Somerset Local Safeguarding Children Board

Annual Report 2012 – 2013

www.somersetlscb.org.uk

Foreword by the Independent Chair

This annual report provides an assessment of the performance and effectiveness of local services in safeguarding and promoting the welfare of children in Somerset during 2012-2013, 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.

This is the first annual report to be published since I was appointed as independent Local Safeguarding Children Board (LSCB) chair in September 2012. As is usual in the world of safeguarding, the period has been characterised by significant change to the strategic context in which the LSCB operates, both within and beyond Somerset.

The economic downturn and changes in the rules around welfare and housing benefit will make conditions for vulnerable children tougher from April 2013 onwards. The LSCB, working with the new Health and Wellbeing Board, has an important role to play in monitoring the impact of these changes.

The long awaited revised statutory guidance *Working Together to Safeguard Children* was published in March 2013. It introduces a number of significant changes for LSCBs and their constituent agencies, which will be considered and acted on in the coming year, in the context of the LSCB business plan for 2013-15.

For Avon and Somerset Police, the introduction of the Police and Crime Commissioner has changed the accountability and governance arrangements of the force, and can be expected to have an impact on priorities in due course.

The health sector has seen even more changes, with national as well as local reorganisation including the introduction of the Clinical Commissioning Group (CCG)

locally and NHS England nationally, the cessation of the Strategic Health Authority, and the transfer of Public Health responsibilities into the County Council.

Within the County Council, changes in the leadership of Children's Services led to the Chief Executive temporarily assuming the statutory responsibilities of the Director of Children's Services pending the appointment of an interim DCS.

Representatives on the LSCB of these organisations have worked hard and successfully to ensure that services and relationships have been maintained through this transitional period, together with continuity of LSCB membership.

During this reporting period and since the publication of the last annual report, there has been an inspection by Ofsted of Somerset's safeguarding and looked after children services (in April-May 2012). There have also been two additional independent assessments of safeguarding and child protection arrangements, commissioned by Somerset County Council from the Local Government Association and Children's Improvement Board: a safeguarding practice diagnostic (March 2013) followed by a peer safeguarding review which concluded in April 2013. All of these have shone a helpful light on safeguarding practice and interagency working within the county. Details of their findings are included in the report, together with the outcomes of a serious case review which was published in April 2013.

The LSCB undertook an assessment of its functioning in July 2012, which proved helpful in identifying areas of challenge and improvement. Since then, the Board has begun to grow in confidence and effectiveness, and is in an improving position to have a positive impact on arrangements for safeguarding the children and young people of Somerset, whilst Board members are beginning to reflect together on the quality of their services, learning from their own practice and that of others. However, members are of course reliant on the skills and dedication of their staff who – working together with families and communities – are the ones who make the difference day to day. I thank them for their work, as well as the members of the LSCB and its support team.

Sally Halls
Independent Chair

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1. Preface

1.1 This is the annual report and business plan for the Somerset Local Safeguarding Children Board. It covers the reporting period between April 2012 and March 2013 and evaluates the work and impact of the Board whilst identifying 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 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 The report has been ratified by the Executive Group of the LSCB in June. It was presented in final version to the full Board in July 2013 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 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 bodies 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.

2.3 Governance and accountability arrangements for the Board are described, 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 external challenge to the work of the LSCB in the form of the Ofsted inspection and the issues that it produced. This was further added to by the peer review of spring 2013 and the publication of the 2013 version of Working Together which outlines increased responsibilities for, and expectations of, the LSCB. In response, there has been significant activity within the wider LSCB in order to improve accountability and effectiveness, led by the newly appointed independent chair. There have been practical and structural changes as well as a 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 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 has been completed during 2012/13 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 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 Finally, challenges are identified for local agencies and partnerships, as well as for the LSCB itself.

2.8 The LSCB has identified a number of priority areas of work for the coming three year work plan cycle and these are included here. 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

2.9 It also identified the following cross-cutting themes which underpin the effectiveness and quality of the 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)

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

2.11 To improve the effectiveness of the LSCB itself, there is likely to be a need for additional capacity and resources. This will be negotiated with partners during the year ahead.

3. Local background and context

3.1 Somerset is a large, mainly rural, county with an area of 3,452 square kilometres. The total population is approximately 525,000 people (amounting to 10% of the population of the south west region) and of these 108,782 are children aged 0 to 17 years old – about 21%. 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 some 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 10,717, approximately 2% of the total population.

3.3 In comparison to England, deprivation levels are low 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 is 21.1%

3.4 The number of children with a child protection plan has largely levelled off – although an increasing trend is beginning to show in 2013. At the end of March 2013, there were 317 children with child protection plans (from 155 families) living in the county. This is approximately 30 per 10,000 compared to a national rate of 37.8. There were also 25 children with a child protection plan from 20 families who were temporarily living in Somerset during the year.

3.5 Within this reporting period, 1.4% of child protection plans lasted for two years or more with most lasting between six and twelve months. This figure was 5.7% at the time of the previous SSCB annual report and so this represents a significant decrease. The national average is 5.6%.
For the year to date, in Somerset the following categories of child protection plans apply:

- Multiple – 17.8 %
- Emotional – 48.4 %
- Neglect – 28.6 %
- Physical – 4.1%
- Sexual – 1.3 %

3.6 At the end of March 2013 there were 513 children in care – 47.2 per 10,000 children compared to a national rate of 59. 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.

3.7 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 2013, there were 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.

3.8 There were 9 children notified as privately fostered; although it is likely that there is 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.

3.9 As of March 2013, there were 238 fostering households approved by Somerset, providing approximately 373 beds across all approval categories, five local authority residential children's homes offering 21 beds plus three homes designed for children with disabilities which provide long terms and respite placements. Of Somerset children in care, 139 were placed with independent providers (both fostering and residential placements), some within the county boundary and others outside.

3.10 In the year between April 2012 and March 2013, 40 children were given permanence either in adoptive placements (30) or through Special Guardianship Orders (10).

4. The Local Safeguarding Children Board

4.1 Statutory and legislative context

4.1.1 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.

4.1.2 The Somerset LSCB was established in 2006. It 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 (Sec. 14, Children Act 2004)

4.1.3 In addition, Regulation 5 of the LSCB Regulations 2006 sets out that the functions of the Board, in relation to the 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.

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

4.2 Governance and accountability arrangements

4.2.1 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.

4.2.2 This is achieved through collaborative working which ensures that children remain the primary focus of all activity.

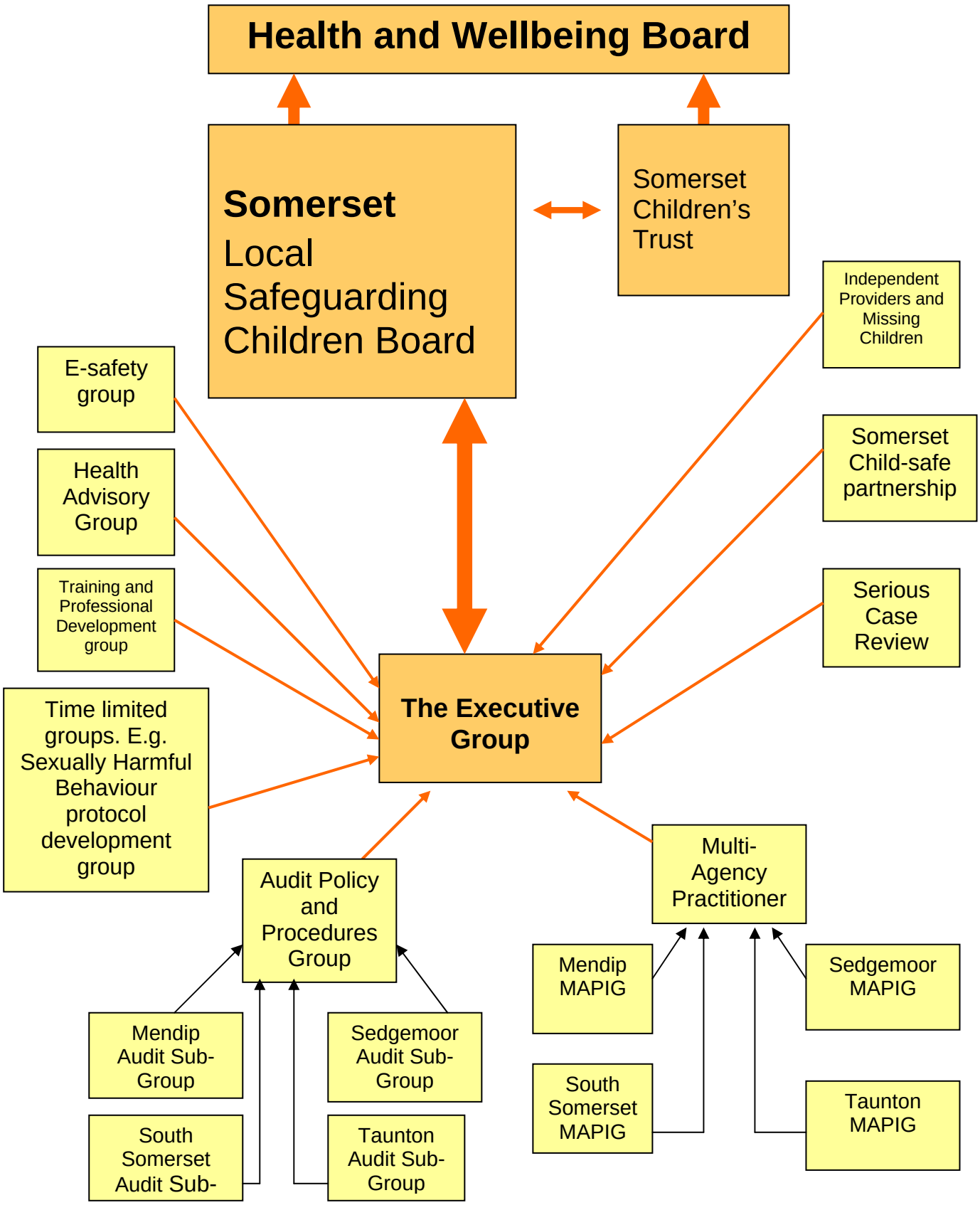
4.2.3 Each Board member has a primary responsibility for delivering the objectives of the Board with a secondary role of representing their agency. They are expected to ensure that their agency fulfils their responsibilities for safeguarding and protecting children.

4.2.4 Somerset has retained a Children's Trust and there is currently a Health and Wellbeing Board that is in transition from shadow form to full function. 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.

4.2.5 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) works effectively and has an independent voice. The Chief Executive, 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 autumn 2012.

Somerset Local Safeguarding Children Board

Structure chart – 2011/12



4.3 Financial and resourcing arrangements

4.3.1 The LSCB is supported by members in terms of financial contributions and contributions "in kind". The core funding is provided by the local authority, Avon and Somerset Police and the Health organisations, primarily the Clinical Commissioning Group (CCG), previously the Primary Care Trust (PCT). 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.

4.3.2 The 2012-13 LSCB budget was £261,950. A breakdown of income and expenditure is included as Appendix 1.

4.3.3 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 Child Protection Advisor – 0.6 full time equivalent
- 1 Child Death Review Manager – full time (CCG employee)
- 1 Child Safe Coordinator – 0.5 full time equivalent
- 1 Child Death Review Administrator – 0.5 full time equivalent
- 1 LSCB Administrator – 0.5 full time equivalent

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

4.3.5 In addition, during the reporting period, the following responsibilities were included under the management of the Service Manager – Safeguarding:

- Management of the independent Child Protection Conference Chairs
- The Local Authority Designated Officer for the management of allegations against adults who work with children (LADO) (since April 2013)
- The management of Children Act complaints

4.3.6 These arrangements have been the focus of review and are expected to change during 2013, with a resulting increase in capacity for the LSCB.

4.4 LSCB Membership and Attendance

4.4.1 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 (formerly the PCT) 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

4.4.2 The full Board meets four 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.

4.4.3 Board attendance April 2012 – March 2013 was as follows:

Statutory Board partners

Agency	**% Attendance (4 meetings)**
SCC, Chief Executive	50%
Director of Children's Services, SCC	75%
Adult Services, SCC	0%
Education (Central Services)	100%
Children's Social Care, SCC	100%
District Councils	50%
Avon and Somerset Police	75%
Probation Trust	75%
Youth Offending Team, SCC	100%
Somerset PCT, Patient Safety	25%
PCT Designated Nurse and Doctor	100%
Somerset Partnership	100%
SCC, Lead Member	100%
Taunton NHS Trust	100%
Yeovil District Hospital Trust	100%
CAFCASS	50%

Additional partners

Agency	% Attendance (4 meetings)
Action for Children	75%
Barnardo's	50%
Armed Forces	50%
Connect SW/Connexions	0%
Crown Prosecution Service	0%
General Practitioners (GPs)	25%
Public Health	25%
Domestic Abuse Services	75%
Drug and Alcohol Advisory Team	50%
Ecumenical Churches	75%
Fire Service	25%
LSCB Central Team	100%
Children's Centres	50%
Primary Schools	25%
Secondary Schools	75%
Independent Schools	25%
FE Colleges	75%
Somerset Skills and Learning	0%
Special Schools	50%
Somerset Racial Equality Network	50%
Strategic Health Authority	75%

4.4.4 Much of the work of the LSCB is conducted through subgroups, and by its central support team. Details of these are found in appendix 2.

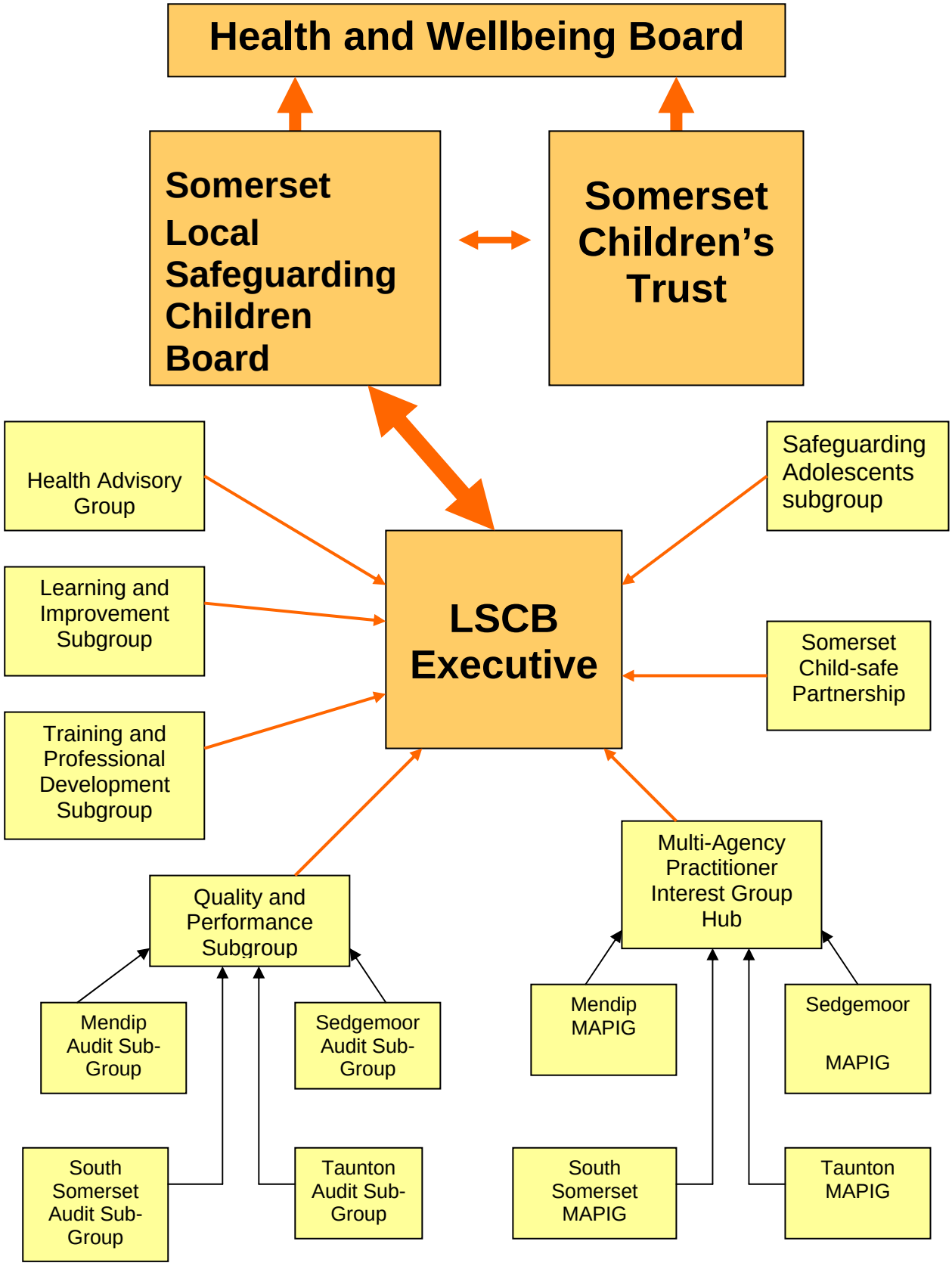
4.4.5 The Executive Group has the responsibility of monitoring and co-ordinating the work of the LSCB. Task and finish groups are convened as required in order to carry out specific pieces of work. These groups collectively support the work of the LSCB by completing specific tasks from the work plan and are well supported by LSCB members.

4.4.6 In order to strengthen the LSCB arrangements, there is a Safeguarding Adolescents subgroup now in place which draws together a number of closely related priorities and work areas including those previously covered by the Missing Children, Sexually Harmful Behaviour and E-Safety Subgroups.

4.4.7 The Audit, Policy and Procedures subgroup has been reviewed and strengthened to become the Quality and Performance Subgroup. A new Learning and Improvement Sub-group – which incorporates the functions of a SCR panel – is now in place.

Somerset Local Safeguarding Children Board

Structure chart – 2012/13



4.4.8 The specific work plans of the subgroups are included in the Board's business plan (see Appendix 3).

5. Assessment of LSCB effectiveness

5.1 There are areas in which the LSCB is carrying out its co-ordinating and assurance role effectively. In addition to areas mentioned elsewhere in this report, these include:

- The co-ordination and oversight of safeguarding in health services through the Health Advisory Group and regular assurance reporting to the LSCB
- The early development and implementation of Child Sexual Exploitation MACs (multi-agency conferences)
- Early engagement with the Adult Safeguarding Board through joint work (although this needs further development)
- Increasing engagement of the LSCB in oversight of commissioning activity
- Using a multi-agency approach to auditing case files

5.2 However, the LSCB was criticised by Ofsted (2012) for being too 'comfortable'. As a first step in addressing this, an online survey was completed in September with members of the LSCB which was designed to elicit from members what aspects of Board meetings were found to be most and least helpful. A number of suggestions were made for positive changes and these have already been put in place. They include simple steps such as organising the LSCB agenda to focus on its key functions of co-ordinating and ensuring effectiveness of safeguarding arrangements.

5.3 The LSCB has not included community (lay) members to date. A recruitment process has been completed and three community members appointed, who will commence during the summer/autumn of 2013. They will 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 safety issues and an improved public understanding of safeguarding and the work of the LSCB.

5.4 Further changes to the architecture, membership and organisation of the LSCB will follow in 2013-14.

5.5 A major task has been to strengthen the Board's challenge role and ensure that members of the Board itself and its sub-groups are clear about their responsibilities: to date, the LSCB has not carried out its function of challenging performance with sufficient rigour, focussing more on "monitoring" activity. In order to do this, the LSCB must have well developed quality assurance arrangements and capacity, supported by a comprehensive performance framework.

5.6 Following the publication of the Department for Education LSCB Performance

Framework requirements, the Somerset LSCB has been developing a framework that incorporates the national requirements and prescribed local information, together with data which derives from the identified priority development areas for the LSCB business plan. This incorporates some of the information that was previously reported through the local LSCB Performance Indicators into a single reporting document. Its development forms part of the activity aimed at improving the effectiveness of the LSCB's multi-agency quality assurance arrangements, which has focused to date primarily on Children's Social Care.

5.7 Sensitivity to equality and diversity is an area of work that needs more attention. It is not specifically addressed in any LSCB activity, such as case reviews and audit where it should be actively considered. In terms of ethnicity, the information about the Somerset population is made available to LSCB members and other demographic information can be made available upon request. 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. However, within the work of the LSCB, this information is not used to inform work. Nor has the LSCB challenged the performance of other agencies in this respect.

5.8 Other areas where improvement is still needed include:

- Completing and publishing a multi-agency 'threshold' document which addresses access to universal, targeted and specialist services
- Improving alignment with the Safer Somerset Partnership arrangements, specifically in relation to domestic abuse
- Developing engagement with the Youth Justice Board and Local Family Justice Board
- Developing engagement with services to vulnerable adults who are parents

5.9 In conclusion, there have been improvements in the functioning of the LSCB over the past months, supported throughout by the continued commitment of partners. Board members appear to be enthused by the more rigorous approach and are becoming energised: it is now important to sustain and further enhance this work in order to continue to improvement effectiveness and impact. A necessary pre-requisite, however, will be increased resourcing and capacity. The prompt implementation of the outcomes of the review of the Independent Reviewing Unit within the council should assist, but will need to be carefully monitored.

6. Performance and effectiveness of local arrangements

6.1 Somerset County Council: Children's Social Care

6.1.1 In addition to LSCB oversight, there have been external assessments of the effectiveness of Children's Social Care services provided by the County Council.

6.2 Inspection of safeguarding and looked after children services

6.2.1 This was carried out by Ofsted in April - May 2012. The judgements were as follows:

Safeguarding Services

- Overall Effectiveness Grade 3 - Adequate
- Capacity to Improve Grade 3 – Adequate

Looked After Children

- Overall Effectiveness Grade 3 - Adequate
- Capacity to Improve Grade 3 – Adequate

6.2.2 Whilst recognising that the local authority and its partners have clear ambition and appropriate priorities for children and young people across the county, and many strengths, the inspection also highlighted a number of areas in need of significant improvement and Ofsted made the following requirements:

Immediately:

- Ensure consistent and effective strategy discussions in child protection enquiries as well as their timely recording

- Clarify precisely how the requirements of the DCS roles and responsibilities are to be discharged effectively.

Within three months:

- Ensure that no vulnerable young person over 16 years is provided with bed and breakfast accommodation in response to homelessness

- Improve the quality of assessments ensuring full consideration of significance of familial history, individual diverse factors and ensure that children are sufficiently engaged in assessments and planned work

- Ensure that child protection and other plans are more outcome focused with appropriate contingency arrangements

- Review thresholds for prioritising timely interventions for children with emotional and mental health difficulties by the CAMHS

- Develop performance management arrangements that demonstrate good analysis and evaluation of performance information which should include performance

reporting and aggregated learning from independent reviewing officers and case conference chairs

- Provide sufficient and sustainable support services to young carers and a clear response to their concerns.

6.2.3 The Council established a multi-agency Improvement Board to oversee the improvement activity, which has included the LSCB chair. Regular reports on progress have been made to the LSCB throughout the year. These show that, whilst some progress has been made, the pace and consistency of improvement needs accelerating.

6.3 Safeguarding practice challenge and peer review

6.3.1 The Local Government Association Peer Review and safeguarding practice challenge, both of which took place in spring 2013, again noted a number of areas of strength and progress, including within the LSCB itself.

6.3.2 A number of areas were highlighted as being in need of action both within the council and across the wider partnership:

- Developing a co-ordinated and strategic approach to the provision of early help, including to families where domestic abuse is an issue
- Improving quality and consistency of assessment, care planning and outcomes for children
- Workforce engagement, support and development
- Increasing the engagement with and influence of children, young people and families in the planning and delivery of services
- Developing a comprehensive approach to quality assurance, including the use of performance information to drive improvements.

6.3.3 Actions arising from the peer review have been incorporated into the improvement activity noted above. In addition, a rigorous case mapping exercise was completed with the following conclusions and outcomes:

- A need to strengthen multi-agency awareness of other services, duties, responsibilities
- Procedures and thresholds. There was evidence of concern from agencies regarding what were considered to be excessively high thresholds for involvement and intervention
- A need for improved and shared recording systems to support effective child protection work

- A need for better communication between agencies following referrals or key developments in a particular case.

6.3.4 A number of actions were identified following the case mapping exercise:

- Members of the case mapping group will roll out the learning from this exercise to the relevant agencies

- Children's Social Care have committed to sharing the learning from this process with the area teams within three months of the peer review

- The agencies involved will look to develop case mapping as an audit process

- Where chronologies have been created as a direct part of the case mapping group work, these are intended to be placed on the relevant file for future use

- This report will be shared with the Local Safeguarding Children Board, the Children's Improvement Board, and the Social Care Management Group.

6.3.5 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 safety and robustness of interim senior management arrangements that were in place, following recent significant staff and management changes within Children's Services in the local authority. Future scrutiny will be extended to incorporate the outcomes of a more recent Ofsted inspection in June 2013.

6.3.6 Critical to improvement in Children's Social Care is the development of a more robust Quality Assurance function. Improving the effectiveness of the Independent Reviewing Unit (IRU) is central to this. In early 2013, through the SCC Improvement Board, a review of the Independent Child Protection Conference chairs and the Independent Reviewing Officers (IROs) for children in care was commissioned; the report author was a senior manager in Adult Services with experience of managing Children's Services. This review of the IRU functions made a number of recommendations for the improvement of the service in the context of a number of other required structural and organisational changes required in Children's Services following the Peer Review. One aspect of the review, particularly pertinent for the LSCB, was the identification of a serious capacity issue within the management and operational structure of the central LSCB team. Rectifying this is necessary in order to provide sufficient capacity to carry out the work identified to bring about the required improvement in the work of the Board.

6.4 Private fostering

6.4.1 The LSCB receives regular reports relating to children who are privately fostered. The most recent of these was received before this reporting period. This will be rectified in 2013/14.

6.5 Health assurance

6.5.1 NHS organisations are enthusiastic and knowledgeable contributors to the LSCB. NHS Somerset continues to ensure that safeguarding remains a priority area during the period of change and transition to Clinical Commissioning Groups. It is critical that the high level of decision making, clear lines of accountability and leadership are maintained. A robust approach is taken to the performance monitoring of safeguarding children arrangements in all commissioned services. The designated nurse for safeguarding children works closely with all NHS Trusts to advise on safeguarding practice, and to monitor the effectiveness of their arrangements.

6.5.2 Safeguarding practice is complex and continually evolving and the process of effective commissioning seeks to maintain the high quality of services to safeguard and promote the welfare of children and young people, including the service provision for children who are looked after. In the new NHS all organisations and services must seek to enhance and develop safeguarding practice to include more effective inter-agency working to help children and young people, who are suffering and protect the most vulnerable who are likely to suffer significant harm.

6.5.3 The Board of NHS Somerset will continue to receive regular reports on compliance and progress.

6.5.4 During the reporting period, a number of audits and case reviews have been carried out as follows:

SOMERSET CLINICAL COMMISSIONING GROUP

SAFEGUARDING CHILDREN AUDITS IN HEALTH SERVICES 2O12 – 13

Organisation	Audits	Outcome
Somerset Partnership NHS Foundation Trust	Public Health Nursing Child Protection Clinical Supervision Audit	Illustrated an overall improvement in the quality of child protection clinical supervision compared to the previous audit. . A key piece of work to come out of the audit was the development of a new integrated Trust *Child Protection in Clinical Supervision Case Work Policy*.
	Local Safeguarding Children Board Audit of Pre Birth Assessments	The report concluded that health visitors correctly recorded child protection concerns. Concerns were identified regarding communication from Children's Social Care to the health visiting service in terms of placement moves and dates and times of meetings.

	Post OFSTED/CQC Inspection Public Health Nursing Documentation Audit	The results of the audit illustrated a significant improvement in the quality of clinical records in all areas with only one audit standard remaining with a red RAG rating.
	CAMHS Safeguarding Knowledge and Skills Audit	Overall staff reported a positive experience for all safeguarding processes they are involved with. Staff reports of training and clinical supervision processes were particularly positive. A key recommendation from this audit was a requirement for all CAMHS managers who provide child protection clinical supervision to their staff to attend the Local Safeguarding Children Board *Child Protection Clinical Supervision* training course.
	Quality of Looked After Children Health Review Assessments / Looked After Children Team Documentation Audit	The Looked After Children team have now migrated to the RiO electronic clinical records system which is substantially improving the quality of the records completed. Changes to internal processes have also improved the quality of the health assessments completed.
Taunton and Somerset NHS Foundation Trust		
	Compliance with Safeguarding processes in the Emergency Department (ED)	Sequential ED notes were reviewed of all children attending over a single month in February 2013 to ensure that safeguarding issues were identified and appropriately managed according to local policy. 100 % of cases where concerns were identified were managed appropriately.
	Compliance with Policy "Children not being brought for outpatient appointments"	Audit of compliance against previous policy revealed inadequate documentation of actions following a DNA. Compliance was variable across departments within the Trust. Review of the policy led to simplification of the process, re-writing of the policy and a planned re–audit.

	Compliance with Policy "Weighing of infants attending ED"	Since coming in to post in November 2012, the Specialist Nurse has performed a rolling audit of compliance against this policy in which all children under 12 months old are weighed and information shared with the primary care team (following recommendation from SCR) showing progressive improvement.
	Compliance with Skeletal Survey Guidelines	2010 / 11 demonstrates 100 % compliance with surveys undertaken in line with the required standards and documentation
	Documentation audit – Integrated Child Protection completion	Demonstrates 100 % use of body maps, discussion with consultant paediatrician and recording of outcome of strategy meetings in the medical record. 90% demonstrate consultant opinion sort for discharge decision
Yeovil District Hospital NHS Foundation Trust		
Audits completed in 2012 - 13	• Audit of completion of the Child Protection Tool within the Emergency Department • Audit of weighing children within the Emergency Department • Audit of documentation and process for children seen in hospital about whom Child Protection Concerns are raised.	

Recent Case Reviews Recommendations and Health Action Plan

Recommendation	Action required	Lead Officer	Evidence & Progress	RAG Rating
Where there are safeguarding concerns and/or Children Social Care involvement with a sibling of an unborn infant, there should be a prebirth planning meeting.	Midwifery services to use the health communication form to share risks with health visiting primary care services. Health staff to use early referral pathway to children social care to ensure risks and protective factors are fully considered to protect the unborn child.	Named Professionals	The health communication form has been reviewed to share information where there are identified risk factors for antenatal patients, vulnerable families and their children. Named and specialist midwives have become confidently proactive in escalating families of concern to ensure early pre birth planning is instigated.	
Historical information must be used to inform family assessments as well as parental vulnerability factors and behaviour, particularly where there is parental non- compliance.	Health staff to review previous records, parental history and 'patterns' of behaviour to inform their holistic family health assessment of risks and protective factors.	Designated and Named Professionals	The Health Visitor Service Practice Guidelines for Completion of Family Health Needs Assessment has been updated. The Family Health Needs Assessment is based on the Framework for Assessment for children in need and their families (DOH 2000). A RAG system is used to assess each domain to ensure the correct level of support is provided by the Health Visiting Team.	
For community health records to demonstrate clear planning purpose and analysis for family and child contacts.	For a report of the audit of record keeping to be provided to NHS Somerset.	Named Nurse Community Services	Following the audit of health visiting records in November 2011 where compliance with the Record Keeping criterion was good an updated tool was developed through consultation with the staff. In 2012 200 records were reviewed demonstrating an improvement of standards of recording.	

Health professionals must discuss complex family concerns with their safeguarding lead for escalation and referral to Children's Social Care, particularly for families who demonstrate poor compliance.	Provider services to review escalation and non compliance policies.	Designated and Named Professionals	All providers have reviewed their escalation processes Health Visiting and school nursing teams have regular supervision to discuss cases of concern, practice issues and review domestic abuse notifications. Midwives also receive team supervision across the county with the named midwife, specialist midwife and named nurses.	
For professionals to have clear guidance for families where there are child protection concerns/section 47 to inform agency contacts and expectation of family engagement.	For child protection plans to be clear of the level of engagement required by parents. A non invite to health to be raised as an incident as well as escalating to the children social care team leader or manager.	Designated and Named Professionals Partner agencies	Updated guidance in place and Safeguarding Children Team and Public Health Nursing staff now involved in Strategy Meetings – decrease in incident reports as a result.	

6.5.5 In order to continue to provide assurance, the following recommendations apply:

- The Designated Nurse for safeguarding children to continue to monitor the compliance of all NHS Trusts with the Care Quality Commission standards, through attendance at Trust Safeguarding Children Forums

- For all NHS Somerset policies to be reviewed with regard to current and new statutory guidance

- The Designated Nurse to work in partnership with primary care to support independent providers to provide assurance of safeguarding arrangements, with clear pathways to support, training and advice

- To monitor and quality assure the action plans from the Serious Case Review, ensuring the lessons are embedded in practice; the Designated Nurse to provide progress reports to the Patient Safety Quality Assurance Committee and the Clinical Commissioning Group

- The Designated Nurse to provide clinical leadership and support to continue to

develop a robust supervision process across children and maternity services

- Review and support commissioned health services and independent providers in developing improved practice in identifying and responding to domestic violence

- Oversee the implementation of the Ofsted/CQC action plan following the review of Safeguarding and Looked after Children Services to inform future commissioning arrangements.

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6.5.6 Nevertheless, a recent audit of GP attendance at child protection conferences and provision of reports showed no change and identified that there was further improvement needed.

6.5.7 The LSCB has requested more information on impact in future assurance reports from the CCG.

6.6 Education assurance

6.6.1 It has been pleasing to note the increased level and quality of engagement by education services, schools and colleges during 2012-13.

6.6.2 The Learning and Achievement Service has sought to ensure the safety of children and young people through assuring its own procedures and practices and providing advice and guidance to schools and monitoring performance. Data for outcomes is collected through LSCB performance monitoring using agreed data sets. In a more recent development, the Learning and Achievement Senior Management Team (SMT) will receive a report from the designated person and deputy to ensure regular monitoring of the key issues. The report will outline to the SMT areas where there is non compliance with expectations or where improvements can be made.

6.6.3 Learning and Achievement (L&A) safeguarding policy and guidance is available for all on the L&A website safeguarding page. The safeguarding policy is reviewed and updated annually by the deputy designated person. Staff can access Guidance for Schools from the same website. This is reviewed and updated annually and links to the LSCB website.

6.6.4 The designated teacher is responsible for overseeing the school's safeguarding policy and procedures. A cascade training pack is available from the LSCB for the designated person to train all staff in schools and ensure induction for new staff and volunteers. Cascade training should also be refreshed. Whole school training is also available from the LSCB for schools to purchase. Training in safeguarding in specialist areas is also available from the LSCB and staff are encouraged to attend where this has relevance to their role.

6.6.5 Training is available for schools through the LSCB training programme. Designated persons and deputies are expected to attend Working Together training and this should be refreshed every 2 years. Managers within school responsible for recruitment are expected to have safer recruitment training.

6.6.6 Governor training is available through governor services for nominated safeguarding governors and a checklist for governors and heads is available in the Guidance for

schools. The current training is being revised following feedback from nominated governors, highlighting their need for greater training to more fully scrutinise school's safeguarding as part of the work towards the annual report.

6.6.7 All training is reported and monitored through the schools' Annual Safeguarding Report to the Governing Body which is also copied to the LSCB Educational Advisor for monitoring and feedback.

6.6.8 The detail and impact of this activity will be collated and presented to the LSCB in the form of an annual assurance report, with effect from the coming year (2013-14).

6.7 Police and public protection

6.7.1 During this reporting period, specific assurance regarding police public protection arrangements has not been sought by the LSCB. It is anticipated that this will occur during the next reporting period 2013 -14 and will be reflected in the next Annual Report. However, there has been some scrutiny of the interface between the police and children's social care, particularly in relation to referrals of incidents of domestic abuse where there have been children directly affected. It has been accepted by Avon and Somerset Police that there are improvements that need to be made in order to ensure that those families with children at highest risk of harm are prioritised. This has resulted in a commitment to co-location of key staff with children's social care as a first step towards integrated 'front door' arrangements. The LSCB will monitor the pace and impact of these developments.

6.7.2 Avon and Somerset Police has also reported on the incidence of young people held overnight in custody pending being found an appropriate placement. The LSCB will continue to monitor this.

6.7.3 There is strong engagement with the Avon and Somerset Police through the Board, Executive and subgroup arrangements.

7. Progress on priorities 2012-13

7.1 By agreement with the previous LSCB Independent Chair and the Executive Group, the Annual Report for 2011-12 did not include a detailed work plan for 2012-13 but carried activities related to three broad priorities. These are set out in the 2012-13 business plan:

- Develop and maintain child protection and safeguarding partnership working across Somerset and the wider south west region in order to ensure robust arrangements are in place within and between organisations

- Develop the provision and delivery of training, support and advice regarding child protection and safeguarding to all agencies across Somerset, in order to develop high quality inter-agency child protection practice

- Monitor and challenge the performance of partners, including the Children's Trust, to ensure that all agencies are keeping child protection central to their

business.

7.2 Work associated with these priorities has had the following outcomes:

- Through training and other LSCB events, 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. This is evidenced through training evaluation and audit

- Multi-agency engagement in appropriate application of child protection procedures across all partner organisations can be evidenced through multi-agency case audits

- Improved management and reporting of allegations against adults who work with children, demonstrated by significantly increased reporting rates across agencies

- Robust child protection training and guidance continues to be available, specific to Somerset agencies

- Staff in partner agencies are trained to the appropriate level given their role and responsibilities within their organisation. Designated officers for child protection have access to LSCB cascade material, allowing them to deliver training to their own staff. Training is regularly refreshed

- Through annual reporting to the LSCB, partner organisations give assurance about the appropriateness of their child protection and safeguarding arrangements, including training compliance

- There is accessible, informed and consistent advice for child protection available to all organisations in Somerset, especially universal services including education settings

- There is a continuing drive to achieve better outcomes for children and young people with effective intervention based on clearly assessed needs and assessment of risk, including those requiring early help

- The South West Shared Child Protection Procedures have been maintained and enhanced and are available to all practitioners working in Somerset and the south west. This helps to ensure a consistent response to child protection and safeguarding concerns. The site has recently been redesigned to improve access

- Improved child protection and safeguarding accountability is in place: arrangements and activity, reporting and structure within partner organisations is clear as a direct result of positive and constructive challenge from the LSCB

- There continues to be significant activity for the reviewing of cases of concern, making recommendations for change and monitoring compliance. This has been further strengthened by the new subgroup arrangements.

7.3 The LSCB has already set clearer priorities for the years to come, and will be monitoring the impact of its activity on outcomes for children.

8. Learning and Improvement

8.1 Quality assurance

8.1.1 During this reporting period, quality assurance for the LSCB has primarily been driven by the Audit, Policy and Procedures (APP) subgroup under the direction of the Executive Group.

8.2 Multi-agency auditing

8.2.1 There has been a range of multi-agency audit activity that has led to a greater understanding of how effectively agencies are working together. Where significant areas of deficit have been identified and improved through action planning, monitored by the Audit Policy and Procedures Subgroup (APP). These have included improvements to strategy meetings, such as appropriate involvement of key agencies, timeliness of discussions and the provision of an interim protection plan.

8.2.2 The following table indicates the range of multi-agency audits carried out by the LSCB during this reporting period.

	Audit	**Date**	**Background**
1.	CP Plans for older children	Spring 2012	Planned ASG work (Ofsted recommendation / APP)
2.	Transfer Child Protection Conferences	Summer 2012	Planned ASG work
3.	Training effectiveness	June 2012	Evidence needed for LSCB training team
4.	Allegations management	June 2012	LSCB Performance Indicator
5.	Induction training	June 2012	LSCB Performance Indicator
6.	Strategy discussions	July 2012	Children and Families Service Director
7.	Effectiveness of LSCB meetings	August 2012	LSCB Executive Committee
8.	Multi-agency involvement in CP Plans	Autumn 2012	Planned ASG work

9.	S11 Action plan check	December 2012	Follow up to S11 audit
10	Strategy Discussions	Winter 2012	Planned ASG work
11	Pre-birth assessment	Winter 2012	Ofsted / SCR / case reviews
12	E-safety audit	Spring 2013	E-Safety group
13	Children receiving a subsequent CP Plan	Spring 2013	Planned ASG work

8.2.3 The following outcomes are amongst those arising from this audit activity:

- Work commenced with District Councils to implement required safeguarding arrangements
- Children's Social Care challenged over the provision of chronologies within Child Protection conference reports
- Partners have self-assessed their allegation management arrangements
- Partners evaluated their induction training arrangements against agreed minimum requirements
- Assessment of the effectiveness of LSCB meetings in order to inform the review of structure and processes
- The pre-birth referral process was reviewed and implemented
- LSCB Escalation policy was re-launched.

8.2.4 Further work is needed to improve the focus on outcomes for children of this activity.

8.3 Section 11 Audit

8.3.1 The LSCB has a statutory responsibility to complete an audit of partners' safeguarding arrangements – the "Section 11 Audit". This refers to section 11 of the Children Act 2004, which describes the key safeguarding related arrangements that statutory agencies are expected to have in place.

8.3.2 The most recent methodology to be used by Somerset LSCB was agreed by the

Executive Group in November 2010. It was considered important that audit centred on key partners and that the audit tool allowed completion to be based, as far as possible, on information that would already be collected within organisations. The tool was agreed and sent to agencies for completion with returns being considered by the APP Subgroup. In 2012 agencies were asked to provide a progress report on their action plans and it was agreed to repeat the full Section 11 audit in 2014 when the range of the audit will be widened to include other partners.

8.3.4 There were significant difficulties in securing some audit returns. Most notable of these was Children's Social Care.

8.3.5 Across the 12 completed audits there was a total of 540 standards to meet. The breakdown of responses is shown below.

Status	**Number**	**Percentage**
Met	423	78%
Not met	24	4%
Partially met / work in progress	75	14%
Not applicable	18	3%
Total	**540**	

8.3.6 Three recommendations were accepted by the LSCB Executive Group:

- Somerset LSCB Coordinator continues to work with the District Councils in order to support the improvement of safeguarding arrangements in the Districts

- Confirm with South West Ambulance Service Trust (SWAST) about representation at LSCB meetings

- Repeat the audit in 2014. At this point consideration should be given to increasing the scope of the audit, for example to consider including other NHS bodies and CAFCASS.

8.3.7 It is anticipated that some aspects of the next Section 11 audit will be carried out in collaboration with neighbouring local authorities as there are partners who work across borders – for example, the police and the Probation Trust plus some Health organisations. Activity and outcomes from the Section 11 are being incorporated into the developing LSCB Performance Framework.

8.3.8 As can be seen, this Section 11 audit did not identify any cross-agency areas of

significant weakness. However, the quality of and evidence for agencies' self-assessment is likely to be a focus for future section 11 audit activity. The immediate impact of the work to date is most likely to be felt in District Councils, with work in hand to significantly improve child protection and safeguarding arrangements in those settings. This will continue through the current reporting period.

8.3.9 A review of child protection arrangements and awareness for staff working in Accident and Emergency departments in the two major Somerset hospitals was completed, improvements made and learning disseminated. Agencies reviewed their induction and supervision arrangements to ensure that they included consideration of child protection matters for staff in regular contact with children and families.

8.3.10 Clearly, the provision and scrutiny of an effective and well informed performance framework, allied to strong quality assurance arrangements, supports the core functions of the LSCB – ensuring effectiveness and providing a clear and robust challenge to partner agencies. The framework that is being developed in Somerset adheres to national reporting guidance and includes local information. To reflect this, the APP subgroup has been reviewed and renamed the Quality and Performance subgroup, with revised terms of reference, membership and governance arrangements. It will lead significant developments in the QA function of the LSCB.

8.4. Single and multi-agency training provision

Multi-agency training

8.4.1 The LSCB delivers multi-agency safeguarding training to partners in accord with the LSCB training strategy. This was written to meet the requirements of Working Together 2010 and is still considered to represent appropriate arrangements for Somerset following the publication of Working Together 2013. The core training provision is a multi-agency progression for staff who need to understand child protection in a multi-agency context, including those who have a designated responsibility. In addition, Safer Recruitment courses are delivered alongside a series of "specialist courses", some of which are run by commissioned trainers and specialists.

8.4.2 All courses are evaluated through use of a paper based evaluation sheet. Work is continuing to develop a more rigorous evaluation methodology which seeks to determine the longer term impact of training on professionals' practice. This is a priority area of work for the LSCB and is reflected in the work plan.

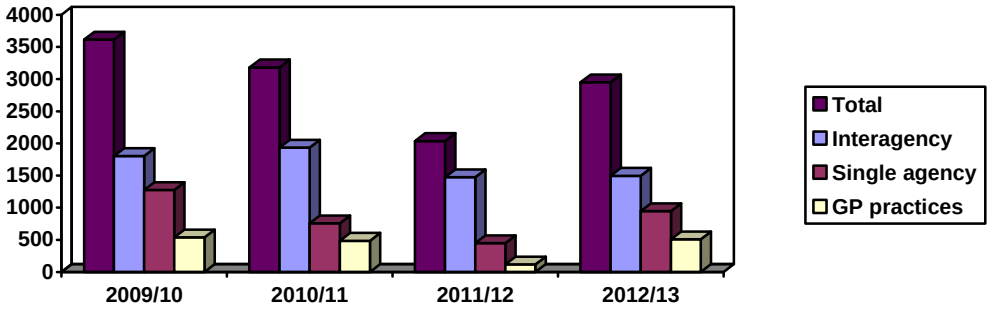
8.4.3 The current LSCB training programme covers January 2013 to December 2013 and includes courses that relate to previous and current LSCB priorities:

- Safeguarding adolescents
- Hearing children's voices
- On line safety

- Domestic abuse and its impact on children
- Children who display sexually harmful behaviour
- Working with hard to engage families

8.4.4. The LSCB continues to offer the opportunity for partners to commission child protection and safeguarding training. Most commonly this is single agency "basic awareness" but is can also be themed or tailored to specific settings – for example independent boarding schools, housing providers or health settings.

8.4.5 During this reporting period a total of 2948 delegates attended training provided by the LSCB; this is a 44% increase in attendance from the previous year. It comprised 1495 people who attended inter-agency training across 66 courses, 23 more than the previous year; 935 people who attended single-agency awareness training from 23 different establishments, including schools (maintained and independent), the Devon and Somerset Fire and Rescue Service, a Dental Practice, private care providers and the voluntary sector; and 508 people who attended practice based GP training in 28 practices.



Single agency training

8.4.6 The demand for single agency training delivered by the LSCB has increased after a drop last year. This is primarily delivered to organisations which do not have 'in-house' access to this training. This half-day session is commissioned by individual organisations and delivered on-site by LSCB trainers, there is a standard charge made for this and can be delivered to up to 40 participants per session. Smaller schools will often join together to share costs. During 2012-13, 18 schools commissioned this training, of which four were independent. Basic awareness training was delivered to other organisations including a housing provider, a YMCA and a fostering agency.

8.4.5 The LSCB trainers also offered a half day session for governors of independent schools focusing on the governors' role in safeguarding. Governor safeguarding training for maintained schools and academies is offered by Governor Services; the LSCB trainers have also delivered this during the year. The LSCB trainers have also provided basic awareness sessions for small voluntary organisations via Child Safe.

8.5 LSCB annual practitioners' conference

8.5.1 The most recent LSCB annual practitioners' conference was held in early December

2012 and was attended by more than 100 practitioners and managers. The theme of the conference was “safeguarding adolescents” and the aim was to raise awareness and provide information indicating the inter-relatedness of a number of areas of child protection concern – children and young people who go missing from home and care, on-line safety and on-line grooming, child sexual exploitation (CSE) and other aspects of risky behaviour.

8.5.2 Keynote presentations were made by the Centre for Exploitation and On-line Protection (CEOP), Barnardo’s and an academic from Bristol University who had been involved in research about neglect in older children. Delegates had the opportunity to select from a number of smaller groups in order to develop their understanding of an issue, or add to the overall information they gathered.

8.5.3 Feedback from the day was very positive, indicating that practitioners identified the importance of the issues and wanted to understand the implications for their organisations and their own practice. The work of the conference was carried forward and further discussed at the subsequent LSCB Development Day where this area of work translated into one of the identified priorities.

8.5.4 The theme of the 2013 Conference will be focused on domestic abuse, and will be jointly planned and delivered with the Safer Somerset Partnership.

8.6 Case reviews

8.6.1 Case reviews have been overseen by the Executive Group and APP subgroup. Future case reviews, including Serious Case Reviews, will be managed through the Learning and Improvement Subgroup which, in turn, will be able to commission the Quality and Performance Subgroup to carry out work in order to audit and evaluate the effectiveness of action plans and recommendations.

8.6.2 This will bring a more systematic and robust approach to the commissioning of reviews and the identification of key areas of practice improvement arising from them. Impact of this activity will form a central part of the next LSCB annual report and will be reflected in the performance framework as appropriate.

8.7 Child Death Overview Panel (CDOP)

8.7.1 The CDOP in Somerset is chaired by a senior manager from Public Health. There are a number of examples of learning and practice change that have arisen as a result of the panel’s work. These include:

- Supporting arrangements for Samaritans to offer direct support to children and young people in schools and colleges
- Ensuring that there are robust arrangements in place in hospitals for the identification of domestic abuse
- Improving clinical ventilation options for premature babies
- Improving communication between schools and colleges and other agencies when a child dies.

8.7.2 The CDOP annual report gives further details and is available on the LSCB website.

8.8 Serious Case Review

8.8.1 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 Overview Report and Executive Summary were published in April 2013. This is the first Somerset SCR that has been published in full.

8.8.2 Twin babies aged six and a half weeks, having been born prematurely, were admitted to hospital in Somerset and were found to have serious head injuries and body bruising. The babies had moved to Somerset from Nottingham with their parents eleven days earlier and were living with family. Both parents were arrested and charged with causing grievous bodily harm. The father was convicted and received a 45 month prison sentence. The mother was found not guilty of any offence.

8.8.3 The mother and father had received services in seven different local authority areas and had been in contact with a significant number of health providers, both during the pregnancy and following the birth of the twins.

8.8.4 The overview report is available on the LSCB website
http://www.somersetsafeguardingchildrenboard.org.uk/content_view.asp?did=23551

8.8.5 The recommendations arising from the SCR concerning babies A and B were as follows:

- LSCBs should review their pre-birth assessment guidance to ensure that it highlights the particular risks that need to be considered in the case of multiple births and the need to gather and analyse all relevant historical information.

- LSCBs should ensure that an audit of pre-birth assessments takes place, in order to ascertain whether they are fit for purpose, in line with the guidance and adequately analyse the potential risk to the unborn child.

- LSCBs should review supervision arrangements across the partnership and establish, implement and audit a core standard for safeguarding supervision.

- LSCBs should ask agencies to review their internal escalation and resolution processes and ensure that policies are combined with regular activity to evaluate and review the health of relationships at the front line and first line manager level.

- LSCBs should review and monitor single agency or multi-agency safeguarding training strategies to ensure the promotion and embedding of relevant research, in relation to the assessment of risk and young babies, the importance of cumulative histories in analysing risk and working with resistant and/or mobile families.

- Somerset LSCB should raise with the appropriate Government department the issue that unborn children currently do not have the same right to protection in law

as children post-birth, and ask that Government child protection guidance should adequately address the rights of the unborn child.

8.8.6 In addition, there are detailed action plans arising from the Individual Management Reviews carried out by over 35 separate organisations who had contact and were involved with the family. The progress on these, and the plan linked to the main recommendations, above, is currently monitored through the Audit, Policy and Procedures Subgroup, an activity which will move to the new Learning and Improvement subgroup.

8.9 Management reviews

8.9.1 During 2012/13, completed management reviews were considered by the APP Subgroup and, where appropriate, multi-agency action plans were agreed and are being monitored by that group.

8.9.2 Reviews included:

- Baby M: this review considered the use of the pre-birth referral protocol and accompanying multi-agency guidance; the child protection supervision of midwives

- Children C and D: This health community review was in respect of a sibling pair who both presented with unexplained bruising. Concerns were raised about practitioner understanding of the significance of bruising in an immobile child and hence a review of the case was undertaken

- SUI – Child E: This review concerned a child who was brought to the Hospital Emergency Department, having sustained burns to his anterior and posterior trunk and left arm whilst at home. The review was undertaken to identify lessons for improving safeguarding children practice, for children subject to a child protection plan for the category of neglect.

8.9.3 The following learning results from these management reviews:

- For early identification of high risk or vulnerable families there must be appropriate sharing of information concerning medical, social and emotional health between primary care, hospital and community services to inform family health assessments and assist in the evaluation of risks and protective factors to children or unborn child

- Where there are safeguarding concerns and/or Children's Social Care involvement with a sibling of an unborn infant, there should be a pre-birth planning meeting to share information and consider risks and protective factors to the unborn child

- Health professionals must be clear about their duty to refer to Children's Social Care for any unexplained injury or bruising and ensure arrangements are in place for a paediatric medical assessment

- Historical information must be used to inform family assessments as well as parental vulnerability factors

- All contacts by the health visiting service with families and children must have a

clear plan, purpose and analysis, with a clear agreed time frame for actions to be completed, to avoid drift

- Agencies must be clear in their child protection plans of the level of engagement required by parents and not accept less progress as positive change.

8.10 Leaving care

8.10.1 A review has been commissioned of 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 had formerly been in care. This review will conclude and report in autumn 2013 and will be reported on in next year's annual report.

9. Issues and challenges facing safeguarding in Somerset

9.1 As is indicated from the evidence in the body of the report, performance in children's social care, in particular, needs to improve rapidly. The resourcing and operation of an effective IRU is a critical component of this improvement.

9.2 Partner agencies – including those offering services to adults - each have work to do to improve quality and impact of their work on outcomes for children. This will include closer integration of services, particularly for those children and families who need a co-ordinated multi-agency response to ensure their safety and promote their wellbeing. Improved participation in core child protection processes is also needed, including engagement with the Local Authority Designated Officer. The effectiveness of multi-agency arrangements to support young people leaving care are in need of development.

9.3 The Children's Trust has a key role to play in overseeing the development and delivery of an early help strategy which brings together the wide range of services for children, young people and families across Somerset into a coherent range of resources which are accessible when needed. This should include improved access to child and adolescent mental health services (CAMHS) at tiers 1 and 2, and provision of adequate tier 4 provision.

9.4 The Health and Wellbeing Board must show leadership in ensuring that the Joint Strategic Needs Assessment is strengthened to provide a stronger evidence base for safeguarding activity and service commissioning.

9.5 The Corporate Parenting Group should be actively overseeing the arrangements for children in care placed within Somerset, including those in care to other local authorities, and those placed beyond the county's boundaries by the council.

9.6 The Safer Somerset Partnership should assist the LSCB in developing the understanding by practitioners of the impact of domestic abuse, and the commissioning of services in response to need.

10. Priorities

10.1 Somerset LSCB held a multi-agency development day in February 2013. All members of the LSCB and subgroups were invited and attendance was very good, although some agencies were better represented than others. The key statutory partners –

Public Health, Police, Community Health, Children's Social Care and Education - were invited to present relevant information in order to provide an initial basis for discussion. After due consideration of the evidence presented, the following were identified as top priorities for 2013 – 15 and subsequently endorsed by the LSCB Executive:

10.2 Strengthening core multi-agency child protection practice and processes

This includes:

- 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 access to application of the LSCB escalation process
- Conducting QA activity of child protection practice and basic performance, using benchmarking from other authorities.

10.3 Early help for children and their families, including child and adolescent mental health services

This includes:

- 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.

10.4 Safeguarding vulnerable adolescents

This includes:

- Completion of the review following the deaths of care leavers 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.

10.5 The following 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. This will include:
  - Auditing the impact of multi-agency training
  - Promoting the importance of effective supervision
  - Developing an LSCB training pool to support multi-agency training delivery

- Promoting partnership working and information sharing;
  This will include:
  - Promoting awareness and promotion of the current (reviewed) Somerset inter-agency information sharing and confidentiality protocol
  - Developing the LSCB as the hub for the latest information, policy and guidance relating to child protection and safeguarding
  - Improving engagement with District Councils about safeguarding and child protection
  - Improving engagement with General Practitioners about safeguarding and child protection
  - Monitoring the effectiveness of CAMHS (thresholds, capacity, response to Children in Care)

- Improving communication about the LSCB and its work (including development of the LSCB website).

10.6 In addition, Working Together 2013 sets out an increased set of responsibilities for and expectations of the LSCB.

10.7 Finally, there are national priorities which include:

- Child Sexual Exploitation (CSE)

- The management of allegations against professionals who work with children

- The recruitment, training and retention of qualified social workers who are responsible for statutory work

- Children who go missing from home and care

- Online protection; the growth, influence and risks of social media.

These are all reflected in the LSCB's business plan for 2013-15, which is included as Appendix 4.

Matthew Turner
Service Manager – Safeguarding
June 2013

Appendix 1: Budget

Safeguarding 2012/13

Source / Agency	Amount
Avon & Somerset Constabulary	£19,630
Somerset NHS PCT	£38,640
Avon & Somerset Probation	£4,100
Connexions	£480
CAFCASS	£570
Taunton Deane DC	£1,540
South Somerset DC	£1,540
Mendip DC	£1,540
Sedgmoor DC	£1,540
Somerset County Council	£124,140
Income generated from training and conferences	£68,230
Total Income	**£261,950**
Salaries and on costs	£224,490
Conference and Training Course expenses	£37,460
Total Expenditure	**£261,950**

Appendix 2: Subgroups 2012- 13

This information relates to the reporting period 2012 – 2013. It is important to note that during this time changes have begun to be implemented in terms of reviewing and strengthening the subgroup arrangements, seeing them as part of the whole continuum of work – the "wider LSCB" – rather than semi-independent workgroups that report to the Board.

Executive Group

Core membership and attendance	**Chair: LSCB Independent Chair – 80%** Children's Services, SCC – 80% Children's Social Care – 100% Somerset Primary Care Trust – 100% Avon and Somerset Police – 100% Learning and Achievement Services – 100% LSCB Coordinator – 100%
Frequency of meetings	Quarterly
Main focus	Develop the LSCB agenda, agree priorities monitor 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.
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.

Audit, Policy and Procedures Subgroup

Core membership and attendance	**Chair: Children's Social Care, moved to Police and EIS joint chairing during this period** Somerset Partnership – 40% Somerset Primary Care Trust – 60% Children's Social Care – 80% Learning and Achievement – 80% Avon and Somerset Police – 60% LSCB Coordinator – 100% LSCB Audit Officer – 100%
Frequency of meetings	Quarterly
Main focus	Agree priority areas for audit, monitor progress and subsequently consider audit outcomes and dissemination of learning, evaluate impact, SCR work, Section 11 audit, develop, signoff and disseminate new multi-agency policies and procedures
Activity	The subgroup has progressed the recommendations arising from the Serious case Review for Child A and Child B; it has overseen the work of the LSCB Audit Subgroups and other specific audits.

Future work	This group will be strengthened and become the Quality and Performance subgroup in 2013 with a primary focus on Quality Assurance and challenge of multi agency practice and performance

Health Advisory Group

Core membership and attendance	**Chair: Designated Nurse, Somerset PCT – 100%** Somerset Partnership (multiple representation) – 100% Taunton and Somerset NHS Trust (multiple representation) – 100% Yeovil District Hospital Trust (multiple representation) – 66% LSCB Coordinator – 100% South West Ambulance Services Trust – 0% Children's Social Care – 33%
Frequency of meetings	3 times per year
Main focus	The subgroup provides a forum for lead health professionals, including designated and named professionals to discuss practice issues and developments. The group oversees policy and practice development across the Health Providers, provides a forum to discuss national guidance, new initiatives and share best practice and expertise on safeguarding issues.
Activity	A number of case reviews and learning have been shared to embed lessons and inform practitioners across the health community and other agencies as follows. Following a review of young people accessing services following sexual assault, the analysis enabled procedures to be clarified for the examination and care of children and young people following allegations of sexual assault. The Health Advisory Group also provides the forum to discuss both learning and areas for development from case reviews with practitioners being able to take away lessons to both embed in training and practice.
Future work	The subgroup will continue to be the main Health based forum for discussion regarding best practice in child protection. This will be particularly important as the new Clinical Commissioning group arrangements are developed and implemented. Learning from case reviews, including SCRs, will be incorporated into the work plan of the group.

E Safety (On-line) Protection Subgroup

Core membership and attendance	**Chair: Avon and Somerset Police – 100%** LSCB Coordinator – 100% Education Learning and Information Management (SCC) – 50% Independent Schools – 25% Further Education Colleges – 25% South West Grid for Learning – 100% Devon and Somerset Fire Service – 0% Somerset Primary Care Trust – 50% Children's Social Care - 0% Voluntary Sector – 0%
Frequency of meetings	Quarterly
Main focus	Developing and supporting single and multi-agency arrangements for safety (on-line) protection, monitoring the effectiveness of the E Safety Strategy
Activity	The subgroup considers all aspects of safeguarding and child protection that relate to internet and electronic device safe use. This includes ensuring there is appropriate advice and support available to professionals, parents, children and young people. There is close engagement with the South West Grid for Learning which leads on regional and national activity.
Future work	The work of this subgroup will be subsumed in the work of the Safeguarding Adolescents Subgroup from April 2013.

Sexually Harmful Behaviour Subgroup

Core membership and attendance Please note: attendance information not available	**Chair: SCC Youth Offending Team Manager** LSCB Coordinator Children's Social Care Learning and Achievement Avon and Somerset Police Somerset Primary Care Trust
Frequency of meetings	Quarterly
Main focus	To provide a consistent strategic response to supporting agencies in their work with children and young people who show sexually harmful behaviour towards others.
Activity	The group initially monitored the effectiveness of inter-agency responses to children who showed sexually harmful behaviour towards others. This focus changed over the course of the year to look at the Somerset response to Child Sexual Exploitation and invited colleagues from Barnardo's to discuss next steps with the group.

Future work	The work of this subgroup will be subsumed in the work of the Safeguarding Adolescents Subgroup from April 2013. This will include the development of a Children's Sexual Exploitation (CSE) Strategy for Somerset.

Missing Children and Independent Providers Subgroup

Core membership and attendance	**Chair: LSCB Coordinator – 100%** Somerset Primary Care Trust – 50% Children's Social Care – 75% Avon and Somerset Police – 50% PROMISE Advocacy and Mentoring – 75% SCC Specialist Placements – 75% SCC Information Management Team – 100% Education Attendance Service/Children Missing Education – 100% Youth Offending Team – 50%
Frequency of meetings	Quarterly
Main focus	To oversee the effectiveness of the Missing Children multi-agency protocol, monitor prevalence of repeat "missing" episodes, consider and challenge the practice of independent placement providers
Activity	The group receives information from the police about incidents and reports of children and young people who go missing from home and care. This information has been developed over time to reach the level of the individual allowing the identification of repeat episodes and geographical "hotspots". The group then agrees specific interventions with individuals or providers of accommodation in order to reduce risk. Information is available about those who are considered at risk of CSE or as victims or perpetrators of crime. Other local authorities are contacted about high risk young people placed within Somerset.
Future work	The work of this subgroup will be subsumed in the work of the Safeguarding Adolescents Subgroup from April 2013.

Training and Professional Development Subgroup

Core membership and attendance	**Chair: Designated Nurse, Somerset PCT – 100%** LSCB Coordinator/LSCB - 75% LSCB Trainers – 100% Avon and Somerset Police – 75% Avon and Somerset Probation Trust – 25% Taunton and Somerset NHS Trust – 75% Yeovil District Hospital Trust – 75% Somerset Centre for Integrated Learning (SCC) – 50% Somerset Partnership – 75% Learning and Achievement – 75%

Frequency of meetings	3 times per year
Main focus	Ensuring the appropriate provision and effectiveness of multi-agency safeguarding and child protection training.
Activity	Following a mapping exercise of individual agencies with key frontline practitioners involved in child protection, it was clear that there could be no uniform approach to training levels. The assurance sought was that practitioners received training appropriate for their practice area embedding lessons from research and serious case reviews. Compliance with training levels has been identified as an ongoing challenge for agencies and the scoping exercise identified approaches already in place and tasks for the group to complete to improve the uptake and quality of training, which included: • Individual agency development of e-learning modules (although not suitable for all staff) • Cumulative training sessions approach and peer review to support demanding clinical commitments and case loads • The provision of bespoke training for social workers provided by the Somerset Drug and Alcohol Partnership to support their work with vulnerable families and those with children subject to a child protection plan • Development of an induction training leaflet for agencies who do not have this currently in place • A review of the evaluation of specialist courses to determine how training has improved and/or influenced the practitioner's practice. 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 paramount to continue to provide quality assured training, to provide delegates with the appropriate knowledge and skills to protect children and young people. In addition the theme for the LSCB conference for this current year focused around the older child and included presentations about online safety, missing children and associated risky behaviour.

Future work	Future work includes the quality assurance of training and the recommendation from the Somerset Serious Case Review to include: • the development of an audit tool to quality assure agency training • a review of agency training strategies to ensure the promotion and embedding of relevant research, in relation to core requirements to specific areas of risks when working with children and families • reviewing lessons from serious case reviews and the implications for practice in Somerset

Child Death Overview Panel (CDOP)

Core membership and attendance	**Chair: Public Health Consultant – 80%** LSCB Coordinator – 100% Child Death Review Manager – 100% Avon and Somerset Police – 100% Somerset Primary Care Trust – 100% Taunton and Somerset NHS Trust – 100% Yeovil District Hospital Trust – 100% South West Ambulance Service Trust – 80% Learning and Achievement – 100% Children's Social Care – 80%
Frequency of meetings	Approximately quarterly
Main focus	To review the deaths of all children and young people who die in Somerset
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.

There are two other groups that, although not formal LSCB subgroups, clearly support child protection and safeguarding arrangements in Somerset.

Children & Young People's Health & Wellbeing Subgroup

Activity over past year	This group has met three times in the past 12 months with one meeting having to be cancelled due to lack of member's availability. In March 2012 the group identified key areas of priority for action covering:- - Parenting - Child Accident Prevention - Healthy eating - Physical activity - School readiness In June 2012 the group established a task and finish group to review parenting and school readiness support in the county
Achievement	Somerset Parenting Strategy revised Parenting support framework written Report and recommendations re parenting support written Quality Assurance of CAF exercise completed to support Ofsted Safeguarding Review.
Issues identified	Review of group remit alongside healthy Child Commissioning Group undertaken with proposal they should merge to be taken to Children's Trust
Priorities going forward	Establishment of merged groups Parenting support School Readiness Early Help / intervention strategy Healthy Child Programme 0-19
Attendance	Membership to be reviewed in light of merger with Healthy Child Commissioning Group. Need for strategic commitment to the group form within the Local Authority and Health including Clinical Commissioning Group

Child Accident Implementation Group

Activity over past year	The group has met twice in the past year with one meeting having to be deferred due to lack of member's availability and transition of Public Health into the Local Authority
Achievement	Refresh of the County Accident Prevention Strategy. Implementation lead produced quarterly Child Accident Prevention calendar based on data and info from the SW Public health Observatory and Child Accident prevention Trust. Programme of work for early years settings revised and developed in Bridgwater area . A small budget has enabled resources to be purchased to support promotional events.

Issues identified	Joint working with partners remains difficult due to agency capacity and priorities. Implementation through the Healthy Child Programme requires energetic support at a strategic level and needs to be incorporated into commissioning processes.
Priorities going forward	Direction re strategy to be agreed. Remit of group and relationship with other agency working to be reviewed.
Attendance	The group is attended by a mix of practitioners and strategic leads. Key areas of delivery remain un represented including from Ambulance Service, Police, A&E services; Road Safety, Schools.

Appendix 3: Multi-agency Audit Outcomes

1. S11 Audit	December 2011

Purpose:
To ensure the effectiveness of work to safeguard and promote the welfare of children by LSCB member organisations

Background:
The DCSF statutory guidance "making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004" sets out national key arrangements for statutory agencies and applies to all the bodies named in section 11(1) of the Children Act 2004. Further information will be found in the Guidance and this should be read prior to completing this audit. In particular, Part Two of the Guidance details the arrangements for individual agencies.

Somerset LSCB S11 audit process was agreed by the Executive Committee on 5th November 2010.

Methodology:
Somerset LSCB will assess compliance with section 11 through an audit undertaken by the LSCB, with each statutory agency at least every 4 years with a review of progress during interim years.

The S11 toolkit was sent to LSCB members in November 2011.

Key findings:
- Self assessment by agencies produced individual action plans.
- Findings analysed by the Audit Policy and Procedures Group (APP). The APP was particularly vigilant to the possibility that the audit may evidence an area of safeguarding work which demonstrated particular weakness in Somerset practice. No question was scored 'red' (standard not met) by more than 2 agencies, indicating that there were no identifiable area/s of weakness.
- The District Councils audit returns were the subject of particular concern, and as the result of this the LSCB Coordinator is working closely with one council to support improvements to their safeguarding work. It is anticipated that the learning from this exercise will then be rolled out across the other Councils.

Actions:
- Agencies working on action plans – update to be requested end of 2012.
- Full audit to be repeated in 2014. At this point consideration should be given to increasing the scope of the audit, for example to consider in including other NHS bodies and CAFCASS[1]
- Significant difficulties in achieving audit return flagged to LSCB – five reports received more than 3 months after the deadline agreed by the Exec committee.

2. Audit Sub Group Child Protection cases older children	**Spring 2012**
Purpose: For the Audit Sub Groups to audit the quality of multi-agency work in Somerset, in specific areas.	
Background: The four Audit Sub Groups are sub groups of the LSCB Audit Policies and Procedures Group (APP) and have a work programme determined at an annual workshop. This audit was requested by the APP in response to the Ofsted report 'Ages of Concern'.	
Methodology: Relevant paperwork retrieved, and sent to ASG members with Audit Tool. Each ASG audited 4 cases, (12 cases in total).	
Key findings: No concerns specific to the work with this age group. Lack of chronologies sent out with conference packs	
Actions: · Lack of chronologies being presented to conferences raised with CSC · Agreed to look at chronologies again in Autumn 2012 ASG · Some individual case issues identified and raised with Managers in Health, Police and CSC.	

3. Audit Sub Group Transfer-In Child Protection conferences	**Summer 2012**
Purpose: For the Audit Sub Groups to audit the quality of multi-agency work in Somerset, in specific areas.	
Background: The four Audit Sub Groups are sub groups of the LSCB Audit Policies and Procedures Group (APP) and have a work programme determined at an annual workshop. This audit was a repeat of 2011 work, which had identified difficulties in obtaining documentation from OLA.	
Methodology: Relevant paperwork retrieved, and sent to ASG members with Audit Tool. Each ASG audited 3 cases (12 cases in total).	
Key findings: Much improvement in the information available to Conference.	

Actions:
One case was referred to OLA LSCB, recommending case audit – this was followed up by the OLA.
CSC Managers followed up on issues raised on individual cases.
Need for Protocol record to accurately reflect conference invitees and attendees flagged with admin staff.

4. Training Effectiveness	**June 2012**

Purpose:
Pilot survey to test the feasibility of feed back from course participants when they were back in their workplace, demonstrating the longer term impact of training.

Background:
Requests for better evidence that LSCB training is effective – part of the continuing problem of understanding the longer term impact and consolidation of learning arising from multi-agency LSCB training.

Methodology:
Electronic survey created, and link emailed to people who had attended the following LSCB courses.

Introduction
March 2012 - Wells Football Cub
March 2012 - Sedgemoor Auction Centre
April 2012 - Wells Football Club
April 2012 - Abbey Manor Business Centre, Yeovil
May 2012 - Sedgemoor Auction Centre
June 2012 - Taunton Vale Sports Club
Safer Recruitment
March 2012 - Sedgemoor Auction Centre
June 2012 - Wells Football Club
Update
March 2012 - Sedgemoor Auction Centre
April 2012 - Abbey Manor Business Centre, Yeovil
June 2012 - Taunton Vale Sports Club

Survey gizmo programme used; no supplementary analysis completed.

Key findings:
93 responses from a range of agencies.
Respondents identified that they had increased knowledge and understanding following attendance, and nearly three quarters stated the course had changed their practice.

Actions:
Report was used to inform plans to assess the impact of training.

5. Allegations Management	**June 2012**

Purpose:
To ensure that all LSCB member organisations have robust procedures for handling allegations, and that these are available to staff.

Background:
In 2010 concerns were raised in Somerset about the handling of allegations against staff, and the availability of Allegation Management Policies to staff. The LSCB was asked to introduce a Performance Indicator to ensure that all LSCB organisations have robust allegation management practices, and that these are easily accessed by managers.

Methodology:
An audit tool was sent to all members of the LSCB for completion.

Key findings:
Only 7 completed audit tools were returned.

- 5 agencies reported that they had referred no cases to the LADO April 2011 – March 2012. The other two organisations had each made 2 referrals.
- 6 organisations reported that they had allegation management procedures – 5 agencies supplied a copy as requested.

Actions:
Report included in Performance Information data

- Participant organisations who have not responded to this audit are asked to ensure their agencies have robust allegation management practices and that these are easily accessed by managers.
- All LSCB member organisations are asked to participate in future audit activity.

6. Induction Training Audit	**Spring 2012**

Purpose:
To ensure LSCB member organisations have 'Safeguarding children' included in their induction programme, and to ascertain what subjects are covered.

Background:
In 2006, a Somerset Local Safeguarding Children Board audit into Safeguarding training identified some inconsistencies in Safeguarding training across organisations. This became a LSCB priority and the subject of a LSCB Performance Indicator.
In 2009 an audit established a baseline for this, and the audit was repeated in 2011.

Methodology:
An audit tool was sent to all members of the LSCB for completion.

Key findings:
Completed tools were received from 12 organisations.
One organisation does not provide face to face contact with children or vulnerable adults and does not provide induction training of this nature.
All organisations had a safeguarding element in their induction package (81% 2009).
The areas of weakness through all three audits is ensuring that whistle-blowing procedures and allegations management procedures are covered in induction, and this is still not covered comprehensively.

Actions:
LSCB partners were reminded of the LSCB recommendation that safeguarding induction training is completed in the first 4-6 weeks of employment, and the areas which should be covered in it, with particular reference to ensuring new staff are made aware of whistle-blowing and allegations management procedures.

7. Audit of Strategy Discussions	**August 2012**

Purpose:
To assess the quality of recording of strategy discussions.

Background:
The audit was requested by the Children and Families Service Director following criticism in the 2012 Ofsted Inspection of Children's Services:

> "Strategy discussions are timely, although not always well recorded or with sufficient detail. Some lacked effective multi-agency communication resulting in single agency enquiries to ascertain the need for immediate protection of a child. While communication between social care and Avon and Somerset Police is adequate, there had been some recent difficulties that managers are aware of and are beginning to address." [2]

Methodology:
In order to give time for improvement from the June Ofsted report, strategy discussions that took place between 2 – 13th July were audited. Any repeat strategies were excluded. The audit took place in mid August, giving time to ensure that late recording of strategy discussions could be captured.

Case details were obtained by an ICS report on Child Protection Strategy Discussions. Additional information was obtained directly from ICS Protocol.

Key findings: There is good recording of the nature of the concerns leading to the strategy. It is not always possible to tell basic information about the strategy (where it was and who contributed), or what each agency contributed. The recording of strategy discussions is not always timely, with an average of 4 days. Protocol tick boxes are not consistently used and are not a reliable indicator of performance.
Actions: Report to SCMG. Themes to be picked up in next ASG audit of strategy meetings

8. Structure and effectiveness of Somerset LSCB meetings	**August 2012**
Purpose: To inform the review of the structure and mechanics of the actual LSCB meetings using the opinions and experiences of members – what should be kept and lost in the way that the meetings were working.	
Background: Requested by LSCB Executive Committee	
Methodology: An online survey was created and a link emailed to all LSCB members, with request for completion from the LSCB Chair.	
Key findings: Four out of five respondents stated they saw their attendance at the LSCB meetings as a priority. Members wanted more chance to contribute, with a clearer and more focused agenda.	
Actions: Audit findings were considered by the Executive during the discussion about LSCB changes.	

9. Audit Sub Group Multi-agency involvement in CP Plan (first nine months)	**Autumn 2012**
Purpose: For the Audit Sub Groups to audit the quality of multi-agency work in Somerset, in specific areas.	

Background: The four Audit Sub Groups are sub groups of the LSCB Audit Policies and Procedures Group (APP) and have a work programme determined at an annual workshop.
Methodology: Relevant paperwork retrieved, and sent to ASG members with Audit Tool. Each ASG audited 2 cases, except TWS which audited 1 (7 cases in total).
Key findings: Some progress on invitees and attendees, but this is still not completely accurate Risks not clearly identified in CP Conferences, so plans not clearly addressing all risks. Chronologies not routinely being sent out with conference packs.
Actions: Case issues raised Admin staff have been reminded about recording all invitees and attendees CP Chairs have been asked to clearly state risks The need for chronologies to be written and distributed has been raised with CSC

10. S11 Audit – follow up	**December 2012**
Purpose: Check progress on action plans arising out of S11 audit	
Background: See Audit 1	
Methodology: Email contact of organisations who had made a S11 audit return, except for District and Borough Councils who are being dealt with separately.	
Key findings: Organisations are working through the identified actions.	
Actions: Discussion at APP March 2013. Small number of issues identified by APP to be discussed with individual agencies.	

11. Audit Sub Group	**Winter 2012**
Purpose: For the Audit Sub Groups to audit the quality of multi-agency work in Somerset, in specific areas.	
Background: The four Audit Sub Groups are sub groups of the LSCB Audit Policies and Procedures Group (APP) and have a work programme determined at an annual workshop.	

Methodology:
Relevant paperwork retrieved, and sent to ASG members with Audit Tool.
Each ASG audited 4 cases, (12 cases in total).
The strategy documentation included information from the Police

Key findings:
New procedures are not yet embedded
Difficulties in communication between Police and CSC
No evidence of strategy document being signed and returned by partner agencies

Actions:
- Work at the APP to improve communication between Police and CSC
- CSC single agency audit to drive improvement
- Clarification of standards expected by CSC staff written and circulated by CSC

12. Audit of pre-birth assessments	**Winter 2012**

Purpose:
To ensure that pre-birth assessments are routinely carried out, in a timely fashion, whenever there may be safeguarding risks

Background:
The APP group considered the Ofsted report, and linked it to:
- Somerset's own recent experience with the SCR into Baby A and B.
- Concerns raised in other recent serious cases considered by the APP
- Difficulties identified by health agencies when referring unborn babies to Children's Social Care

Methodology:
ICS report, interrogation of Protocol, and information requested from midwives, health visitors and CSC admin staff.

Key findings:
Problems with communication, particularly for health visitors.
Questions about effective use of escalation policy

Actions:
The following are in progress:
1. Audit of recording of safeguarding concerns by midwives and health visitors
2. Six cases where there are questions about the transfer of information will be followed up (initially by health)
3. Delay in the progression of casework to be followed up by CSC
4. Check that HVs consistently receive information about placement moves to be carried out by Health
5. Relaunch of escalation policy
6. CSC conference invitees list to be checked

13. E-safety audit	March 2013
Purpose: To find information to enable completion of the SWGfL E-Safety Self Review tool	
Background: This audit was part of the LSCB E-Safety Self Review, which is being completed by the LSCB E-Safety Sub-Group using the SWGfL E-Safety Self Review tool.	
Methodology: Online audit tool devised using Survey Gizmo, sent to all LSCB partners 1st March – closing date 22nd March.	
Key findings: *Audit is in progress*	
Actions: *Audit is in progress*	

14. Audit Sub Group Multiple child protection plans ('Re-registrations')	Spring 2012
Purpose: For the Audit Sub Groups to audit the quality of multi-agency work in Somerset, in specific areas.	
Background: The four Audit Sub Groups are sub groups of the LSCB Audit Policies and Procedures Group (APP) and have a work programme determined at an annual workshop.	
Methodology: Relevant paperwork retrieved from CSC and police records, and sent to ASG members with Audit Tool. Each ASG audited 2 cases (8 cases in total).	
Key findings: *Audit is in progress*	
Actions: *Audit is in progress*	

Appendix 4 – Business plan 2013 – 2015

Somerset Local Safeguarding

Children Board

Business Plan

2013 - 2016

Governance and Accountability – Ensuring Effectiveness

Priority	Key Activities	Outcome	Lead Role	Timescale
Strengthen the Governance of the Board	Develop Board constitution including Terms of Reference and structure chart including sub groups	Board constitution agreed and in place, followed by all members	Service Manager – Safeguarding	September 2013
	Review and develop protocols describing relationship between Board and Children's Trust and Health and Wellbeing Board	Protocols agreed and in place, reporting arrangements secured	Service Manager – Safeguarding LSCB Chair	September 2013 and ongoing
	Review Board membership, Executive membership, appoint deputy Chair and Community members	Board arrangements comply with requirements and are effective – ensuring appropriate responsibilities are in place	Service Manager – Safeguarding LSCB Chair	September 2013
	Ensure all subgroups have agreed Terms of Reference and workplans linked to overarching Business Plan	Subgroups have TOR and Workplans that describe appropriate range of activity to safeguard children. These are regularly reviewed	Chairs of Subgroups Service Manager – Safeguarding	September 2013
	Develop subgroups arrangements: Quality and Performance, Learning and Improvement, Safeguarding Adolescents, Training and Professional Development, Health Advisory Group, Child Death Overview Panel	As above. Individual subgroups' own workplans are progressed and reported regularly to the LSCB	Chairs of Subgroups Service Manager – Safeguarding	September 2013
	Develop Risk Register for the	Risks identified and mitigated to	Service Manager –	September 2013

Priority	Key Activities	Outcome	Lead Role	Timescale
	LSCB activity: Monitor and review risks	ensure continual effectiveness of LSCB	Safeguarding LSCB Chair	
Respond to Government legislation and guidance	Consider implications from Working Together 2013 relating to governance and accountability of the LSCB. Report compliance to LSCB	All requirements of Working Together are met by the LSCB ensuring effective multi-agency working and challenge	LSCB Chair LSCB Members	September 2013

Performance – Ensuring Effectiveness

Audit, monitor, evaluate and challenge practice to ensure compliance, best practice and individual areas for improvement	Develop and implement LSCB Performance Framework and scorecard to include national and local requirements and comparators. Report to LSCB	Comprehensive multi-agency framework is in place and used to identify good practice, identify and challenge areas of concerns, lead to improvement	Service Manager – Safeguarding SCC Information Manager	April 2013
	Establish audit framework of specific commissioned audit and repeat activity: - Section 11 audit - CDOP - Learning and Improvement Subgroup - Quality and Performance Subgroup - Audit Sub Groups	Comprehensive programme of audit informs the priorities and development of the LSCB work	LSCB Audit Officer Service Manager – Safeguarding	December 2013 and ongoing
	Repeat full Section 11 Audit	Section 11 is completed and compliance fully assessed with deficits challenged and rectified appropriately	LSCB Audit Officer Service Manager – Safeguarding	September 2014

LSCB Priority Areas

Priority	Key Activities	Outcome	Lead Role	Timescale
Monitor the effectiveness of basic child protection practice and process across partner agencies	Review and audit multi-agency practice across partnership: - Child protection strategy discussion - Single assessment process - Child Protection Conferences	Child Protection practice is demonstrated as being effective leading to safer outcomes for children and young people	Chair Quality and Performance subgroup	April 2014
	Ensure access to, understanding and promotion of the LSCB Escalation process	All agencies have access to and understand the LSCB Escalation process	LSCB Audit Officer	September 2013
	Develop and implement QA framework of Child Protection Conference process and practice. Develop and implement QA framework for Looked After Children processes and practice	CP Chair and IRO QA arrangements in place and report regularly to the LSCB in order to identify good practice and deficits – leading to improved outcomes for children and young people	Service Manager – Safeguarding "Carolyn's post"	April 2014
	Drive, monitor and review the implementation of co-located single point of access for child in need / child protection services in order to improve response and outcomes	Multi-agency team established with common thresholds, information sharing arrangements and partner protocols in place to ensure timely response to concerns about children	Director of Children's Services	September 2013 and ongoing

Priority	Key Activities	Outcome	Lead Role	Timescale
	Arising from the Serious Case Review into Child A and Child B, the LSCB will ask agencies to audit a number of cases involving unborn children in order to establish the robustness of agency arrangements. The LSCB will review multi-agency guidance in light of the audit outcome	The LSCB and partner agencies have appropriate arrangements in place and agency assurance is provided to the LSCB	Service Manager – Safeguarding LSCB Audit Officer	September2013
	Arising from the Serious Case Review into Child A and Child B, the LSCB will ask agencies to review their internal escalation and resolution processes and ensure that policies are combined with regular activity to evaluate and review the health of relationships at the front line and first line manager level	Partners have robust internal escalation policies in place that connect with the over-arching LSCB Escalation Policy	Service Manager – Safeguarding LSCB Audit Officer	September 2013
Information sharing and Partnership working	Ensure that Somerset inter-agency information sharing and confidentiality protocol is reviewed, published and promoted. - Audit effectiveness and impact	Effective information sharing arrangements are in place for all agencies in Somerset	"Carolyn's post" Service Manager – Safeguarding	September 2013
	Develop and maintain LSCB website to ensure all	All professionals and members of the public have direct access to	Service Manager – Safeguarding	June 2013

	information is accessible and contemporary allowing single access to information and guidance relating to child protection and safeguarding	appropriate information as required		
	Improve engagement with District Councils about safeguarding and child protection – roles and responsibilities	District Councils understand their responsibilities towards safeguarding, are Section 11 compliant and therefore have appropriate safeguarding arrangements in place	CEO, SCC Service Manager – Safeguarding	December 2013 and ongoing
	Improve engagement with General Practitioners about safeguarding and child protection - roles and responsibilities	GPs are aware of their roles and responsibilities and act accordingly	Director of Patient Safety, CCG	April 2014
	Publish a Threshold Document applicable to the child's journey through the progression of support	All agencies and members of the public have access to a threshold document allowing them to understand the services that are available to protect children	Director of Children's Services Service Manager – Safeguarding	December 2013
	Publish a Learning and Improvement Strategy incorporating all key lessons from LSCB activity, indicating activity for partners	Learning and Improvement strategy allows all lessons arising from case reviews to be incorporated into multi-agency practice	LSCB Chair Chair of Learning and Improvement subgroup	April 2014
	Improve the understanding and effectiveness of CAMHS – thresholds, capacity, response to children in care and other vulnerable groups	Improved access to CAMHS for children and greater understanding for professionals and families about the parameters of the service	CAMHS Director	April 2014

Priority	Key Activities	Outcome	Lead Role	Timescale
Early Intervention; including Think Family, Troubled Families	Publish a multi-agency Early Intervention Strategy: - Role of Early Intervention Services and Children's Centres - Thresholds - Role of the Common Assessment Framework (CAF) - Developing resilience of children	Early Intervention arrangements are clear, robust and available to all; describe service response and anticipated outcomes. CAF embedded and impact evaluated.	Director of Children's Services LSCB Chair	September 2014 and ongoing review
	Ensure appropriate integration of early help programmes to include Troubled Families initiative, moving through thresholds to Children in Need	Related areas of activity are co-ordinated for implementation and effectiveness, in order to improve impact, reduce repetition of activity	Director of Children's Services	April 2014
Multi-agency training and supervision	Audit and evaluate the effectiveness of multi-agency training delivered by the LSCB and partner agencies	Training programme reflects content with clear learning objectives and consideration of outcome	Chair of Training and Personal Development subgroup Service Manager – Safeguarding	April 2014
	Review the effectiveness of induction and supervision arrangements in partner organisations	All agencies understand the basic requirements for induction and supervision, model policies published and outcome evaluated by LSCB	Chair of Training and Personal Development subgroup Service Manager – Safeguarding	April 2014

Priority	Key Activities	Outcome	Lead Role	Timescale
	Consider the development of an LSCB training pool to support multi-agency training delivery through the appropriate subgroup and using messages from case reviews and quality assurance measures	Improved access to multi-agency and single agency child protection and safeguarding training	Chair of Training and Personal Development subgroup Service Manager – Safeguarding	April 2014
	Consider breadth of case reviews through the appropriate subgroup to identify key lessons emerging from reviews – dissemination of learning and development of practice	The Learning and Improvement Subgroup considers and commissions case reviews as required, identifying methodology where necessary: key learning disseminated to multi-agency audience	Chair of Training and Personal Development subgroup Service Manager – Safeguarding	June 2013 and ongoing
Adolescent Safeguarding	Develop new subgroup focussing on Adolescent Safeguarding incorporating the work of: The Missing Children Subgroup, On-line Child Protection subgroup, Sexually Harmful Behaviour subgroup	Subgroup considers full range of issues relating to the wellbeing of adolescents including specifically vulnerable groups	Chair of Safeguarding Adolescents subgroup Service Manager – Safeguarding	June 2013 and ongoing
	Develop and agree a Child Sexual Exploitation Strategy for Somerset ensuring compliance with legal guidance and requirements	A CSE Strategy is agreed and published describing Somerset's multi-agency response to the issue	Chair of Safeguarding Adolescents subgroup Service Manager – Safeguarding	January 2014

Priority	Key Activities	Outcome	Lead Role	Timescale
	Continue to develop multi-agency response to Child Sexual Exploitation CSE MARACs Scoping Training and awareness raising	Multi-agency response identified based on local and national best practice leading to improved outcomes for vulnerable children and young people	Chair of Safeguarding Adolescents subgroup Subgroup members Service Manager – Safeguarding	April 2014 and ongoing
	Review the Missing from Home and Care Protocol to improve understanding and effectiveness	Protocol is appropriate and reflects current required practice	Service Manager – Safeguarding	April 2014

Learning and Improvement

Ensure effective understanding of key issues across multi-agency partnership	Develop Learning and Improvement Subgroup to identify key issues arising from: Serious Case Reviews, Other case reviews under SCR threshold, Root Cause Analysis, Systems Reviews	Subgroup is effectively constituted and operates effectively to identify and disseminate key learning from case reviews. The group is the Serious Case Review panel for Somerset and carries responsibility in this regard	Chair of Learning and Improvement Subgroup Service Manager – Safeguarding	June 2013
	Conclude Leaving Care System Review reporting findings as required: develop action plan, recommendations and monitoring and compliance arrangements	Review concluded, learning and recommendations identified and implemented	LSCB Chair Service Manager – Safeguarding	January 2014

Priority	Key Activities	Outcome	Lead Role	Timescale
Ongoing Work	Continue co-operation with required LSCBs to maintain shared on-line child protection procedures	Somerset LSCB continues to contribute to and work with the regional Child Protection Procedures group to review and develop shared procedures	Service Manager – Safeguarding	June 2013 and ongoing
	Ensure that the views and experiences of children are used – 'the voice of the child' – to inform priorities and developments of the LSCCB	Appropriate activity is developed in order to identify key messages from children and young people. LSCB and partners reflect these in the development if their work	LSCB Chair LSCB members Service Manager – Safeguarding	September 2013 and ongoing
	Embed CDOP activity into the wider work of the LSCB to ensure that issues relating to child deaths are addressed	The CDOP continues to be an effective multi-agency group, which identifies issues of practice and policy, leading to improved outcomes	CDOP Chair CDOP Manager Service Manager – Safeguarding	September 2013 and ongoing
	Develop and strengthen work with the Adult Safeguarding Board and the Community Safety Partnership, including: Domestic Abuse, Domestic Homicide Review, Suicide prevention	There is improved integration of work between the groups leading to improved coherence of priorities and improvement to practice	LSCB Chair ASB Chair	April 2014
	Organise LSCB Annual Practitioners' Conference	Multi-agency practitioners' conference held	Service Manager – Safeguarding	December 2013 and annually