Giving children and young people a chance to give their views is a less well developed area of work. This is being progressed, with the LSCB due to receive a report on students' views on safety. Likewise, the LSCB has requested information from schools about staff perspectives on safety in future assurance reports.

6.8.9 Recently published attendance data for the academic year 2012 – 13 shows attendance rates in primary schools in Somerset (95.0%) were just below national and regional averages (both 95.3%), whilst in secondary schools Somerset (94.0%) was in line with the regional average but just below the national average (94.2%). The percentage of persistently absent pupils was 2.9% in primary schools, compared with 2.7% in the south-west and 3.0% nationally. The corresponding figure for secondary schools was 6.7% in Somerset, compared with 6.6% regionally and 6.4% nationally.

6.8.10 The number of CAFs completed by schools (19) was very low in the first 11 months of the 2013-14 financial year, but 17 were completed in March 2014. Work is needed to increase the engagement of schools in early help and CAF arrangements.

6.8.11 Areas which will be monitored by the LSCB in the coming months include:

1) The engagement of schools in early help arrangements, as evidenced through numbers of CAFs initiated;
2) Safe recruitment and the management of allegations against staff;
3) Participation by schools in statutory child protection processes;
4) Evidence of the voice of children influencing safeguarding understanding and practice;
5) Efforts made to reduce the number of children absent or missing from education, or on reduced timetables;
6) Practice in relation to children who are educated other than in school.

Criminal justice and public protection

6.9 Avon and Somerset Constabulary

6.9.1 Avon and Somerset Constabulary is a statutory member of the LSCB, and its officers play an active role in the Board, the Executive and its sub-groups. The Child Sexual Exploitation sub-group was chaired by the police for a period, and will be so again once revised organisational arrangements are in place.

6.9.2 The police are a key service in identifying children and young people who may be vulnerable both within and outside their families. They tend to be the first response to domestic abuse incidents, and notify both children's social care and schools when a child is thought to be at risk of harm in such circumstances. High volumes of referrals to children's social care, without an accompanying risk assessment, have been challenged at the LSCB, and revised arrangements put into place to ensure a more proportionate and risk based approach. This is an initial step in the establishing of a multi-agency safeguarding hub (MASH) in Somerset. Further work is needed to engage police officers more positively in early help arrangements.

6.9.3 The Southern Safeguarding Coordination Unit (SCU) has relocated to join Children's Social Care in Taunton. Work is currently underway to look at how consistency can be achieved across the three SCUs in the force area. Partners were recently invited to an

event to share ideas, thoughts and discuss core principles as to what the future may look like in terms of SCUs. It is anticipated that all five local authorities and other statutory partners will work together with the police to realise the vision of creating greater efficiencies within safeguarding and ease the transition to creating Multi-Agency Safeguarding Hubs. The LSCB will monitor the progress and impact of these changes.

6.9.4 The Constabulary is in the process of changing its Operating Model, reshaping the way it manages and organises its people, processes and systems. This is intended to enable the Constabulary to prioritise the most vulnerable victims, and the management of Dangerous Offenders, as well as improve the response to victims of crime. As indicated in their assurance report to the LSCB, this is a complex and far reaching programme of change, which includes the "civilianisation" of a number of posts and changes in senior management arrangements. This is leading to an impact not only on commitment of time to the LSCB but also to aspects of safeguarding practice where resources are sometimes stretched.

6.9.5 During the year the Board has challenged the Constabulary, together with the Youth Offending Service and Children's Social Care, concerning its management of young people charged with an offence. It had noted that there were relatively high numbers of young people being held overnight in custody pending their appearance in court. This is dealt with elsewhere in this report. Following this challenge, practice has been revised and – pleasingly - there have been no young people held overnight in custody since April 2013.

6.9.6 The LSCB has also challenged the Constabulary over its proposed arrangements for health care provision for young people in its new custody suites, one of which is due to open in Bridgwater during late 2014. Paediatricians, in particular, were concerned that the proposed arrangements were adult focused, and that young people's mental health needs, in particular, might not be adequately assessed and responded to. Following a constructive meeting between Board representatives and senior police officers with responsibility for the custody suites, revised arrangements were agreed which satisfied paediatricians. This will continue to be monitored as the suite becomes operational.

6.9.7 During the reporting period, Avon and Somerset Constabulary put itself forward as a pilot for a child protection inspection by Her Majesty's Inspectors of Constabulary (HMIC). Findings confirmed LSCB information and assessment: the inspection team highlighted a number of areas of good practice, including a strong strategic grip with clear leadership; a clear focus on children by specialist staff; and good levels of police engagement at LSCB level through to involvement in the work of the subgroups. Its positive practice of sharing information regarding domestic abuse with schools and health organisations was noted.

6.9.8 A number of areas for improvement were identified, regarding consistency of practice in identification of and responses to children in need across the force area, the management of and planning for young people taken into custody, and the need for consistency of management oversight and support. Inspectors noted that '*practice is stronger when, from the outset, the matter is clearly one of child protection or when a perpetrator is a known sex or violent offender or when the case is managed by a specialist team*.' The inspectors found practice to be '*more variable where the concern of itself may not be the most serious but is part of a pattern of concerns, or where there is little information to substantiate the concern. Uncertain or less thorough assessment and inter-agency working is most evident in cases of domestic abuse*.'

6.9.9 The findings from the inspection have been shared at Board level and through the work of the Quality & Performance Sub-group, and the Constabulary has developed an action plan in response to inspection findings.

6.9.10 The Chief Constable made a decision, without consultation with partners, to apply (with effect from 1 April 2014) the new ACPO definition of 'missing' and 'absent' in relation to young people who are not where they should be (*Interim Guidance on the Management, Recording and Investigation of Missing Persons,* ACPO 2013). Whilst this has been based on what is regarded as successful practice developed elsewhere in the country, it comes at a time when awareness of behaviours associated with child sexual exploitation are increasing. Being absent from home, school or care is a key indicator. The Board will be monitoring the impact of this change in practice, in order to satisfy itself that risks to children are not increasing as an unintended consequence, and that practice is consistent with the *Statutory guidance on children who run away or go missing from home or care* (DfE, January 2014).

6.9.11 Areas which will be monitored by the LSCB in the coming months include:

1) The impact of the new operating model;
2) The impact of the implementation of the new 'missing from home' protocol;
3) Progress towards full implementation of the MASH;
4) Implementation of improvements following the HMIC inspection;
5) Numbers of young people held in custody overnight, and the suitability of the custody suite arrangements for access to health care.

6.10 Avon and Somerset Probation Trust

6.10.1 Probation Trusts are subject to 'section 11' duties. They are primarily responsible for providing reports for courts and working with adult offenders both in the community and in the transition from custody to community to reduce their reoffending. They are, therefore, well placed to identify offenders who pose a risk of harm to children as well as children who may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and of other poor outcomes due to the offending behaviour of their parent/carer(s).

6.10.2 The LSCB has not requested an assurance report from the Probation Trust this year. However, it has received a briefing from the service about the forthcoming major changes to the delivery of probation services which are taking effect in 2014-15. The creation of the National Probation Service (NPS) and local Community Rehabilitation Companies (CRC) have the potential to create risks for children, at least during the transition period when there will be considerable upheaval involving staff, management oversight, functions, and information systems.

6.10.3 The LSCB anticipates that the majority of cases involving child protection and domestic abuse will be managed within the CRC, where there are potentially staff capacity issues on start up.

6.10.4 Areas which will be monitored by the LSCB in the coming months include:

1) The impact of the organisational changes on the ability of the Probation services to engage fully in local child protection arrangements;
2) The level of supervision, training and management oversight available to staff in the new CRC;

3) The engagement of both the NPS and the CRC in local child protection processes and the LSCB.

6.11 Youth Offending Service (YOS)

6.11.1 Youth Offending Teams (YOTs) are subject to the 'section 11' duties. Somerset YOS is a multi-agency team responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals and is therefore well placed to identify children known to relevant organisations as being most at risk of offending and to undertake work to prevent them offending. The YOS is also responsible for the provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers, hence are significant in ensuring the safety and welfare of children in particular circumstances.

6.11.2 The YOS has led work in Somerset on reducing the number of children held overnight in police custody. This was requested by the LSCB following the HMI report "*Who's Looking out for the Children*", which investigated the journey of a child or young person from arrival at a police station though to charge. The report made twelve recommendations which require effective partnership working between police, youth offending teams, health and children's services. The report also recognised the role of the LSCB in overseeing this area of work, and the important role of strategic leaders in the relevant agencies.

6.11.3 Whilst operations during daytime hours were regarded as satisfactory, the LSCB was concerned about overnight detention of young people. This concern was reinforced by local data supplied by the police: in 2011/12 there were 24 such detentions involving 18 young people. One had been arrested on a warrant (children arrested on warrant or breach of bail cannot be transferred to Local Authority care). The remainder were all produced in Court and in most cases the court released them on conditional bail. This suggested that it should be possible to reduce the number of cases in which children were detained overnight. Following consideration by a group of representatives of Police, Children's Social Care and the Youth Offending Team, certain changes were made to processes within all 3 agencies, with the result that, with the exception of two children detained in custody overnight for court in April 2013, for whom no suitable local authority accommodation was available, there were no children charged and detained overnight for court in Somerset during the remainder of 2013.

6.11.4 The local authority is actively developing alternative accommodation for young people in these circumstances, by use of remand foster placements.

6.11.5 Areas which will be monitored by the LSCB in the coming months include:
1) Numbers of young people held overnight in police custody;
2) The rising number of young people who are being convicted of sexual offences, and the services that are available to them.

6.12 Somerset County Council: Children's Services

6.12.1 Following the departure of the Director of Children's Services and the Operations Manager, Somerset County Council appointed a new interim leadership team within Children's Services, comprising a Director, a Deputy Director and an Operations Manager. These individuals took up post between April and June 2013.

An unannounced inspection of local authority arrangements for the protection of children was carried out by Ofsted in June/July 2013. The overall effectiveness of the arrangements to protect children in Somerset County Council was found to be 'inadequate' across the four judgement areas for safeguarding:

- the overall effectiveness
- the effectiveness of the help and protection provided to children, young people, families and carers
- the quality of practice
- leadership and governance

6.12.3 The report, published in August 2013 contained eleven areas for improvement (three for immediate action; six for action within three months; and two within six months). In light of this, a revised Strategic Service Improvement Plan was developed and priority areas for improvement were clustered within three themes:

- Early Help
- Workforce
- Quality Assurance

6.12.4 Subsequent to the inspection, in August 2013, the Local Authority was issued with a formal Improvement Notice by the Department for Education, lasting twelve months with a formal review of progress and improvement after six months. It specified requirements to be met by "the Council and its partner agencies" during the period of improvement. These improvement areas had largely been anticipated by the LSCB when setting its priorities for 2013-14, and were already part of the Board's business plan.

6.12.5 The Council had previously established a multi-agency, Children's Improvement Board (CIB) following the outcome of the previous Ofsted *Inspection of Safeguarding and Looked After Children Services* (in June 2012). With the addition of an independent chair and a representative of the DfE, this body was charged with the responsibility of overseeing the improvement activity. The membership of the CIB includes the LSCB chair and regular reports on progress have been made to the LSCB throughout the year. Throughout the year there has been continuing challenge from the LSCB about improvement and the timely implementation of new initiatives, such as the revision of the threshold document, Early Help and the delivery of basic Child Protection processes, including the introduction of the Signs of Safety approach.

6.12.6 The Council has now appointed a Chief Executive, who confirmed that the current temporary leadership arrangements (of DCS, deputy DCS and Head of Operations) would remain in place for the foreseeable future in order to provide continuity. Whilst providing welcome assurance, this does mean that there will be further changes of leadership in the near future, which is a cause for concern.

6.12.7 The interim leadership team took immediate steps to address problems with the structure and organisation of children's services, aimed at improving consistency of service, management and supervisory oversight. This has been welcomed by both staff and partners.

6.12.8 At practice level, two large scale audits have been carried out following the Ofsted inspection, the outcomes of which were reported to and scrutinised by the LSCB and the Children's Improvement Board (CIB).

6.12.9 Reporting in December 2013, the first audit was carried out by an independent company, Core Assets, and focused on more than 500 'Children in Need' cases held by Children's Social Care. In excess of 500 cases were considered. The quality of work in approximately 12% was graded as Good or Outstanding, 58% as Adequate and 30% as Inadequate (or received no grading).

6.12.10The audit summarised the "direction of travel" as follows:

> "*Whilst it is fair to state that there are deficits within areas of practice around assessment, planning and review, there is a clear marked improvement evidenced within Protocol [the Children's Social Care database] of management oversight and supervision in the last four months. The Disabled Children Service has made a good effort to ensure that children receiving a service had an assessment, evidencing a clear improvement since February 2013. There is some evidence of very good assessments being completed and in most instances the use of Signs of Safety is evidenced within planning for children and young people. Partnership working is good."*

6.12.11The second was led by Children's Social Care and audited over 450 Child Protection cases. Of these, approximately 13% were rated as Good or Outstanding, 42% were considered to be Adequate, and 43% were graded as Inadequate or were "ungraded". A number of recommendations were indicated in the audit report. In summary, they considered the need to strengthen the arrangements for safeguarding children temporarily residing in the county, the quality of social workers' recording to evidence professional judgement and decision making, demonstrating the "voice of the child" in case work and the need to consider core training requirements relating to child protection.

6.12.12 The LSCB continues to receive regular assurance and progress updates from Somerset County Council on progress in these areas, challenging the focus and pace of improvement as and when required. This has included scrutiny of the implementation of a number of closely related initiatives: the major reorganisation of the service; the Early Help offer and the Common Assessment Framework; the Threshold document indicating "step up" and "step down" arrangements; and the introduction of the Signs of Safety approach to child protection work.

6.12.13The capacity and experience of the social work workforce is a focus of continuing concern. There are significant numbers of vacancies at social worker and team manager level. There have been changes of personnel across Children's Social Care and many posts have been filled on an interim basis and through the use of locum staff, including managers. Although this has allowed the organisation to maintain core business, it does mean that the workforce has been unsettled and there has been some impact on the stability of caseloads, with some children and families experiencing changes of workers more frequently than is desirable.

6.12.14The introduction of the Signs of Safety initiative, after a slow start, has gained pace and is leading to clearer outcome in child protection work. The forthcoming period of consolidation of practice with continued improvement will be crucial.

6.12.15 Areas which will be monitored by the LSCB in the coming months include:

1) The delivery of early help services;

2) The quality and timeliness of child protection work, including numbers of children on child protection plans for a second or subsequent time;
3) The rate of re-referrals;
4) The delivery and impact of early help;
5) The resilience of the social work workforce.

7 The children's workforce

7.1 The LSCB received the annual report of the Local Authority Designated Officer for 2012-13 in July 2013. This detailed the range of activity which had been undertaken to raise awareness of the role of the LADO, and the responsibilities of partner agencies to maintain a safe workforce. As a result, there appears to be raised awareness of the requirement to report allegations made against adults who work with children, leading to more appropriately concluded allegation investigations. The number of allegations received has continued to rise and it has been necessary to increase the capacity of the Local Authority Designated Officer (LADO) function. This work was further strengthened by moving the management of the LADO into the newly formed Quality Assurance Team within Children's Social Care.

7.2 The 2013-14 LADO Annual Report was received in October 2014. It indicated a significant increase in allegations received to 405, up from 272 the previous year. This represents an increase in referrals of 148%. The annual report provides details of the nature of allegations and the source in terms of organisation. Most referrals relate to allegations of physical abuse and the main referring organisations are schools and independent children's homes operating in Somerset. Of all referrals received in this reporting period, 34% required no further action on the part of the LADO; any action needed was carried out by the organisation concerned. 14% were substantiated.

7.3 The capacity afforded to the LADO function is of concern given this increase in work, the need to ensure a timely and effective response, and staffing and recruitment matters connected with the post. There are a number of recommendations for development that are designed to ensure that all partners understand the role of the LADO and make appropriate referrals, including training and awareness raising. This will ensure that those agencies who made no, or very few, referrals to the LADO understand their responsibilities. It is also planned to connect strongly the LADO function with the implementation of the MASH.

7.4 The LADO has had a significant impact upon the work force, helping to ensure that individuals who are not safe and appropriate to work with children are dealt with effectively, involving the police and barring services as required. The contribution of the LADO in promoting Safer Recruitment and safe care practices in making Somerset children is distinct and essential.

7.5 There is evidence that organisations in Somerset recognise the importance (and in some cases, requirement) to ensure that their staff and volunteers are appropriately and regularly trained in safeguarding and child protection and that this training is effectively delivered. The LSCB is often commissioned to deliver single agency child protection training, including a significant commission to train all staff working in Adult Services in the County Council. LSCB Cascade training material, regularly reviewed, is available.

8 Private fostering

8.1 Private fostering became an important area of focus following the enquiry into the death of Victoria Climbié. The National Minimum Standards for Private Fostering and the Children (Private Arrangements for Fostering) Regulations 2005, together with the Children Act 2004, placed additional responsibilities on local councils to raise awareness about, and address the needs of, privately fostered children.

8.2 Somerset County Council provides an annual report each year to the LSCB detailing how it fulfils its duties and responsibilities, and highlighting proposed areas for development. The monitoring and support of private fostering arrangements has been more effective since the appointment of a specialist worker by the Council in 2012-13. The most recent inspection by Ofsted (June 2013) found that:

> *Arrangements for assessing and meeting the needs of children who are privately fostered are appropriate and largely effective with some good examples of assessment and support seen. Partner agencies, such as schools, report they are aware of the need to notify the council of possible private fostering arrangements, but the numbers overall remain low.*

8.3 Between September 2012 and December 2013, 16 private fostering notifications were received, all but 3 of which concerned White British children. The primary reasons why children move into private fostering arrangements in Somerset are due to:

- difficulties within their own families resulting in them being unable to remain there;
- attendance at school in Somerset during term time.

8.4 Despite continuing awareness raising across the county, with information about private fostering and the responsibility to report communicated regularly to all of the schools, the number of private fostering cases notified in Somerset remains lower than might be expected, given the significant amount of boarding school provision in the county, although there has been an increase in the number of notifications over the year. Schools report an increasing number of 'guardianship' arrangements which do not appear to be considered as private fostering; nevertheless, it is of concern that there may still be under reporting in this area.

8.5 There were no child protection concerns during this period. The Private Fostering worker has highlighted concerns where appropriate; these have been assessed by a qualified Social Worker and appropriate action has been taken. Concerns about the home conditions for one of the young people were addressed jointly with the young person's allocated social worker and the private fostering worker.

8.6 There is a small number of children in private fostering arrangements from minority ethnic groups. Supporting private foster carers to meet the cultural needs of children and young people they are caring from different backgrounds can be a challenge in a predominantly white, rural county such as Somerset. It is expected that this is addressed and appropriate support provided as part of the assessment of the arrangement. Interpreters are used where appropriate.

8.7 The LSCB remains concerned at the low number of notifications in Somerset, and supports the proposed awareness raising campaign.

9 Quality Assurance

9.1 The LSCB has worked to increase its ability to assess and assure effectiveness of local safeguarding arrangements. This area of work is led by the Quality and Performance Subgroup (formerly the Audit, Policy and Procedures Subgroup), with input from the Learning and Improvement Subgroup in relation to learning arising from case reviews, and supports the Board's challenge function by providing direct evidence of partners' performance.

9.2 Following the publication of the Department for Education performance Information Framework for LSCBs, the Somerset Board developed and agreed a QA Framework. The Framework consists of a multi-agency dataset, a range of single and multi-agency audit activity (described below) and a reporting cycle that bring information from partners to the Subgroup, the LSCB Executive Group and the full Board along four identified themes, which reflect the Board's statutory responsibilities and accompanying priorities: early help and intervention, safeguarding and child protection, looked after children and care leavers, children's workforce and LSCB effectiveness.

9.3 This is a key area of development for the coming year and its growing impact will be reflected in subsequent annual reports as the new arrangements are embedded. The challenge to partners is to provide meaningful information in a timely way, whilst indicating significant areas of concern or exceptions.

9.4 Multi-agency auditing

9.4.1 There are three main strands to multi-agency audit activity that fall directly under the remit of the LSCB:

- The four area-based multi-agency child protection Audit Subgroups (ASGs);
- The annual Section 11 audit (see below);
- Audits arising from Serious Case Reviews and other multi-agency case reviews.

9.4.2 The programme for 2014 is based on the eight LSCB minimum standards of partner agencies, as described in the QA Framework. These, in turn, relate to the new Ofsted inspection framework for LSCBs:

- Key professionals understand how to identify if children are suffering or likely to suffer abuse or neglect;
- Threshold for access to services are clear, understood and implemented locally by all professionals working with children, young people and families;
- Practice is consistently child-centred, effective and of a high standard, contributing to significantly improved protection outcomes for children and young people;
- Vulnerable children and young people are helped and protected through a clear, outcome-focussed plan that is shared with, and understood by, the family and which is regularly reviewed;
- Decision making for vulnerable children and young people is taken by suitably qualified and experienced staff and/or managers, as appropriate, and those decisions are recorded effectively;
- Case recording is coherent, timely, reflects the work undertaken and the outcomes achieved, and includes an up-to-date case chronology;

- Information sharing between agencies and professionals is timely, specific and effective;
- Multi-agency case conferences, strategy meetings and core groups and other multi-agency meetings are effective.

9.4.3 Other audits are commissioned through the LSCB as required and reporting is agreed as appropriate.

9.5 Audit sub-group – Theme 1: Adherence to child protection plans

9.5.1 The ASG reviewed a total of 11 cases. In nine of the eleven cases the plan was clear and addressed the risks identified in the Initial Child Protection Conference (ICPC).
An appropriate contingency plan was identified in nine of the eleven plans although the minutes of core group meetings frequently did not reflect systematic monitoring of the Child Protection plan.

9.5.2 Child Protection Conferences and core groups did not always respond to new or increased risk by ensuring that plans were amended. Where plans were not being adhered to, there was little sense of challenge by professionals at Conference or core group. As a result of these issues being identified, the following actions were initiated:

- The Children's Social Care (CSC) Area Manager was asked to urgently review one case.
- The CSC Business Management Group improved methods to ensure accurate reporting of conference invitees and attendees.
- The CP Chair Manager discussed ensuring risks are clearly recorded with CP Chairs, and the need for plans to be SMART.
- The need for challenge at Conferences and core groups when plans are not adhered to was reiterated with CP chairs and through an LSCB newsletter article.
- Core group minute guidance was reviewed and reissued to ensure the meetings monitor progress of the plan and that minutes reflect this; plans need to be amended when risks increase to reflect the changes in circumstances.

9.6 Audit sub-group – Theme 2: Multi-agency engagement with child protection plans

9.6.1 The ASG noted particular issues around General Practitioner (GP) attendance and reports submitted to conference. 12 ICPCs (3 cases for each of 4 CSC areas) were audited. There was no GP report or attendance at 8 of the 12. There was attendance only, with no report, at 2 and a report only, with, no attendance, at 2 meetings. There was a similar pattern regarding review conferences. As a result of this, information was passed back to the CGG and they were asked to address the matter, which will be audited again during the course of 2014-15.

9.6.2 The audit also identified that a chronology was supplied to conference in 4 of the 12 cases and risk factors identified in reports to conference were picked up in 10 of the 12 sets of conference minutes. There was clear evidence that the core group had minuted the Child Protection plan in 7 of the 12 cases. The plan was developed by the core group or RCPC in 7 of the 9 instances that this was needed.

9.6.3 In accordance with the feedback process for the ASGs, information was provided for the relevant agency manager with the expectation that the issues are addressed within the agency or setting.

9.7 Audit sub-group – Theme 3: Strategy discussions

9.7.1 A sample of 12 strategy documents were considered, with 5 of the 12 failing to clearly show who took part in the discussion. There was a multi-agency plan recorded to keep the child safe in 8 out of the 12 cases and overall the children and their safety were the clear focus in 11 out of the 12 cases. It was noted that Police PND checks were not carried out in all cases. As above, feedback was provided and actions requested through the feedback process. The outcome of this can be found in the ASG Annual Report, which is available on the LSCB website

9.8 On line safety

9.8.1 An on-line safety audit was conducted in spring 2013, as requested by the On-line Protection Subgroup. The audit was designed to help the LSCB, through the Subgroup, to consider priorities for development regarding on-line and electronic device safety; for example, safe internet and mobile phone use, electronic communication, etc.

9.8.2 The main findings (from 14 responses) were:

- All responding agencies have clear policies about protecting personal data
- 13 agencies reported they had an on-line safety policy, with 11 agencies including on-line safety as part of safeguarding training
- 6 agencies reported that they would be interested in more advanced e-safety training. The LSCB commissions some training from the South West Grid for Learning and will also respond to other requests as required.

9.9 Audits concluded or in progress

9.9.1 As part of the work for the Serious Case Review for Child A and Child B, a number of specific multi-agency audits were commissioned, related to the key findings and action plans:

- Pre-birth assessment and planning: Not all agencies had single agency policies relating to this or had policies that required review. This lead to improvement in single agency arrangements and the commissioning of an LSCB multi-agency policy being progressed through the Quality and Performance Subgroup;
- Safeguarding supervision policy: partners were asked whether they had a robust policy in place with the recommendation that the LSCB published a model policy. This recommendation was subsequently changed to indicate the publication of a good practice guide for child protection supervision which is being progressed though the Quality and Performance Subgroup;
- Multi-agency escalation policy; the LSCB took steps to promote and further publicise the agreed multi-agency escalation policy to all agencies;
- LSCB effectiveness: an on-line audit was carried out looking at aspects of the effectiveness of the LSCB using the new Ofsted inspection criteria. This information was discussed at the LSCB Executive and used to inform the LSCB Development Day scheduled for July 2014;
- Effectiveness of LSCB multi-agency training: surveys are being sent to course registrants pre-training and post-training, and also to their managers in order to

assess the longer term impact of training on practice, leading to the identification of service improvement and better outcomes for children.

9.10 Section 11 Audit

9.10.1 Section 11 of the Children Act 2004 describes the key safeguarding related arrangements that statutory agencies are expected to have in place. The LSCB seeks to assure itself of the robustness of these arrangements though a regular 'Section 11 Audit', which is carried out biannually.

9.10.2 The previous full audit was carried out in 2012 and was reported in a previous Annual Report. A progress audit was carried out in the following year in order to monitor and challenge partners' progress with their action plans. The current Section 11 audit began in Spring 2014 as a collaborative approach with a number of neighbouring LSCBs, using a methodology agreed by the Quality and Performance Subgroup and subsequently endorsed by the CIB. The results of this audit will be published on the LSCB website and reported in the Annual Report for 2014-15.

10 Learning and Improvement

10.1 Working Together (2013) sets out the requirement that LSCBs *"should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.*

"Each local framework should support the work of the LSCB and their partners so that:

- *reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;*
- *reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;*
- *action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and*
- *there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public."*

10.2 The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. The LSCB and its partner organisations translate the findings from reviews into programmes of action (some of which are described in this report) intended to lead to sustainable improvements and the prevention of death, serious injury or harm to children. This includes incorporation into the LSCB's programme of training and development.

10.3 Case reviews

10.3.1 The Learning and Improvement subgroup (L&I) met for the first time in May 2013. The main purpose of the group is to promote a culture of continuous learning and improvement across organisations that work together to safeguard and promote the welfare and protection of children in Somerset, primarily by using learning from case reviews to drive improvements in practice.

10.3.2 The group was tasked to:

- develop a learning and improvement framework;
- consider serious child protection cases that could reach the threshold of Serious Case Review (SCR) and make recommendations to the LSCB chair about such reviews;
- convene a SCR Panel when required;
- commission and conduct learning reviews that are likely to produce significant learning, develop action plans in response to review findings and monitor implementation;
- ensure that children and families are appropriately involved in reviews;
- ensure training reflects learning, leading to improvement;
- maintain oversight of reviews carried out elsewhere.

10.3.3 The group maintains a Learning Log which indicates the learning from reviews, the impact on multi-agency practice and on outcomes for children. The group also has responsibility for making recommendations to the LSCB chair regarding cases that may

meet the threshold for Serious Case Reviews (see below). In turn, the recommendations arising from SCRs and any resulting progress activity are monitored by this group.

10.3.4 The subgroup has already completed a number of tasks and considered findings from a number of reviews. These have included consideration of reviews conducted by the Somerset Drug and Alcohol partnership and under the Domestic Homicide review process. In addition, through a Root Cause Analysis (RCA) review, partners were challenged about specific actions taken in a case not meeting the criteria for a Domestic Homicide Review and some single agency actions identified. The case also helped to inform the development of the Learning and Improvement Subgroup.

10.3.5 There are some emerging areas of impact arising from the work of the subgroup:

- Key messages about bruising to non-ambulant children have been reinforced, leading to appropriate referrals;
- Representation was made to a neighbouring LSCB regarding a serious incident in which a young person suffered significant harm. The LSCB concerned undertook a case review. This has led to a review of cross-border responsible commissioning arrangements in respect of young people with mental health difficulties;
- General Practitioners have been asked to review patient lists to ensure that children are not being prescribed contraceptive implants.

10.4 Serious Case Review

10.4.1 In early 2011, the LSCB commissioned a Serious Case Review (SCR) to consider the circumstances which led to the serious injury of twin babies, child A and child B. After some delay, largely due to the protracted progress and conclusion of the criminal trial, the SCR was published in full in April 2013. The recommendations have been progressed during the year with most aspects now being completed.

10.4.2 During 2013-14, three cases were referred to the LSCB Chair for consideration. One SCR has been initiated, in respect of a very young baby who suffered significant head injuries whilst in the sole care of his parents. There were identified vulnerabilities of the parents and some concern about information sharing and the use of parental histories to inform risk assessment and single and multi-agency planning for pre-birth and new born babies.

10.4.3 In accord with the requirements of Working Together 2013, an independent author was commissioned and the review is being overseen by a separately constituted SCR Panel led by the chair of the Learning and Improvement subgroup. A proportionate methodology has been agreed which reflects a hybrid of previous methodology (the provision of single agency Internal Management Reviews) and the experiential involvement of the practitioners who worked with the family. Both parents will be offered the opportunity to contribute to the review, which will be published in full on the LSCB website during 2014. The key learning identified through this review and the resulting impact will be reported in the next Annual Report.

10.5 Research into Leaving Care systems and the transition to Adult Services

10.5.1 As indicated in the last Annual Report, research activity has been carried out, jointly commissioned by the LSCB and the Safeguarding Adults Board (SAB), focusing on the effectiveness of service co-ordination and delivery, in the light of a number of unexpected

deaths over the past five years of young adults who were known to the leaving care service. Initial findings have been considered, and further research commissioned from public health regarding suicide and self-harm. A final report will be published in due course on the LSCB website, together with the actions taken in response to findings.

10.6 Child Death Overview Panel

10.6.1 The LSCB Executive Group received the annual report of the Child Death Overview Panel (CDOP) in July 2014. This was Somerset's sixth annual report.

10.6.2 The process of reviewing every child death has been a statutory requirement since April 2008. The overall purpose of a child death review is to understand how and why children and young people die, and identify any interventions or improvements to services which may help to prevent future deaths and/or improve experiences for families receiving services.

10.6.3 The Child Death Overview Panel (CDOP) is a multi-agency group of professionals who are responsible for reviewing information collated on all child deaths, expected or unexpected, in Somerset. The panel considers every death of a child or young person under the age of 18 years. In reviewing each death, the Panel has a particular focus on identifying whether there were any modifiable factors which may have contributed to the death and what, if any, actions need to be taken to prevent future such deaths.

10.6.4 For children who have chronic or a life threatening illness the focus is also to review the services provided and making recommendations for informed changes to improve the care and support for children, young people and their families.

10.6.5 The Panel chair is a Consultant for Public Health, although during the interim period of the post being vacant, the Director of Quality and Patient Safety from the Clinical Commissioning Group and the Local Safeguarding Children Board Safeguarding Manager provided continuity of scrutiny and compliance. During the 2013-14 reporting year, the panel met four times and there was consistent senior representation and commitment from participating agencies.

10.6.6. During the year April 2013 until March 2014 there were 35 notifiable child deaths. A total of 30 deaths were reviewed by the panel. The report summarised the work of the Somerset Child Death Overview Panel during 2013-2014 and looked at the emerging themes from the previous years.

10.6.7 As in previous years, the highest numbers of child deaths relate to perinatal or neonatal events with babies who die before 28 days: 18 neonatal deaths were discussed in this reporting period; of these, 13 were classified as being extremely premature for babies being born before 26 weeks, and a further 5 babies were born before 37 weeks.

10.6.8 The Panel members noted that when a health visitor had been made aware of an antenatal diagnosis of foetal anomaly, there was evidence of excellent liaison with the both the hospital and the mother, enabling the development of a therapeutic relationship with the mother, which was invaluable when sadly the baby died.

10.6.9 The Panel also noted that, where an antenatal diagnosis of congenital anomaly or malignancy had resulted in care being transferred to the tertiary centre, information was not always shared with the health visitors, who were therefore not able to provide the

same sensitive and supportive service. These matters have been raised with the appropriate managers at the tertiary centre.

10.6.10 Due to small numbers of deaths each year, identifying trends and learning themes is problematic. Since 2008, the Child Death Overview Panel has identified a number of modifiable factors and risks, during this year and previous years, which may and have been contributing factors including:

- smoking by one or more partner;
- co-sleeping or unsafe sleeping arrangements;
- alcohol or substance misuse ;
- the prevalence of parental emotional and mental health problems;
- risk taking behaviours by adolescents and suicide risks in young people

These have informed practice by midwives and others across the healthcare system.

10.6.11 The CDOP annual report gives further details of this area of work and is available on the LSCB website.

Training and development

10.7 Multi-agency training

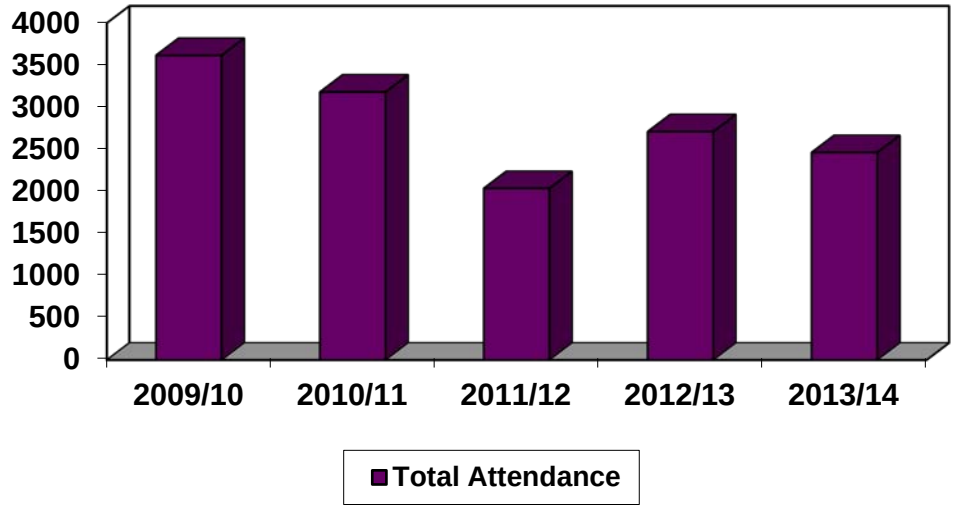
10.7.1 The LSCB delivers multi-agency safeguarding training to partners in accord with the current LSCB training strategy. This was written to meet the requirements of Working Together 2010 and is now being comprehensively revised to reflect the need to more clearly demonstrate the effectiveness of multi-agency training and the less prescriptive requirements of Working Together 2013. At its heart remains a core training provision, largely delivered by the LSCB training team, represented by a multi-agency progression for staff who need to understand child protection in a multi-agency context, including those who have a designated responsibility. A number of refresher and specialist courses are also delivered, including, Safer Recruitment courses.

10.7.2 This work is overseen by the Training and Professional Development subgroup which has this year improved multi-agency representation and now has revised terms of reference. This means that the evaluation of multi-agency training will become more effective, not least because the Subgroup has also taken responsibility for delivering the Annual Practitioners' Conference and the Multi-Agency Practitioner Interest Groups (MAPIGs). These are short, area based themed awareness and training sessions open to practitioners from across the county. The MAPIGs held this year addressed Child Sexual Exploitation and the early help and CAF development whilst the Practitioners' Conference took Domestic Abuse and its impact on children as the main theme.

10.7.3 To date, all courses have been evaluated through use of a paper based evaluation sheet. The Training and professional development Subgroup has been concerned that this is an ineffective methodology and from April 2014 a new, more rigorous approach has been used. In summary this includes an electronic baseline questionnaire for delegates, a paper based evaluation completed on the day which will be independently evaluated by someone who was not directly involved in the training delivery, an evaluation completed by the trainers which will be similarly considered, an online questionnaire for delegates a month after the course asking questions about impact on practice and an online questionnaire for mangers three months post-training asking about longer term impact on

training. Clearly, it is too soon to be able to comment on the impact of this development but it is anticipated that the impact of this will allow the Subgroup to ensure that the training available through the LSCB and partners meets the needs of the multi-agency audience.

10.7.4 During the reporting period 2463 delegates attended training provided by the LSCB which is a 9% decrease from the previous year, although 21% higher than 2011/12.



10.7.5 It comprised 1476 people who attended inter-agency training across 70 courses (8 more courses than 2012/13), 39 more participants than the previous year. Overall, the uptake of multi-agency training remains consistent although the themed courses do show a small decline in attendance. The uptake of commissioned single agency basic awareness has increased again.

10.7.6 During the reporting period, LSCB courses continued to be evaluated by delegates very positively. They were asked to rate their experiences across three aspects: standard of training, knowledge gained and improvements to practice. In summary, for the progression of three multi-agency courses, about 85% rated the standard of training as good or excellent, approximately 65% rated knowledge gained as good or excellent (partly a reflection that a number of delegates were repeating courses) and about 70% considered that there would be significant improvement to their practice.

10.8 Single agency training

10.8.1 A total of 990 people attended single-agency awareness training from 21 different establishments, including schools (maintained and independent), 2 District Councils, Adult Social Care and the voluntary sector, an increase of 69. (In part, the decrease in overall numbers is a consequence of the CCG deciding not to commission the LSCB to deliver training in GP practices.)

10.8.2 A significant commission has been that from Adult Social Care, which commissioned a range of child protection training for all of their staff members. All practitioners will attend training; most will attend Basic Awareness sessions, managers and senior practitioners will attend the Introduction to Child Protection and a subset of managers will attend a Working Together course. 150 practitioners attended Basic Awareness Training and 42 inter-agency courses during this year. Additional Introduction and Working Together courses have been added to the programme for 2014 to accommodate the additional numbers; the courses are funded by Adult Social Care but will be fully inter-agency.

10.8.3 Somerset Centre for Integrated Learning (SCIL) offer training in addition to LSCB training. Basic Awareness is offered as an e-leaning module and a face to face training session. Introduction to Child Protection is also delivered on behalf of LSCB, in large part to meet the learning requirements of early years practitioners, although includes other practitioners including foster carers and Children's Social Care residential workers. Additional e-learning modules are also offered covering Risk Assessment in Child Protection and Safeguarding Disabled Children. The e-learning modules are supplied by The Safeguarding Academy, part of the Virtual College a well-established provider of e-learning. The following is information supplied by SCIL of those who have accessed their training

10.9 LSCB annual practitioners' conference

10.9.1 The LSCB annual practitioners' conference was held in December 2013 and was attended by more than 120 practitioners and managers from agencies across Somerset. The theme of the conference was Domestic Abuse and the impact upon children. The aim was to raise awareness and provide information about the impact on children, national and local prevalence, the services operating in the local authority area and how to access support as a professional working with vulnerable families.

10.9.2 Keynote presentations were made by the Police and Crime Commissioner (this area of concern is a PCC priority), the Chief Executive of Coordinated Action Against Domestic Abuse (CAADA) and there was a powerful performance from the Geese Theatre Company demonstrating how corrosive the experience of living with domestic abuse really is. Delegates were then asked to attend workshops to develop their understanding of local services and responses to the issue. There was a clear impact on the audience and, by implication, their practice with evaluation comments confirming that delegates left the event being clearer about resources that were available in Somerset, the impact on children of living with domestic abuse, support for victims and how agencies worked together in this arena.

10.9.3 The theme of the 2014 Conference will be focused on Child Sexual Exploitation, drawing upon the Somerset CSE strategy and looking at how professional judgement and risk assessment informs the response to vulnerable children.

11 Conclusion - assessment of effectiveness of multi-agency safeguarding arrangements

11.1 Information available to the LSCB, gained direct from partners as well as from its own QA activity, suggests that, while there are areas of good practice across all agencies, the quality and consistency of services available at every stage of the 'child's journey' in Somerset is not yet consistently good enough and improvement has been relatively slow.

11.2 The early help arrangements are at an early stage in their development, and there is, as yet, insufficient 'buy in' from most universal services (with the exception of children's centres). This means that, despite the revised 'threshold' document, too many referrals are still reaching Children's Social Care without there being an offer of early help. At the same time, the levels of re-referrals are high and rising, which is a concern. At the other end of the system, 'step down' arrangements still need improving, as evidenced by the relatively high numbers of children subject to child protection processes for a second or subsequent time.

11.3 There has been significant improvement in the timeliness of visits by social workers to children who are subject of a child protection plan. Auditing shows that the quality of many of the plans is good, although not yet consistently good for all children. Engagement of agencies other than children's social care remains variable, with significant improvement required by some.

11.4 The CSE strategy is now in place. Actions to deliver improved protection, prevention and prosecution rates are at an early stage, agency engagement is still variable, and rapid progress is needed in order to be sure that children suffering or vulnerable to sexual exploitation are being identified and helped promptly.

11.5 CAMH services remain a major area of weakness in Somerset, with improvement hampered by the complexity of commissioning. Improvements in this service area are long overdue, and are particularly needed in the context of rising levels of self-harm amongst young people.

11.6 Considerable efforts are made by all agencies to ensure their recruitment and employment processes are safe, and that the children's workforce is suitably trained. Engagement with the LADO is generally good, although there remains a concern at the low level of referrals from health services and the police. The availability and quality of professional supervision remains a challenge for some.

11.7 Across all areas of activity, further work is needed to enhance the ability of services to capture children's views and use feedback to develop and improve their services. This also applies to the LSCB itself.

11.8 At an organisational level, partners – notably Avon and Somerset Constabulary and Probation Trust - continue to go through significant structural and organisational changes in response to national and local factors, which brings risk in relation to service quality and continuity and also has an impact on the LSCB itself.

11.9 At the LSCB, engagement of statutory partners is positive and increasingly meaningful. The introduction of a constitution has made the responsibilities of Board members far more explicit and therefore has placed greater demands on them. This

enhanced level of commitment has been discussed and agreed with members but is developing well. Work underway to re-examine LSCB members' views of the effectiveness of the LSCB is indicating disquiet by some with the developing culture (and expectation) of more open and robust challenge across the partnership.

11.10 The relationship between the LSCB and the Safeguarding Adults' Board (SAB) is developing. The SAB has recently appointed its first independent chair and is reviewing structures and subgroups, which is anticipated will improve effectiveness. The Leaving Care research is the first jointly commissioned project between the two Boards and has begun to bring closer working relationships, while the practitioners' conference in 2013 had as its focus domestic abuse, and included a number of adult services colleagues as well as the SAB Chair. The LSCB has a priority area relating to the safeguarding of vulnerable adolescents and there are clear synergies between many aspects of this work and those associated with the transition from Children's to Adult Services. Closely allied to this work is the development of work with the Safer Somerset Partnership which delivers the community safety function in the county. This is at an early stage but will be an important part of improving effectiveness next year.

11.11 The Children's Trust continues to be important in overseeing the development and delivery of a number of services for children living in Somerset including the Early Help offer, the CAF and improved access to Child and Adolescent Mental Health Services (CAMHS). The Health and Wellbeing Board is now fully functioning and needs to show robust leadership in ensuring that the Joint Strategic Needs Assessment (JSNA) is used to provide a strong evidence base for wider safeguarding activity and service commissioning. A good start has been made in this area.

11.12 In short, whilst the direction of travel is clear, and multi-agency arrangements are improving, weaknesses in key areas mean that the children of Somerset and their families are not yet receiving a consistently good service which is accessible equally across the county. The annual report for 2014-15 will detail progress towards the vision of the county's Children and Young People's Plan, that

Somerset children are safe, healthy and cared for
and have integrated support to meet their needs.

Appendix 1: Somerset Local Safeguarding Children's Board Strategic Plan 2014-17

1. **Vision (Children and Young People's Plan):**

Somerset children are safe, healthy and cared for and have integrated support to meet their needs

2. **Priority: Keep Children Safe & Healthy**

Children's Trust, Aim B2: We will ensure clear and robust safeguarding and child protection arrangements are in place to protect children from harm across all statutory agencies

3. **Somerset LSCB**

Section 14 of the Children Act 2004 and Working Together 2013 state that the LSCB has the following statutory objectives and functions:

a. To coordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area, and
b. To ensure the effectiveness of what is done by each such person or body for those purposes.

It carries out these responsibilities through a structure of subgroups, advisory groups and Task and Finish Groups supported by the LSCB Business Team. This operates within the Safeguarding and Quality Assurance Unit and is line managed by the Service Manager - Safeguarding who works closely with the LSCB Independent Chair.

Strategic Objective	Tasks	Responsible
1. Somerset has an effective LSCB which fulfils its statutory responsibilities and promotes a culture of collective accountability, respectful challenge and continuous learning.	a) The governance arrangements enable LSCB partners (including the Health and Wellbeing Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities (including early help) to help, protect and care for children.	LSCB Chair
	b) The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a plan to improve outcomes.	LSCB Business Team LSCB Chair
	c) The LSCB has a local multi-agency Learning and Improvement Framework.	Learning and Improvement Subgroup
	d) The LSCB ensures that high-quality policies and procedures are in place (as required by Working Together to Safeguard Children 2013) and that these are monitored and evaluated for their effectiveness and impact and revised where improvements can be made	LSCB Business Team Quality and Performance Subgroup
	e) The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services.	LSCB Chair Service Manager - Safeguarding
	f) The LSCB is an active and influential participant in informing and planning services for children and families in the area and uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships.	Service Manager - Safeguarding LSCB Chair
2. Somerset has high quality inter-agency safeguarding systems and practice in place which are effective in helping, protecting and caring for children and are delivered by a knowledgeable, experienced and well trained workforce	a) The LSCB has a robust and comprehensive Quality Assurance Framework in place which enables it to monitor the effectiveness of local arrangements and identify where improvement is required in the quality of practice and services that children and families receive.	The Quality and Performance Subgroup
	b) The LSCB has a comprehensive single and multi-agency audit system in place which identifies priorities to improve professional practice and involves managers and practitioners in identifying strengths, areas for improvement and lessons to be learned.	The Quality and Performance Subgroup
	c) Serious Case Reviews, case and management reviews and reviews of child deaths are used by the LSCB partners as opportunities for learning and feedback that drive improvement.	The Learning and Improvement Subgroup Child Death Overview Panel
	d) Sufficient, high-quality multi-agency training is available and is effective in improving front-line practice and the experiences of children, families and carers is evaluated.	Training and Professional Development Subgroup
	e) Annual reports are received and responded to from the Independent Reviewing Unit (IROs and CP Chairs) and the Local Authority Designated Officer (LADO).	Service Manager - Safeguarding
	e) Effective information sharing arrangements are in place for all agencies in Somerset.	Service Manager – Safeguarding LSCB Business Team
3. Somerset has effective arrangements for identifying and responding to the needs of vulnerable children and young people, including promoting early help to prevent escalation of risk and harm.	a) Children at risk of harm are identified early and have their needs met promptly and effectively. This includes vulnerable groups such as children who are privately fostered, those who are disabled, children in care and those with plans (including child protection plans), children living with, and experiencing, domestic abuse and those living with neglect.	LSCB Chair Service Manager - Safeguarding

	b) Thresholds for services are published, widely understood and regularly monitored.	Quality and Performance Subgroup
4. Somerset has effective arrangements for responding to key safeguarding risks, particularly those affecting adolescents (including missing children, child sexual exploitation and trafficking), and through education and training aimed at increasing awareness and resilience.	a) Children and young people are kept safe from harm through a co-ordinated, effective response to the issues of CSE, On-line protection, those who go missing and are at risk of trafficking. b) To reduce incidences of CSE, missing and trafficking through the identification, disruption and arrest of perpetrators. c) Develop training and education for professionals, including schools and colleges, to raise awareness and increase young people's resilience.	Child Sexual Exploitation Strategic Subgroup Child Sexual Exploitation Strategic Subgroup Training and Professional Development Subgroup
5. Somerset LSCB is active and influential through effective engagement with other strategic partnerships, statutory and other partners, front line practitioners, children and young people, parents, carers, and the wider public.	a) Implement the communications strategy to ensure effective communication of key safeguarding messages. b) Engage with children and young people to seek their views and to help shape the work of the LSCB.	Service Manager – Safeguarding LSCB Business Team Service Manager – Safeguarding LSCB Business Team

Appendix 2: LSCB Risk Register

Somerset Local Safeguarding Children Board
Risk Register

1. Introduction

A risk register is a framework for documenting information about risks. It provides evidence that risks to the delivery of business or service objectives are being managed and opportunities for improvement are being identified and actions taken.

The Ofsted inspection framework, published in April 2014, identifies the key aspects that indicate an LSCB is likely to be judged as good. . These form the basis of this Risk Register.

2. Statutory responsibilities

“The Local Safeguarding Children Board (LSCB) complies with its statutory responsibilities in accordance with the Children Act 200431 and the Local Safeguarding Children Board Regulations 2006.32 The LSCB is able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area and there are mechanisms in place to monitor the effectiveness of those local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice. The LSCB checks that policies and procedures in respect of thresholds for intervention are understood and operate effectively and identifies where there are areas for improvement. Challenge of practice between partners and casework auditing are rigorous and used to identify where improvements can be made in front-line performance and management oversight. Serious case reviews, management reviews and reviews of child deaths are used by the local authority and partners as opportunities for learning and feedback that drive improvement. The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and delivery of high-quality services. “

(Ofsted Framework 2014, page 32)

3. Overarching integrity and reputational risk

Description of risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation	Risk owner
1. Inadequate Ofsted inspection outcome	M	H	Deliver a full programme of inspection readiness, linked to self-evaluation and LGA diagnostic	LSCB Independent Chair
2.Negative media exposure	L	L	Clear Communication Strategy: timely communication linked to Communication Policy and role of SCC Communication Team	LSCB Independent Chair
3.Inability to show improved outcomes for children and families	M	H	Dynamic and effective use of the QA Framework and exception reporting through the Q&P subgroup and LSCB Executive, Annual report and other accountability structures	LSCB Independent Chair
4.There is no LSCB vision with explicit priorities which is informed by children and families	L	H	Agreement and review of vision and priorities through Board development activity Effective use of the Voice of the Child Strategy	LSCB Independent Chair

4. LSCB statutory responsibilities

Description of risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation	
5.The requirements of Working Together 2013 are *not* met, required policies and procedures are *not* in place	L	H	Effective membership and use of all LSCB Subgroups including the LSCB Executive. All appropriate and required policies and procedures are in place	LSCB Independent Chair Service Manager - Safeguarding
6. The LSCB business and training plan do not identify outcomes, are not aligned to other plans and do not identify how partner agencies are held to account.	L	H	LSCB agrees the Annual report and Work Plan which reflects priorities, identifies impact and has clear accountability arrangements. There is an effective training strategy and plan in place.	LSCB Independent Chair Chair of Training and Professional Development Subgroup
7.Partners are not			All LSCB members sign the Constitution and understand their	All LSCB partners

engaged in safeguarding and child protection issues and do not deliver local priorities through partnership arrangements	L	H	responsibilities	
8.Partners do not work together within effective governance arrangements	L	H	All LSCB members sign the Constitution and understand their responsibilities. There is clear accountability in place regarding the LSCB, Safeguarding Adults' Board, Children's Trust and Health and Wellbeing Board.	All LSCB Partners
9.The LSCB does not work effectively with the Health and Wellbeing Board and other partnerships	M	M	There is clear accountability in place regarding the LSCB, SAB, Children's Trust, Health and Wellbeing Board and other multi-agency partnerships.	LSCB Independent Chair
10.The LSCB does not monitor and evaluate frontline practice, identifying where improvement is required	M	H	Multi-agency audit and Quality Assurance arrangements are robust and clearly evaluate multi-agency safeguarding practice and communicate clear improvement messages. There is clear accountability and reporting	Chair of Q&P Subgroup LSCB Independent Chair
11.The LSCB cannot show how it and partners hold each other to account	M	H	Challenge log and minutes of meetings are used to provide evidence that is summarised in the Annual Report	LSCB Independent Chair
12.The LSCB does not contribute to an effective commissioning framework	M	M	There is LSCB input to commissioning and planning arrangements across the partnerships	Service Manager - Safeguarding
13.The LSCB does not contribute to the development of a sufficiently skilled, trained and supported workforce	L	H	The Training and Professional Development Subgroup ensures that single and multi-agency training is fit for purpose, supported by audit and lessons from case reviews. Training is well evaluated for its impact on management and practice	Chair of Training and Professional Development Subgroup, learning and Improvement Subgroup, Quality and Performance Subgroup
14.Training does not			Through audit and evaluation ensure single and multi-agency	Chair of Training and

reinforce child centred practice	L	H	training is child centred. Lessons from case reviews are identified, reflected in training and lead to improvements in practice.	Professional Development Subgroup Chair of Learning and Improvement Subgroup
15.The LSCB has no impact on specific vulnerable groups eg CSE, FGM	M	H	Identification of vulnerable groups in LSCB priorities with appropriate subgroup work plans which are monitored for impact	Chairs of all LSCB Subgroups

5. Accountability and review

The LSCB Executive group will review the Risk Register on an annual basis, through the annual reporting process, indicating concerns about risk to that group and the full Board. This review will form part of the content of the LSCB Annual Report which, in turn is presented to other partnerships and bodies as described by Working Together 2013

Matthew Turner
Service Manager – Safeguarding

August 2014

Appendix 3 Budget

Local Safeguarding Children's Board Budget Summary 2013-14

as at 13/03/2014

	SAP Actual/ Committed to date £	Manual Commitments/ Adj to yr end £	Projected 2013/14 £	Budget £	Over/(Under)spend £
Salaries	178,715	11,795	190,510	189,150	1,360
Staff Travel Expenses & Advertising	4,513	1,486	5,999	4,530	1,469
Conference & CP Training costs	34,256	3,247	37,503	34,500	3,003
Multi-agency Case Reviews and Audit	3,000	0	3,000	0	3,000
Total Running Expenses	41,769	4,733	46,502	39,030	7,472
Total Expenditure	220,485	16,528	237,012	228,180	8,832
Income	(127,671)	(114,942)	(242,613)	(228,180)	(14,433)
Overall Overspend(Underspend)	92,814	(98,415)	(5,601)	0	(5,601)

Notes/Assumptions
Expecting Child Death review transfer in £24,300
Expecting income from Adult Social Care in 2014 £10,000
Allows for £3k for serious case review costs

Appendix 4: LSCB: statutory, governance and membership arrangements

1 Statutory and legislative context

1.1 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. The Somerset LSCB was established in 2006.

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

c) to coordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area; and
d) to ensure the effectiveness of what is done by each such person or body for those purposes.

1.3 In addition, Regulation 5 of the LSCB Regulations 2006 sets out that the functions of the Board, in relation to the above objectives, are as follows:

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

- The action to be taken where there are concerns about a child's safety or welfare, including threshold for intervention
- The training of persons who work with children or in services affecting the safety and welfare of children
- The recruitment and supervision of persons who work with children
- The investigation of allegations concerning persons who work with children
- The safety and welfare of children who are privately fostered
- The co-operation with neighbouring children's services authorities and their Board partners

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

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

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

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. This includes Serious Case Reviews (SCRs) and the Child Death Review process.

1.4 Regulation 5 states that the LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

2 Governance and accountability arrangements

2.1 The role of the LSCB is to hold agencies to account, but it is not directly accountable for the operational work of partners. LSCB members are senior managers who are able to:

- Speak for their agency
- Hold their agency to account and challenge its practice
- Make decisions about safeguarding as required and allocate resources
- Ensure that safeguarding is given strategic priority within their own agency.

2.2 This is achieved through collaborative working which ensures that children remain the primary focus of all activity. The LSCB has developed a Constitution that articulates the roles and responsibilities of members who, in turn, are required to sign the constitution.
Each Board member has a primary responsibility for delivering the objectives of the Board with a secondary role of representing their agency. They are expected to ensure that their agency fulfils their responsibilities for safeguarding and protecting children.

2.3 Somerset has retained a Children's Trust and there is also a Health and Wellbeing Board in place. The relationship between the LSCB, the Children's Trust and the Health and Wellbeing Board is one of mutual challenge and holding to account, and is set out in a formal protocol. The document is available on the Children's Trust and LSCB websites. It is also important to note that, following the 2013 Ofsted inspection, there now a Children's Improvement Board in place. The membership of this group includes the chair of the LSCB.

2.4 The independent chair of the LSCB is appointed by the local authority with the agreement of a panel including LSCB partners. The principle role of the chair is to ensure that the LSCB (in the widest sense, including subgroups and time limited work groups) operates effectively and has an independent voice. The Chief Executive of the County Council, drawing on other LSCB partners and, where appropriate, the Lead Member holds the Chair to account for the effective working of the LSCB. The Chair is a participating observer of the Children's Trust and presents the LSCB annual report to the Trust, the Health and Wellbeing Board, the Police and Crime Commissioner and senior leaders across the Council and its partners. The present independent chair took up her role in September 2012.

3 Financial and resourcing arrangements

3.1 The LSCB is supported by members in terms of financial contributions and contributions "in kind". The core funding is provided by Somerset County Council, Avon and Somerset Police and the Clinical Commissioning Group (CCG). Other organisations make smaller financial contributions or contribute in kind. The LSCB budget is largely used to provide staffing, including the Independent Chair, although some posts are financed or employed by other agencies and hosted within the LSCB team. Some statutory partners do not currently make a financial contribution and the LSCB Executive has been given the mandate by the full Board to redress this.

3.2 The 2013-14 LSCB core budget was £228k. A breakdown of this is included as Appendix 1.

3.3 The staffing of the central team of LSCB officers is as follows:

- Service Manager – Safeguarding (LSCB Coordinator) – full-time
- 2 LSCB Training Officers – 1.2 full time equivalent
- 1 LSCB Audit Officer – 0.6 full time equivalent
- 1 Education Safeguarding Advisor – 0.6 full time equivalent
- 1 Child Death Review Manager – full time (CCG employee)
- 1 Child Safe Coordinator – 0.4 full time equivalent
- 1 Child Death Review Administrator – 0.5 full time equivalent
- 1 LSCB Administrator – 0.5 full time equivalent

3.4 Other administrative support is provided from the Children's Social Care Central Support Team.

3.5 The 2012/13 Annual report indicated that a number of additional responsibilities were included under the management responsibilities of the Service Manager – Safeguarding. This arrangements ceased in January 2014, enabling the Service Manager to concentrate on the development and management of the LSCB.

4 LSCB Membership and Attendance

4.1 The following core agencies are represented on the Board itself with others contributing to the work of the subgroups:

- Somerset County Council
- The lead member for children (as a participating observer)
- Somerset Clinical Commissioning Group and other hospital and community health trusts
- Avon and Somerset Probation Trust
- Avon and Somerset Police
- Further Education colleges
- Maintained and Independent Schools
- Devon and Somerset Fire Service
- Voluntary organisations delivering services in Somerset

4.2 The full Board meets between four and five times a year, as does the Executive group. The Board and its sub-groups are supported by the LSCB Coordinator and officers from the central LSCB team.

4.3 There have been changes and a rationalisation of membership during the year. There were five meetings during the reporting period, all chaired by the independent chairperson, with Board attendance as follows:

Statutory Board partners

Agency	% Attendance (5 meetings)
SCC, Chief Executive	40% (Not formally a member)
Director of Children's Services, SCC	100%
Adult Services, SCC	20%
Education (Central Services)	60%
Children's Social Care, SCC	80%
District Councils	80%
Avon and Somerset Police	100%
Probation Trust	100%
Youth Offending Team, SCC	100%
Somerset CCG, Patient Safety	60%
CCG Designated Nurse	100%
CCG Designated Doctor	100%
Somerset Partnership	100%
SCC, Lead Member	60% (Participating Observer)
Taunton NHS Trust	80%
Yeovil District Hospital Trust	80%
CAFCASS	20%

Additional partners

Agency	% Attendance (5 meetings)
Action for Children	40%
Barnardo's	80%
Armed Forces	60%
Community Member	20% (First meeting September 2013)
Connect SW/Connexions	0% (No longer a member)
Crown Prosecution Service	40%
General Practitioners (GPs)	20% (No longer a member)
Public Health	80%
Domestic Abuse Services	20% (No longer a member)
Drug and Alcohol Advisory Team	20% (No longer a member)
Ecumenical Churches	80%
Fire Service	0%
LSCB Central Team	100%
Children's Centres	40% (No longer a member)
Primary Schools	60%
Secondary Schools	20%
Independent Schools	60%
FE Colleges	100%
Somerset Skills and Learning	0% (No longer a member)
Special Schools	40%
Somerset Racial Equality Network	0% (No longer a member)
NHS England	100%
South West Ambulance Service Trust	40%
CHYPPS (Representing small voluntary agencies)	80%

Appendix 5: Subgroups and reporting groups 2013 – 14

1. LSCB Executive Group

Core membership and attendance	• **Chair: LSCB Independent Chair – 100%** • Children's Services, SCC – 75% • Children's Social Care – 50% • Somerset Clinical Commissioning Group – 100% • Avon and Somerset Police – 100% • Learning and Achievement Services – 25% • LSCB Coordinator – 100%
Frequency of meetings	Quarterly
Main focus	Develop the LSCB agenda, agree priorities, receive assurance reports, monitor compliance and improvement and progress work.
Activity	The LSCB Executive group meets between Board meetings in order to agree the business to be taken to the Board, clarify issues and actions that require challenge and attention and generally drive the activities of the LSCB, leading improvement across the partnership, leading to better outcomes for children.
Future work	Following the agreement of the LSCB priorities, the Executive Group will focus on ensuring these are progressed in a timely and effective fashion. It will continue to monitor and challenge partners in order to lead improvement in services.

2. Quality and Performance Subgroup

Core membership and attendance	• **Chair: This has changed during the reporting period, moving from a co-chaired arrangement, to the DCS. In 2014-15 it will be chaired by the Quality Assurance Manager for Children's Services, SCC – 60%** • Somerset Clinical Commissioning Group (now represented by Somerset Partnership – 80% combined • Children's Social Care (Now represented by QA Manager) – 100% combined • Learning and Achievement – 20% • Avon and Somerset Police – 60% • LSCB Coordinator – 100% • LSCB Audit Officer – 80%
Frequency of meetings	Quarterly (Additional meeting during spring 2014 in order to progress work – total 5 meetings)
Main focus	The membership of the Subgroup has changed significantly during this period in order to strengthen the

	work of the group and improve accountability. The work centres on challenge, audit and quality assurance using the agreed LSCB Performance Framework. Agree priority areas for audit, monitor progress and subsequently consider audit outcomes; commissioning training and learning events accordingly. Lead the Section 11 audit, develop, signoff and disseminate new multi-agency policies and procedures
Activity	The subgroup has overseen the work of the LSCB Audit Subgroups and other specific audits, led the development of the now agreed LSCB Performance Framework, developed a collaborative approach to the Section 11 audit, developed an on-line audit tool to evaluate LSCB effectiveness.
Future work	This now strengthened group will settle into quarterly meetings with a primary focus on Quality Assurance and challenge of multi-agency practice and performance using the LSCB Framework as the main mechanism for doing so. It is anticipated that this will in time move the QA function away from the Children's Improvement Board. The current Section 11 report will be concluded and then repeated as required.

3. Learning and Improvement subgroup

Membership and attendance	• **Chair: Director of Nursing and Patient Safety, CCG – 100%** • Somerset Clinical Commissioning Group – 83% • Children's Services, SCC – 83% • Avon and Somerset Police – 83% • Learning and Achievement – 83% • Safer Somerset Partnership- 40% (member for five meetings, attending when required) • Drug and Alcohol Partnership – 50% (member for four meetings, attending when required) • LSCB Central Team – 100%
Frequency of meetings	Six meetings a year
Main focus	The Subgroup receives information and reports relating to cases that are to be considered for multi-agency review, including those that may meet the threshold for Serious Case Reviews. (For these it is charged with making SCR recommendations to the Independent Chair of the LSCB) The subgroup agrees proportionate methodology and uses the submitted reports to identify key lessons for improving interagency safeguarding practice, commissioning training or audit activity as required. A Learning and Improvement Case Log is maintained.
Activity	The Subgroup has considered three cases as possible SCRs, making the recommendation to the Chair of the LSCB in one case that an SCR is initiated. This was accepted and a review conducted. Other reviews have

	been progressed leading to a series of agreed action plans designed to improve outcomes for children. Templates have been developed to ensure consistent and timely gathering of information and a range of methodologies have been considered.
Future work	The Subgroup will monitor and assure the progress of the action plan arising from the Serious Case Review and continue to ensure the progress of other current reviews in order to improve services. It will continue to identify new cases to review and maintain oversight of the Learning and Improvement Strategy in accord with Working Together 2013.

4. Health Advisory Group

Core membership and attendance	• **Chair: Designated Nurse, Somerset CCG – 100%** • Somerset Partnership (multiple representation) – 100% • Taunton and Somerset NHS Trust (multiple representation) – 100% • Named GP – 66% • Yeovil District Hospital Trust (multiple representation) – 100% • LSCB Central Team – 100% • Somerset Drug and Alcohol Partnership – 100% • South West Ambulance Services Trust – 0%
Frequency of meetings	Quarterly but 3 held in this reporting period
Main focus	The subgroup provides a forum for lead health practitioners, including designated and named professionals, to discuss practice issues and developments across the spectrum of health and health-related safeguarding work. The group oversees policy and practice development across the Health Providers (linking to commissioning outcomes with the CCG), provides a forum to discuss national guidance, new initiatives and share best practice and expertise on safeguarding issues including those arising from Serious Case Reviews and other learning opportunities.
Activity	There has been information sharing in order to raise the awareness of the Somerset Common Assessment Framework process, Early Help and the LSCB Threshold document, alongside discussion about other planned restructuring initiatives across services, including SCC Children's Services allowing opportunity to consider the impact on health providers and their desired outcomes for children. There has been a presentation about changes to Drug and Alcohol services in the county with similar opportunity for discussion about impact. There has been opportunity to discuss the learning identified by the Learning and Improvement Subgroup

	and how health agencies can make improvement. The meetings are split into two parts – the first is "business" and the second part is designed to allow practitioners to consider cases and practice examples in order to discuss practice learning and improvement.
Future work	The subgroup is the main Health based forum for discussion regarding best practice in safeguarding and child protection.. Learning from case reviews, including the current SCR, will be incorporated into the work plan of the group.

5. Education Advisory Group

Core membership and attendance	• **Chair: Service manager, Vulnerable Learners, Learning and Achievement – 100%** • LSCB Central Team – 100% • Secondary Schools – 33% • Primary Schools – 100% • Independent Schools – 0% • Further Education Colleges – 33% • South West Grid for Learning – 66% • Health representation – 66% • Children's Social Care - 0% • Voluntary Sector – 0% • Public Health – 33% • Avon and Somerset Police – 33%
Frequency of meetings	Quarterly but three meetings during this reporting period
Main focus	This is a newly initiated group bringing managers from across the range of education settings together to consider key issues about safeguarding and child protection: learning from case reviews and research and specific practice issues within Somerset. .The group also has responsibility for developing and supporting single and multi-agency arrangements for on-line safety, monitoring the effectiveness of the E Safety Strategy and related activity.
Activity	During the meetings within this reporting period the group has considered information relating to the impact, particularly regarding education, on children of having a parent in prison. There has been information sharing and discussion about the Somerset arrangements for the Common Assessment Framework and the implementation of Signs of Safety, particularly focussing on the likely impact for schools. The arrangements for ensuring that police reports of Domestic Abuse incidents involving children are passed to schools in a timely fashion have been reviewed and enhanced, providing improved support for children likely to be affected. Safer Internet Day has been reviewed, considering national activity and local involvement with schools. There have been regular updates from South West Grid

	for Learning about their material including on-line safety self-assessment tools for schools.
Future work	The group will work to include Special Schools and Early Years more consistently in its membership. On-line protection remains a priority and this group is accountable to the Child Sexual Exploitation Sub Group in order to ensure that the clear links are used to inform the overall response to vulnerable adolescents, Education practitioners and managers will continue to use this group as the main location of strategic discussion about safeguarding, potentially developing a clear accountability for the county-wide groups for Designated Teachers.

6. Child Sexual Exploitation Subgroup

Core membership and attendance (Still being established following transition from Safeguarding Adolescents Group)	• **Chair: Operations Manager, Children's Social Care, SCC (Previously Youth Offending Team Manager)** • LSCB Central Team • Children's Social Care • Learning and Achievement/Vulnerable Learners • Avon and Somerset Police • Somerset Clinical Commissioning Group • Somerset Partnership • Somerset Safer Communities • District Council Representation • Youth Offending/Targeted Youth Support • Voluntary Sector
Frequency of meetings	Quarterly
Main focus	This group has developed from the Safeguarding Adolescents Subgroup which began to meet in April 2013, as response to a priority area of development for the LSCB. Its aim is to provide a consistent strategic multi-agency response to Child Sexual Exploitation and support to agencies in their work with children and young people who are vulnerable to CSE. The group will also be responsible for the response to children missing from home and care and on-line safety (through the Education Advisory Group.
Activity	The group has developed and agreed the Somerset CSE strategy and has commissioned a multi-agency on-line audit of CSE awareness across all partners in order to further inform the implementation of the strategy and ensure that appropriate training is in place, Work continues to develop the CSE multi-agency Conferences, locating that activity within the development of the Multi-agency Safeguarding Hub
Future work	In addition to the embedding of the CSE strategy, the Sub Group will need to pay attention to the response to missing children, using data to inform future developments.

7. Training and Professional Development Subgroup

Core membership and attendance	• **Chair: Designated Nurse, Somerset CCG – 100%** • LSCB Central Team - 100% • Avon and Somerset Police – 50% • Avon and Somerset Probation Trust – 25% • Taunton and Somerset NHS Trust – 50% • Yeovil District Hospital Trust – 50% • Somerset Centre for Integrated Learning (SCC) – 75% • Somerset Partnership – 75% • Learning and Achievement/Vulnerable Learners – 100% • Safer Somerset Partnership – 100%
Frequency of meetings	Quarterly
Main focus	Ensuring the appropriate provision, delivery and effectiveness of multi-agency safeguarding and child protection training across agencies represented on the LSCB. The management of the Multi-agency Practitioner Interest groups (MAPIGs) will be taken into this group along with the organising of the LSCB Annual conference.
Activity	The Training and Professional Development Subgroup is responsible for development and assurance of multi-agency child protection and safeguarding training, working closely with the LSCB trainers and central team. It is anticipated that this relationship will continue to develop. The subgroup is also responsible for overseeing the annual LSCB interagency training programme which includes discussion around the monitoring of courses with low attendance, agency attendance at LSCB training and specific agency requests for training. The consideration of developing and maintaining a pool of experienced trainers is required to continue to provide quality assured training, to provide delegates with the appropriate knowledge and skills to protect children and young people. The group has recently taken responsibility for the MAPIGs and the LSCB annual Practitioners' Conference. Working closely with the Quality and Performance and Learning and Improvement subgroups, the group also identifies how to meet single and multi-agency training needs.
Future work	The group will ensure that there are robust Quality Assurance arrangements in place across partners to measure the effectiveness of training. The Training Strategy is currently being revised to reflect changing requirements of partners and reflect Working Together

	2013, including the development of a multi-agency training pool.

8. Child Death Overview Panel (CDOP)

Core membership and attendance (Four meetings)	• **Interim Chair: Director of Nursing and patient safety, Somerset CCG – 100%** • LSCB Central Team – 100% • Child Death Review Manager – 100% • Avon and Somerset Police – 100% • Somerset Clinical Commissioning Group – 100% • Taunton and Somerset NHS Trust – 100% • Yeovil District Hospital Trust – 100% • South West Ambulance Service Trust – 50% • Learning and Achievement – 50% • Somerset Partnership – 25% • Children's Social Care – 100%
Frequency of meetings	Approximately quarterly (based on need)
Main focus	To review the deaths of all children and young people who die in Somerset in line with statutory requirements and Working Together 2013
Activity	In line with statutory guidance, the CDOP reviews the deaths of all children under 18 who die in Somerset. Any modifiable factors are identified and recommendations for action made in order to improve services and outcomes for children and young people across Somerset. There are many examples of specific changes in practice which have come about as a result of CDOP considerations; these can be found in the CDOP annual report, available through the LSCB website.
Future work	Working Together 2013 continues to require LSCBs to have a CDOP as a subgroup and the remit has remained the same. The work of the Somerset multi-agency CDOP will continue, contributing improvement to services across LSCB partners working in Somerset.