South Gloucestershire

Safeguarding Children Board

Annual report

2016 – 2017

Contents

Foreword from the independent chair

 Much has been achieved in South Gloucestershire over the last year to raise awareness of safeguarding and to ensure that everyone works to keep children and young people safe. This annual report sets out what has been done but also the improvements to safeguarding which we are making.

- South Gloucestershire Safeguarding Children Board (SGSCB) has sought the views of children through the Youth Board and via an online survey
- The website has been improved to make it as accessible and relevant as possible to everyone in the area
- Local practitioners have attended the multi-agency training and have given positive comments about its value to them
- Several events have been held to provide information to young people and to local professionals about child sexual exploitation
- The annual practice conference was about domestic violence and abuse and was well attended and positively received
- The Board has examined the quality of safeguarding work through audits and reviews and has ensured action has been taken when needed

I have been the Chair of the Board since March 2017 so I have only become involved with the Board in the last few months. It is clear to me that there is a strong commitment by local agencies and senior leaders to keep children safe in South Gloucestershire.

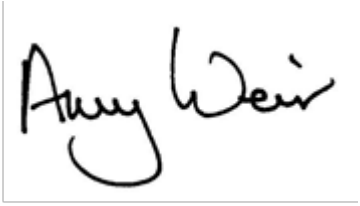
The Ofsted inspection at the end of 2016 identified shortfalls in local safeguarding and found the LSCB to be ineffective as it had failed to identify and act upon serious problems with safeguarding.

The major recommendation for the SGSCB from the inspection was about the Board's need to be better informed and to challenge practice which fell short of what was required to keep children safe. This means that the local authority and all partner agencies must ensure that they act promptly to remedy gaps in the safeguarding system and must inform the SGSB about any failings and what is being done to resolve them. The SGSCB as a partner body must challenge all partners and satisfy itself that the systems and organisational arrangements in place are keeping children safe and improving outcomes for them.

Since the inspection, there have been several improvements made by the SGSCB and there is an Improvement Plan to carry through what remains to be done. There is a renewed focus on considering the quality of practice and the performance of all the agencies.

Looking forward, next year will see the implementation of significant changes to the strategic, partnership arrangements for safeguarding. The Children and Social Work Act 2017 has removed the requirement for local areas to have a Local Safeguarding and Children Board (LSCB). Instead the police, health and the local authority are named as the key strategic partners for safeguarding and will be required to set up appropriate arrangements to oversee safeguarding for children. There has been no decision about what this will mean for South Gloucestershire and discussions will have to take place over the next few months. In the meantime, the SGSCB as the current strategic partnership will take forward its plans and its work to keep children safe.

I would like to thank all those who have worked hard to keep children safe and to make the SGSCB succeed in providing a strong partnership to safeguard children and young people. There is always more to do and I am confident that the coming year will be even more successful for the LSCB.



Independent Chair

South Gloucestershire Safeguarding Children Board

About the annual report

The South Gloucestershire Safeguarding Children Board's (SGSCB) Annual Report is a transparent assessment of the effectiveness of safeguarding and the promotion of the wellbeing of children and young people across South Gloucestershire.

In line with statutory requirements and best practice the 2016-17 SGSCB annual report and 2017-18 business plan will be shared with:

- The Director of Children, Adults and Health, South Gloucestershire Council
- The Chief Executive. South Gloucestershire Council
- The Police and Crime Commissioner
- South Gloucestershire Council Cabinet
- The Children, Young People and Families Partnership
- The Partnership Against Domestic Abuse
- The Health and Wellbeing Board
- The Safer and Stronger Communities Strategic Partnership
- South Gloucestershire Safeguarding Adults Board

This report has been authored by Sarah Taylor, Safeguarding Board Business Manager with the assistance of several contributors including sub group chairs, performance analysts and the independent chair.

The report was approved by SGSCB on 13 October 2017 and published on the SGSCB website on 16 October 2017.

Should you require the report in any other format to support accessibility please contact Sarah Taylor with your request: sarah.taylor2@southglos.gov.uk

Glossary of terms

Cafcass	Child and Family Court Advisory and Support Service
CAMHS	Child and adolescent mental health service
CCG	Clinical commissioning group
CDOP	Child death overview panel
CPD	Continuing professional development
CQC	Care Quality Commission
CSE	Child sexual exploitation
DA	Domestic abuse
DBS	Disclosure and Barring Service
DV	Domestic violence
EHCP	Education, Health and Care Plans
FGM	Female genital mutilation
GP	General practitioner
IRO	Independent reviewing officer
LA	Local authority
LAC	Looked after child/children
LADO	Local authority designated officer
LSCB	Local safeguarding children board
MASH	Multi-agency safeguarding hub
MAPPA	Multi-agency public protection arrangements
MARAC	Multi-agency risk assessment conference
Misper	Missing person
Prevent	A government programme aimed at preventing radicalisation
SCR	Serious case review
SERAF	Sexual exploitation risk assessment framework
SGSCB	South Gloucestershire Safeguarding Children Board
SoS	Signs of Safety
SWCPP	South West child protection procedures

The Board

The SGSCB is the key statutory body overseeing multi-agency safeguarding arrangements across South Gloucestershire. It is governed by the statutory guidance in Working Together to Safeguard Children 2015.

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

> To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by each such person or body for those purposes**[1]**

The independent chair of the SGSCB is Amy Weir. Amy took up post in March 2017 following the departure of the previous chair, Rachel Cook. Amy is accountable to the Chief Executive of South Gloucestershire Council, Amanda Deeks.

The South Gloucestershire Safeguarding Children Board structure can be found in Appendix one. There are several subgroups and an executive group in addition to the main Board.

The remit of the Board is clearly outlined in its constitution (Appendix two). It has a strong commitment from most partner agencies, all of whom sign up to the Memorandum of Understanding (Appendix three).

> The board is appropriately constituted, with wide membership including two lay members. Lay members contribute well to the board's work. An executive group sets the agenda for the board and drives its work programme. It is a strength that the nine subgroups are chaired by partners, for example the Clinical Commissioning Group, the voluntary sector and the local authority. Most of the subgroups are well attended and when this is not the case, the Board robustly challenges the agency concerned.**[2]**

Board membership and attendance for the year can be seen in Appendix four. Attendance below 50% will be addressed by the independent chair. It has become practice to directly challenge partner agencies whose attendance falls below the minimum standard.

During the year the Board has maintained key relationships with South Gloucestershire Council Cabinet members including portfolio holders for children and young people, The Partnership against Domestic Abuse and the Safer and Stronger Communities Strategic Partnership, the Children, Young People and Families Partnership, the Health and Wellbeing Board, the Safeguarding Adults Board, the Clinical Commissioning Group and the Police and Crime Commissioner. The Board also participates in the Avon and Somerset regional LSCB Consortium in working to address common safeguarding issues.

Partner agencies continued to contribute to the SGSCB budget for 2016-17, in addition to providing other resources such as staff time and venues for meetings. There was an underspend carried forward that was due in part to there being no serious case review during the year. The full

financial report can be seen at Appendix five.

Working Together to Safeguard Children 2015 sets out how effective information sharing between professionals and local agencies is essential for effective service provision. SGSCB plays a strong role in supporting information sharing between and within organisations and addressing any barriers to information sharing. This includes ensuring that a culture of information sharing is developed and supported as necessary by multi-agency training.

[1] Children Act 2014 Section 14
[2] South Gloucestershire Ofsted Report 2017

Living in South Gloucestershire

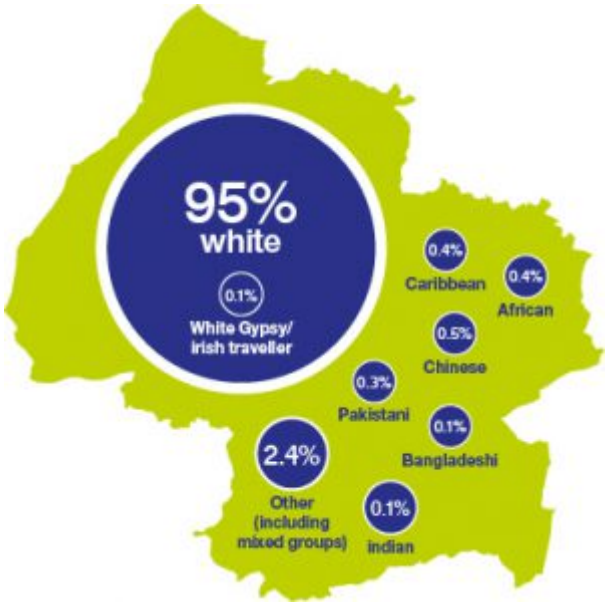
South Gloucestershire is a mix of long established urban communities, market towns, small villages and substantial new development. Characterised by very differing communities with individual needs and aspirations, the diversity of its landscapes and neighbourhoods contribute to a high quality of life.

South Gloucestershire's location and its proximity to the city of Bristol present a number of cross boundary opportunities and challenges which are dealt with by working in partnership with the neighbouring authorities of Bristol City, Bath and North East Somerset and North Somerset. South Gloucestershire is served by Avon and Somerset Police Constabulary and a Police and Crime Commissioner.

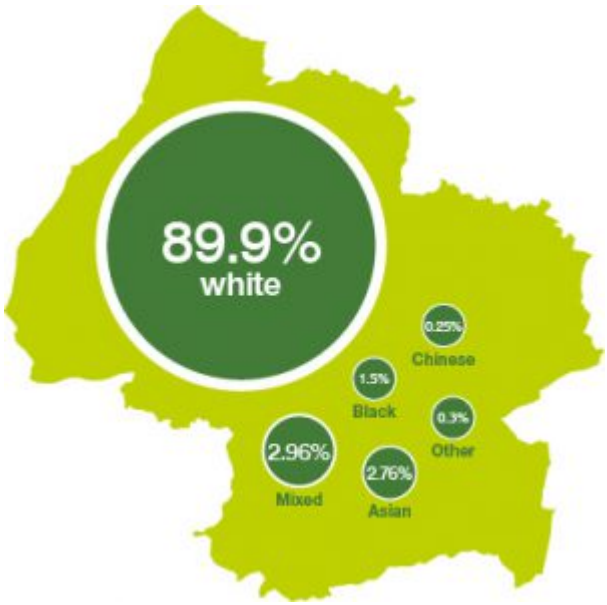
*The Department for Education changed their secondary school performance measures in 2016. The main measures are now Progress 8 and Attainment 8. Attainment 8 is being used more generally and the South Gloucestershire 2016 Attainment 8 score was 47.9. Attainment 8 measures the achievement of a pupil across eight qualifications including mathematics and English, averaged across the school and/or local authority.

0-19 Population

South Gloucestershire has a 0-19 population of around 64,749. (ONS midyear estimate 2016) This makes up approximately a quarter of the total population. The latest official population projections suggest that the number of 0-19 year olds will increase to 76,088 by 2039 (ONS 2014 – based Subnational Population Projections).



South Gloucestershire population ethnic groups (4-18) school census spring 2016



Number of schools and type

South Gloucestershire resident children population by age

Summary of safeguarding activity in South Gloucestershire

Looked after children

A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in sections 20 and 21 of the Children Act 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act.

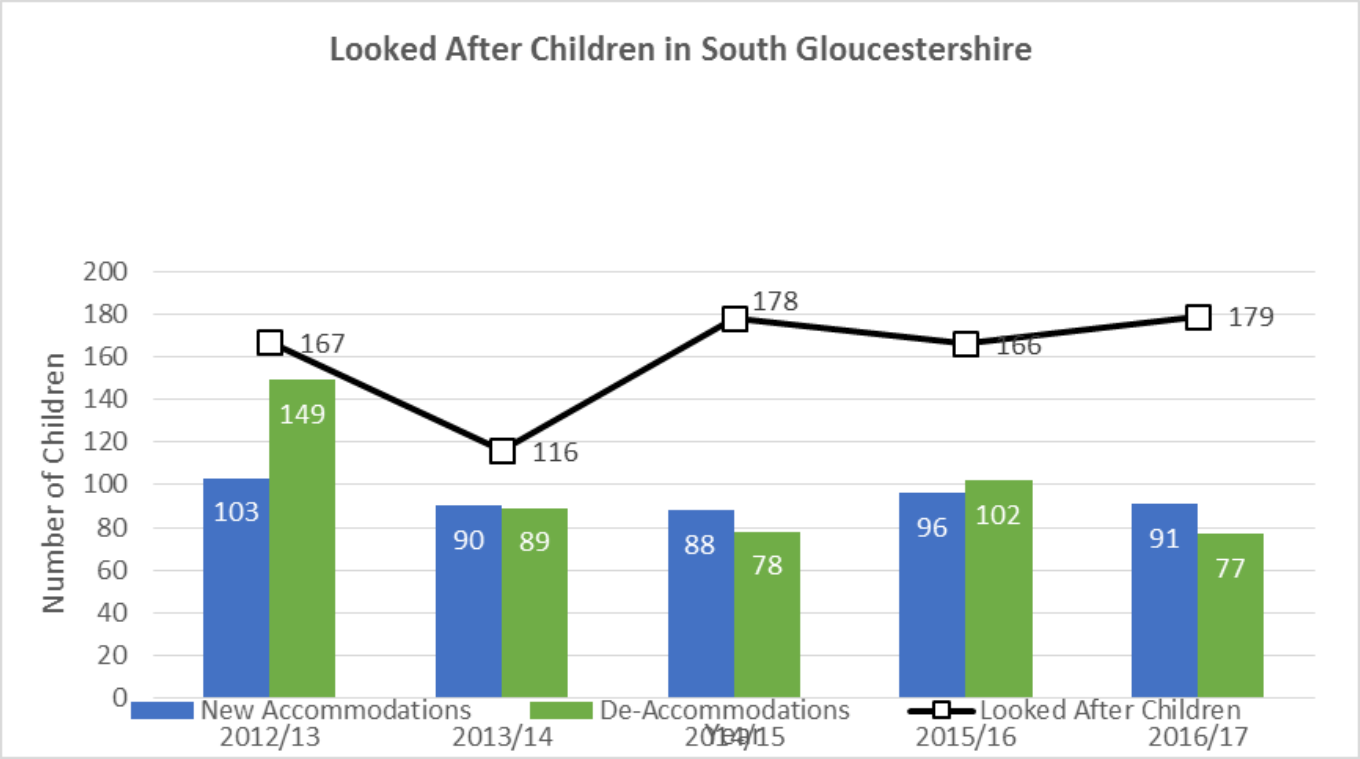
The majority of children who are looked after by the local authority are placed with foster carers as it is believed to be best for children to live within a family environment. For some children however, residential care may be more appropriate.

The number of looked after children has risen this year by 7.8%. At the end of 2016/17 there were 179 looked after children in South Gloucestershire, an increase of 13 on the previous year. 91 children and young people became looked after in the year (a decrease of five compared to 2015/16) and 77 children and young people who had previously been looked after ceased to be (compared to 102 in 2015/16).

More males are looked after than females, although there is no discernible difference in the numbers of females and males becoming looked after in the year. 30.3% of children and young people looked after and becoming looked after were aged between 12 and 15, with 30.7% of children becoming looked after aged 0-4 years.

19.5% of looked after children were recorded as disabled, with 10% of children newly looked after in 2016/17 having a disability.

16.8% of looked after children were from ethnic backgrounds other than White British, with children from Black or Black British backgrounds accounting for the highest proportion of those from non-White British groups.



Child protection plans

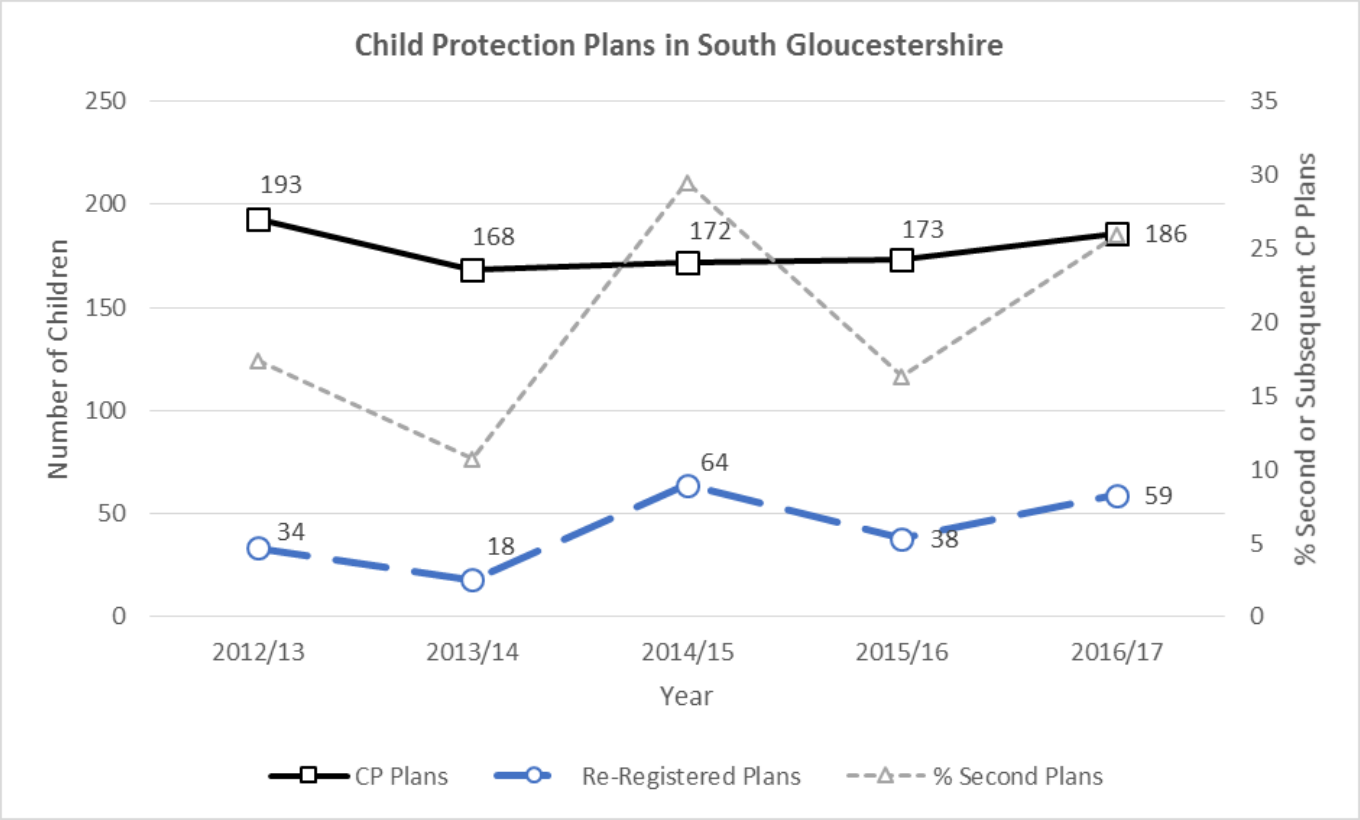
There has been a small increase in the number of children and young people who were the subject of child protection plans. 186 children and young people were the subject of a child protection plan during the year 2016/17, an increase (5%) on the previous year and a 7.5% increase since 2014/15.

The number of children and young people becoming subject of a second or subsequent child protection plan has increased by 9% on the previous year.

There were more males than females subject of child protection plans. The percentage of children and young people who had a disability was 11.8%.

Age ranges for children and young people subject of child protection plans varied, with the lowest group being 16+ yrs (10.2%) and the biggest 0 - 4 years (38.7%). The greatest number of children and young people subject of child protection for a second/subsequent plan was in the 5 - 11 year group (41.6%).

81.7% of those subject of child protection plans were from White British backgrounds, dropping to 78.3% for those becoming subject to a second or subsequent child protection plan. Those from non-White British groups who were subject to child protection were from a varied range of ethnic backgrounds, with no, one significant group.



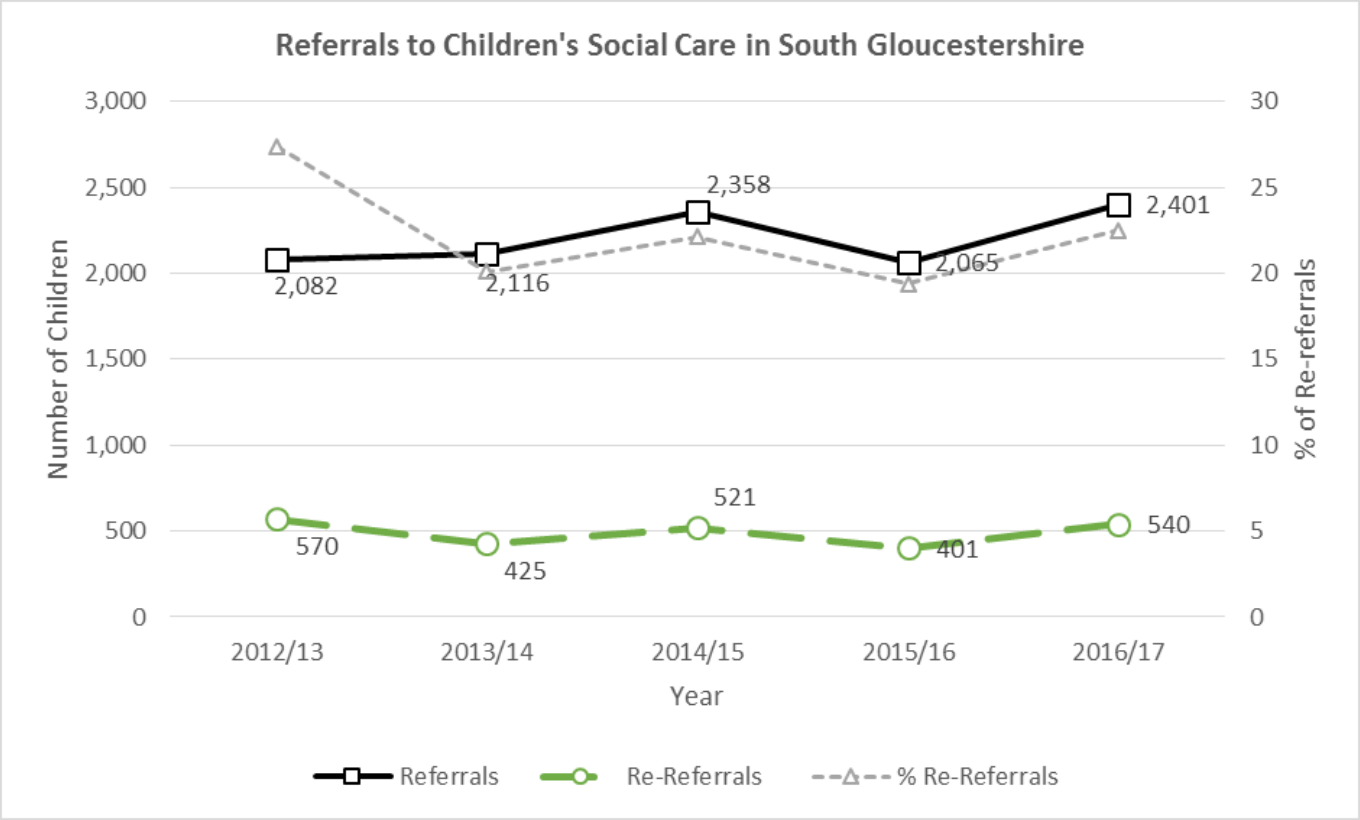
Referrals to children's social care

Over the course of 2016/17 2,401 children and young people were the subject of a referral to social care, an increase of 16.3% on the previous year, and in line with the number of referrals in 2014/15.

As the number of referrals have increased so has the proportion of re-referrals; with a rise of 3.1% when compared to re-referral rates in 2015/16. The number of re-referrals is the highest in 5 years (2012/13).

Referrals were split equally between males and females, with 35.9% of referrals being made for children aged 5-11 and 24.6% for young people aged 12-15.

83.95% of all referrals were for children and young people from White British backgrounds. Referrals for those from non-White British groups were from a varied range of ethnic backgrounds, with no, one significant group.



Children and young people with missing events in South Gloucestershire

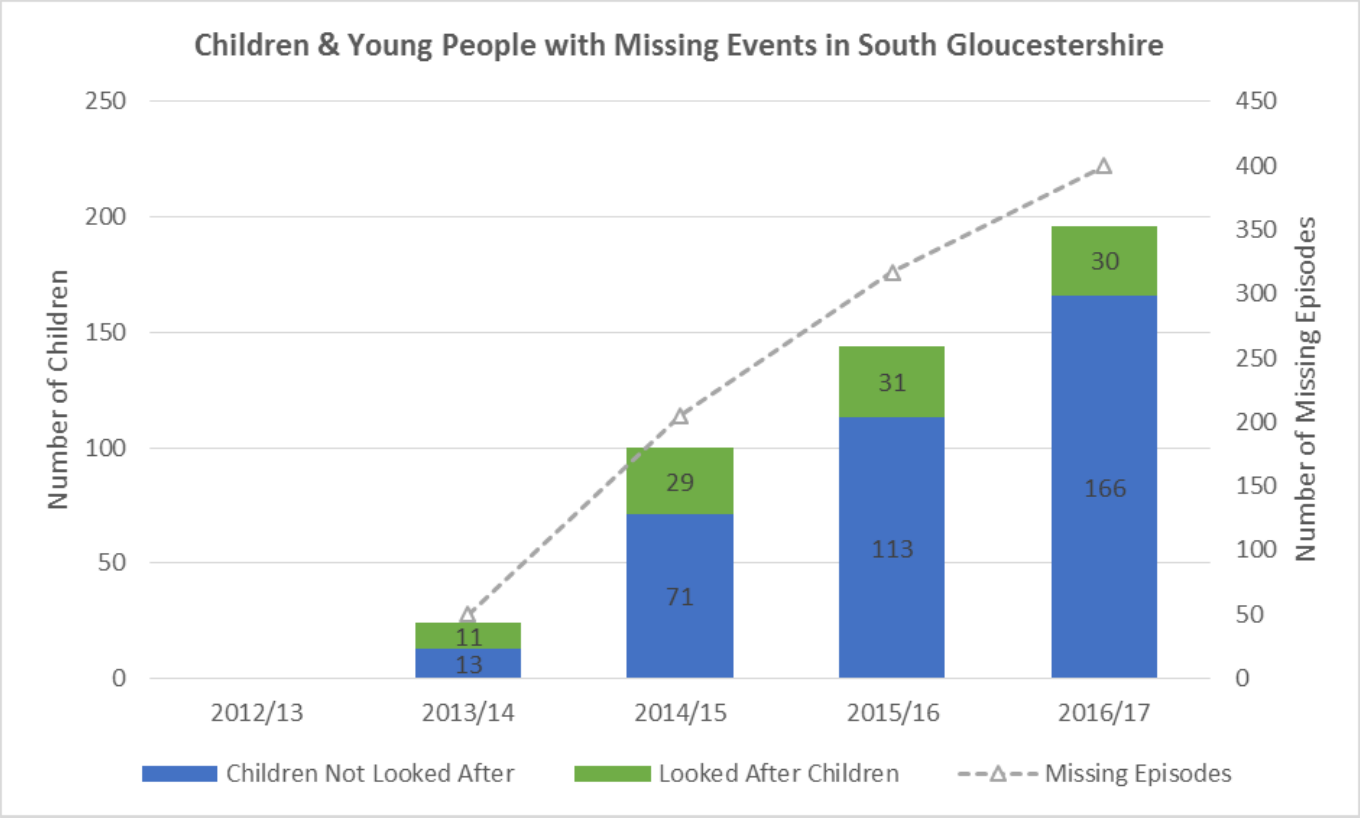
The annual variances in the number of children and young people who have been missing and the total number of missing episodes are accounted for by the growing focus on children and young people who are missing and local and regional improvements responding to this changing focus.

This data set is only available from 2013/14. Year on year comparisons cannot be provided accurately because of this.

In 2016/17 there were a total of 196 South Gloucestershire children and young people reported as missing. 166 children and young people (84.7%) were not looked after children and 30 (15.3%) were looked after children. There were a total of 400 missing episodes reported, with 64 (32.7%) young people having more than one missing episode in the year.

76.5% of children and young people reported missing were from White British backgrounds with the other 23.5% from other or unknown ethnic backgrounds.

159 (81.1%) children and young people reported missing were of secondary school age, with 57.7% aged 14-16 years and 12.8% aged 16-18 years.



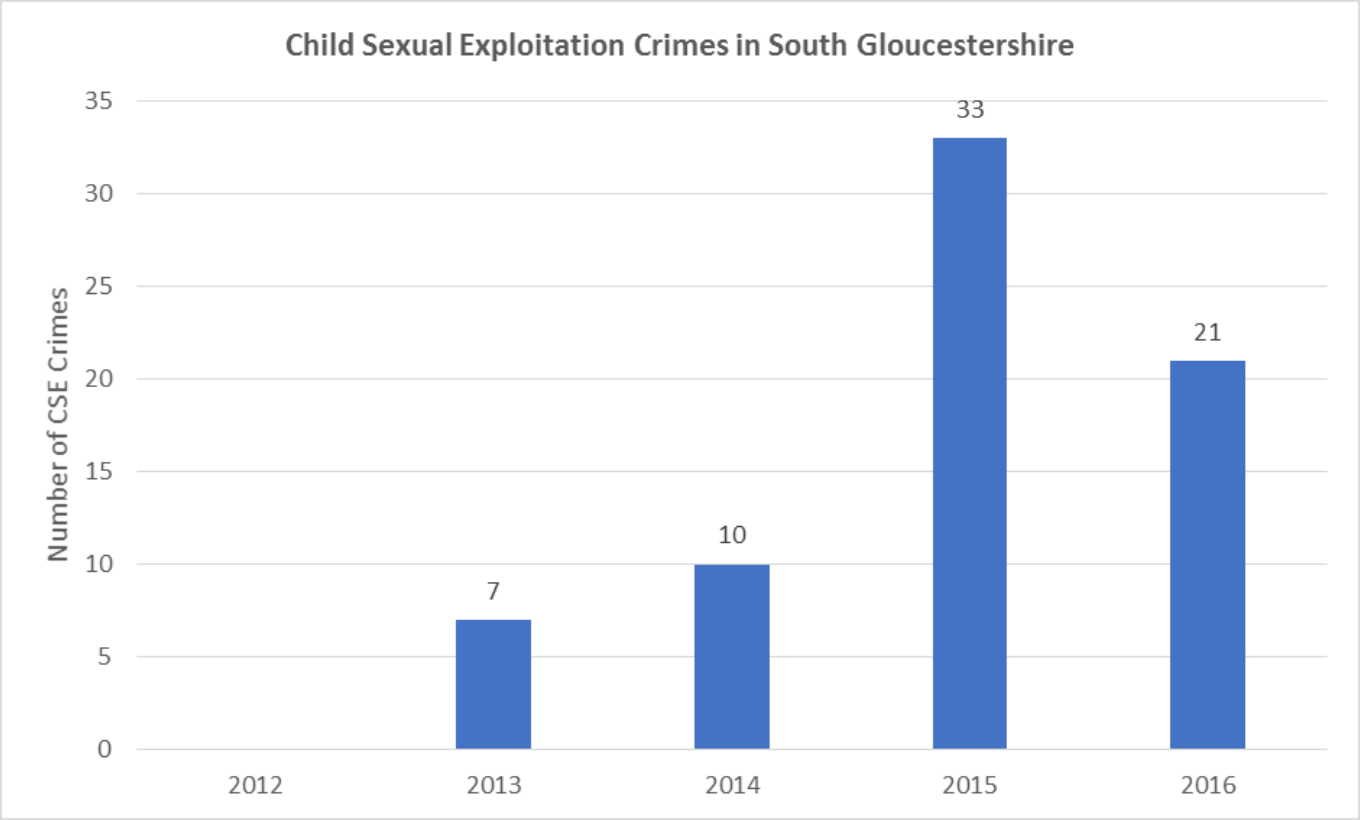
Child sexual exploitation crimes in South Gloucestershire

This data is provided to the South Gloucestershire Safeguarding Children Board by Avon and Somerset Constabulary as part of the multi-agency approach to safeguarding children.

This data set is only available from 2013.

The Child Sexual Exploitation crime tag was introduced which, in addition to providing safeguarding and investigation benefits, allows the monitoring of crimes that fall within the national definition of CSE.

Recorded CSE tagged crimes in South Gloucestershire decreased to 21 recorded in 2016/17, compared with 33 in 2015/16. There were 275 recorded CSE tagged crimes force-wide. It is important to note that the distribution of recorded CSE tagged crimes, both geographically and over time, can be skewed by a relatively small number of investigations identifying comparatively large numbers of victims, perpetrators and offences.


Child Sexual Exploitation Crimes in South Gloucestershire
Number of CSE Crimes
35
30
25
20
15
10
5
0
7
10
33
21
2012
2013
2014
2015
2016

Equality impact assessment (EqIA)

Gathering data and monitoring

The Summary of Safeguarding section includes information that has been collected throughout 2016-17 relating to equalities.

Each quarter the SGSCB receives a performance report which also includes this information.

Analysis

For looked after children, 16.8% are recorded as being Black/Black British. The overall Black/Black British population in South Gloucestershire is 0.9% Black British. This shows that Black/Black British children are over represented when compared to the South Gloucestershire population.

For children with child protection plans, 11.8% have a disability which is as expected according to our South Gloucestershire population. 18.3% are BME (Black and Minority Ethnic). This shows an over representation as the population data indicates a BME community of 8.1% in South Gloucestershire.

The same is true in the number of referrals to children's social care, where 16.05% of referrals are for Non-White British children compared to 8.1% based on the population of South Gloucestershire.

For children who have missing events, 23.5% are from non-white or unknown ethnic backgrounds. Again this shows an over representation when compared to the population of the local authority.

Action

As a Board we will carry out monitoring throughout 2017-18 to look for any emerging trends regarding ethnicity. We will do this by examining the performance data at the executive group on a quarterly basis.

Should trends emerge we will produce a plan to address this.

Communication

A multi-agency communications group, with representatives from both the Safeguarding Children and Safeguarding Adults boards, meets quarterly. The group is accountable to the boards and works to an agreed annual communications plan, supporting the board's objectives and planning and delivering effective communications to:

- ensure that safeguarding is everybody's business
- deliver the common message of 'if in doubt – speak out' across all safeguarding services
- proactively raise awareness of safeguarding issues and the role members of the public can play to create a safer community and enable them to be more likely to recognise and report abuse
- promote creative and engaging safeguarding campaigns that address the issues identified within our community
- promote the welfare of people at risk whether they are children, young people or adults, and their rights to be free from abuse
- reassure children, young people, adults at risk and their families and the general public that they will be listened to and to give details of what happens if a safeguarding concern is reported.

Key achievements

Website

Significant work has been undertaken by the SGSCB to develop its digital capabilities to communicate with all stakeholders. The website is central to this work.

The SGSCB website is accessible, mobile device friendly, easy to navigate and well used. The SGSCB website has received 39,724 page views over the last year.

The most visited pages on the SGSCB website for 2016/17 are:

1. Guidance for Professionals – Safeguarding Guidance, Policies and Procedures
2. Guidance for Professionals – Single Assessment for Early Help

3. Guidance for Professionals – Child Sexual Exploitation.

The website also hosts a range of interactive content such as YouTube videos to highlight key issues such as CSE. The SGSCB Annual Report is now published in an accessible eDoc format.

Social media

The SGSCB raised awareness of CSE on national awareness day in March 2017, asking board members and all South Gloucestershire schools to share key messages from local young people and the signs for parents and carers to spot. This social media campaign was the start of an ongoing local campaign being coordinated by a SGSCB Task and Finish Group with representatives from the CSE, communications and e-safety subgroups. Designated safeguarding leads and head teachers in South Gloucestershire secondary schools have given their commitment to help roll out phase one of the campaign, aimed at secondary school aged children, their parents and carers and teaching staff.

The messages from local young people we promoted achieved an unprecedented reach compared to other proactive social media campaigns we support locally, with 27 Facebook shares and comments including:

“This message needs to be out there”

“Some useful advice on this SG webpage, including Kayleigh’s story. Time to be aware of CSE”

“Some important advice from SG on CSE awareness day”.

Lay members view

The South Gloucestershire Safeguarding Children Board has two lay members and it was noted by Ofsted that they contribute well to the work of the Board.

Karl Stevenson

It is good to see that as a former service user, the views and opinions that I give are put into practice and thus improve the lives of other current service users within South Gloucestershire. The next point that I feel is important to raise is that whilst some of the subjects covered are sometimes quite heavy it is nice to tackle them head on and not to shy away from them.

> "As a lay member on the Safeguarding Children Board I feel immensely proud of the work I do."

Another point it is important to say is that all of the parties represented on the board work together in a way that everybody has a common goal and pulls their weight.

The final point I would like to put in is that the board is a very welcoming environment and that I have been made very welcome and feel as though I am part of a team.

Progress against last year's business plan

Ensure effective leadership, roles and responsibilities within the safeguarding board

- Development morning took place and induction booklet was prepared for all members
- LSCB meeting formats have been explored, key messages have been given to members
- Wood review changes will be led by the LSCB Consortium
- Informal meeting with new Board members and induction in place
- Board manager appointed
- Co-located MASH terms agreed, due to commence April 2017
- Signs of Safety training available to partners

To actively seek to capture and act upon the voice of those affected by safeguarding concerns

- Children and young people are already involved in work of the subgroups
- Capturing the voice of children and families within the audit process for multi-agency audits to be undertaken by Board Manager, rather than lay member as proposed initially

Strengthen board communications, member dissemination and practitioner feedback

- Board members have presented how they disseminate key messages and board information within their individual agencies.
- Next steps are to consider impact on practice of dissemination of information
- Summary of each board meeting is produced and disseminated and published on SGSCB website
- Plans for practitioner forum underway
- Subgroup membership reviewed
- Communication and Engagement subgroup is joint for adults and children boards
- Board newsletter is published quarterly
- Lay members roles extended until end of 2017

Assuring the quality of safeguarding practice in South Gloucestershire and prioritising and sharing best practice

- Joint regional LSCB Section 11 Audit completed
- Peer challenge events planned for autumn 2017
- Improvements have been made to performance report data
- Single agency audits will be captured in a schedule calendar
- Risk register will be in place following appointment of Board Manager
- Ongoing quality assurance of multi agency training programme in place
- Learning briefs are published following any case reviews
- Evaluation process following training has been improved to capture the impact of training

To promote a learning and improvement culture which responds to identified developments and actions

- Four SCRs themed around domestic abuse have been read and summarised by members of the training subgroup. These summaries are being used to inform content of the LSCB conference (22 March 2017)
- Changes to recording of CSE by social care has provided more accurate information to the LSCB
- Problem profile work of CSE in South Gloucestershire is underway, with delays due to availability of partner information
- Analysis of data from South West Child Protection Procedures has taken place regionally. Greater promotion of the website is needed with links to the SGSCB website and vice versa.
- Children, Young People and Families Partnership (formerly Children's Board Trust) have agreed to take overall responsibility for the early help strategy with the LSCB having a 'critical friend' oversight and data is monitored
- Subgroups are well attended, and they monitor data to ensure analysis of the quality of our response to CSE
- Board Manager will explore engagement with faith communities when in post
- Safeguarding audit for schools took place within timescales and data was reported
- Presentation to SGSCB about Prevent agenda took place
- Annual reports for services that report to the SGSCB annually were all received.

Child sexual exploitation

What has worked well

Training on CSE for people who work in the night time economy continued. This reached a large number of individuals. This work is being embedded with South Gloucestershire Council now offering free introductory training for all taxi drivers and it is consulting on making this training mandatory.
South Gloucestershire Council's social work team managers have received training from young people who have experienced CSE. The aim of this work was to make sure that the professional response fits with what children and young people say works. The young people who delivered this training reported significantly increased confidence.

A continuation of the multi agency CSE training programme has been implemented using a freelance trainer and a rota of frontline staff, who all attended specialist CSE train the trainer sessions during the year. This ensures that CSE training in South Gloucestershire is sustainable for the long term.

Reference to CSE within the Online Safety subgroup meetings has strengthened knowledge and understanding of the early years representative. Although already a subject discussed with the Early Years sector in visits and training within safeguarding, this has added awareness and relevance with regards to their young parents. CSE as a standing agenda item ensures this remains as a priority for subgroup members.

The Communications subgroup asked young people to review their CSE poster draft. Young people reviewed the poster on its look and feel. Young people who had been victims of CSE looked in depth at the content of the poster and gave quotes to be added as they felt it was important to encourage other young people to speak out on what was happening to them. As a result of this work the victims of CSE stated they felt 'better' having an active part in helping other young people.

The young people's quotes were used in social media posts to mark CSE awareness day.

The materials being developed will give up to date information and advice to the wider population of young people living in South Gloucestershire and enforce the message 'you are not alone'.

We continue to identify a number of children who face CSE and have a dedicated, commissioned service that works to provide direct support to these children. The young people who received direct support to protect them from CSE reported a range of positive outcomes. These included an increased awareness of their rights not to be exploited, improvements in their health, improvements in their relationships with people who are safe and reduced levels of CSE.

A Workforce Development subgroup member working in public health was responsible for co-ordinating a programme of Chelsea's Choice performances in 10 South Gloucestershire secondary schools. A number of subgroup colleagues attended these performances in order to increase their knowledge of CSE and its impact.

Children and young people who have received input in school on safer and healthier relationships have said they know more about their rights to be safe in personal/sexual relationships.

What we are worried about

As an LSCB we are worried about how well we understand the local picture of what CSE looks like in South Gloucestershire. Though we do know of many children who are at risk, there may be sexual exploitation happening that we do not know about.

We are aware that while guidance and training is available, there may be professionals who are unsure about following the guidance or are not sure what to do when they are concerned about CSE, particularly in sharing concerns about perpetrators with the police.

We do know that we need to better understand the link between children going missing and CSE and, for boys, the links between them being criminally and sexually exploited.

Through consultation with young people who have been victims of CSE the LSCB have been told about professionals ringing young people on their mobiles phones after disclosures have been made. Young people have not always been in a safe place to talk, and haven't always known much about which organisation is ringing and why. Young people found this stressful and they felt they had no control.

The Workforce Development subgroup have particular concerns that those professionals working with younger children e.g. in primary schools do not see CSE training as being relevant for their role, which may lead to gaps in understanding across the workforce. The online subgroup have echoed this concern and recognised that there are still some child care settings and childminders

who may not see the relevance of this in the age group of children they work with.

In addition there are some practitioners who lack confidence in their own knowledge of the online world so feel reluctant to talk to children and young people about social media and other technologies.

What needs to happen

The LSCB plans to review and update the guidance for professionals for what they do when they are worried about CSE, to make sure it is up to date and properly understood.

The LSCB needs to improve understanding of what CSE looks like in South Gloucestershire - who it happens to and where.

There is a need to communicate better with the public, particularly parents and young people, to raise their awareness of CSE, and a campaign is planned to do this.

We will merge the CSE and Missing subgroups to improve links between children at risk of CSE who going missing.

The LSCB will communicate the request from young people to contact them by text message before phoning them to help the young person understand who is phoning them and why, and can choose the best time for them to call.

Training attendance will continue to be monitored via the Workforce Development subgroup and reported to the executive of the LSCB.

CSE and links to the online world will be fed into the training session being developed by the Early Years Safeguarding Forum. This will be used by designated safeguarding leads in early years settings to train whole staff teams.

Resources like Net Aware (NSPCC and O2) will continue to be disseminated by Online Safety subgroup members to increase practitioner confidence in talking to children and young people about their online lives.

Online safety

What has worked well

Young people worked directly with the chair of the Online Safety subgroup to design surveys for young people receiving early help, social care and universal services about internet concerns.

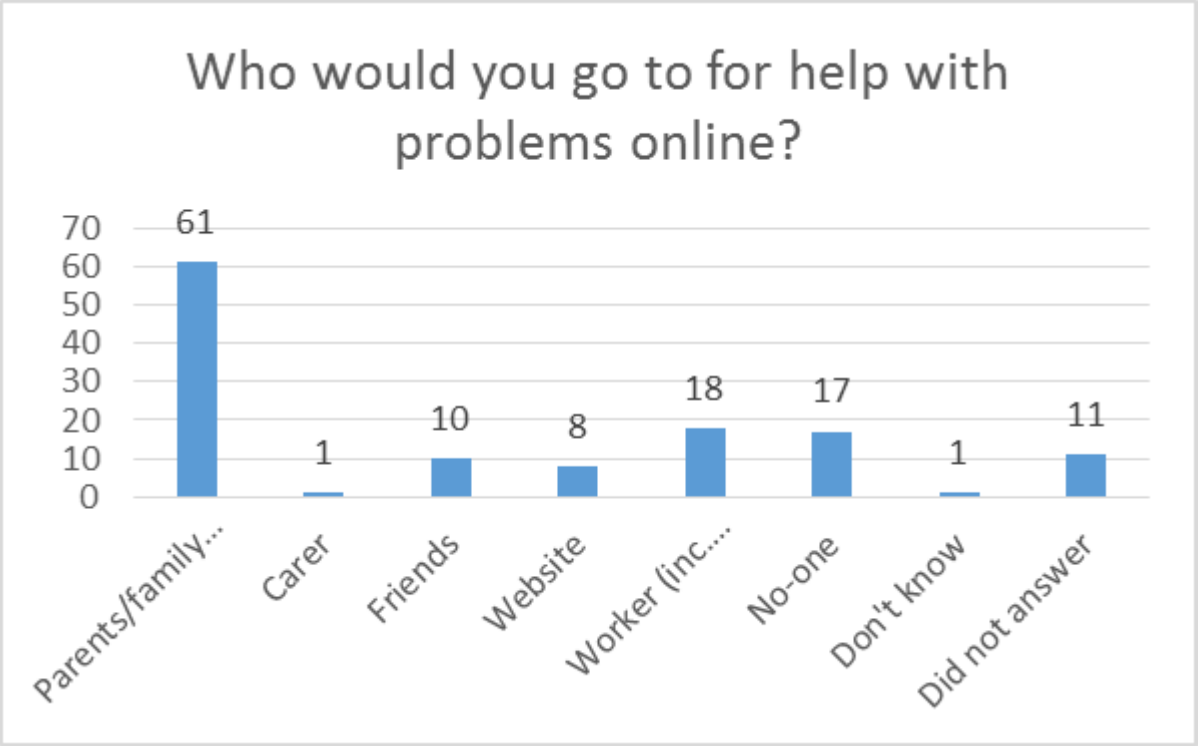
Following this, 120 survey responses were submitted and young people gathered and inputted the data.

As a result young people delivered a conference which included 50% adults and 50% young people. The aim was to explore internet use and feedback the outcomes. The tables included in this section show responses from the online survey.

There was good multi agency attendance including practitioners from early years, South West Grid for Learning, police and the local authority.

Southern Brooks, priority neighbourhood youth centres and members of the Youth Board created films and presentations.

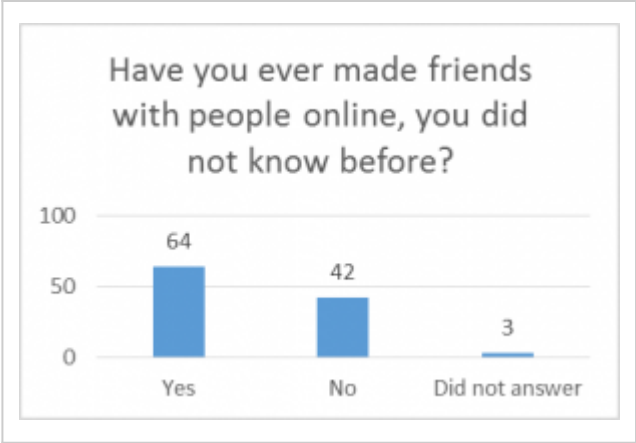
The young people workforce who were present have increased their knowledge around internet usage.

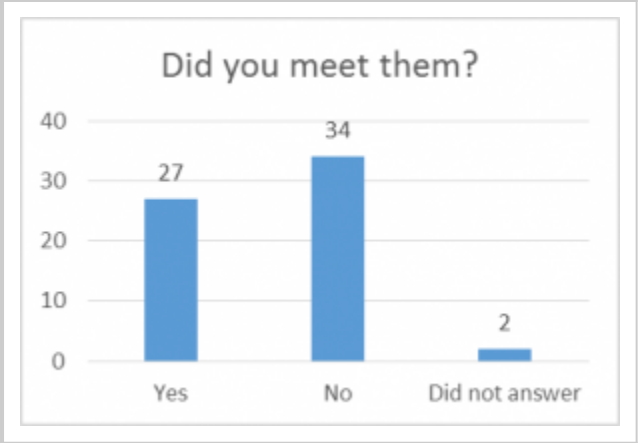


Youth centre responses that showed a high number of young people 'sexting' were asked to hold sessions about this and were provided with resources to help them.

The child protection update training content includes a section on online safety including showing Kayleigh's Love Story. This is a film produced by Leicestershire Police following the murder of Kayleigh Haywood, aged 15.

This increases practitioner knowledge around the risks children and young people face when meeting people they have had contact with online.





The training also includes an online safety quiz with reference to the NSPCC/O2 'Net Aware' website. This increases practitioner knowledge about the most popular apps, how they can be used and what the risks/benefits are according to parents, children and young people.

Practitioners have reported showing Kayleigh's Love Story to either their own children or those they work with, therefore increasing the awareness of young people of the associated risks.

The use of Net Aware increases practitioner knowledge of apps and their own confidence in having effective conversations with children and young people.

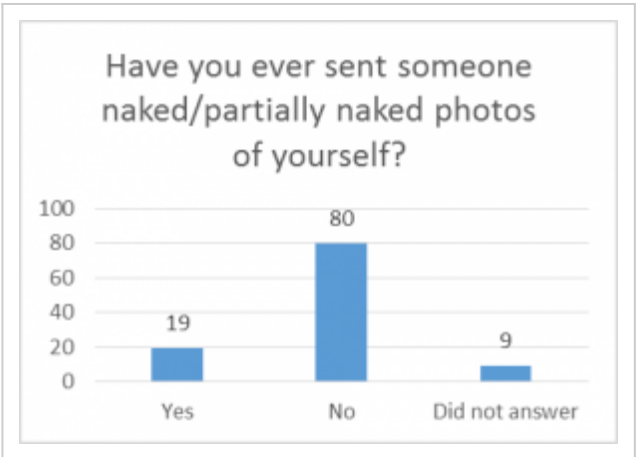
A safeguarding audit has been distributed to schools and the early years sector with a focus on online safety. Analysis will highlight strengths and areas for improvement.

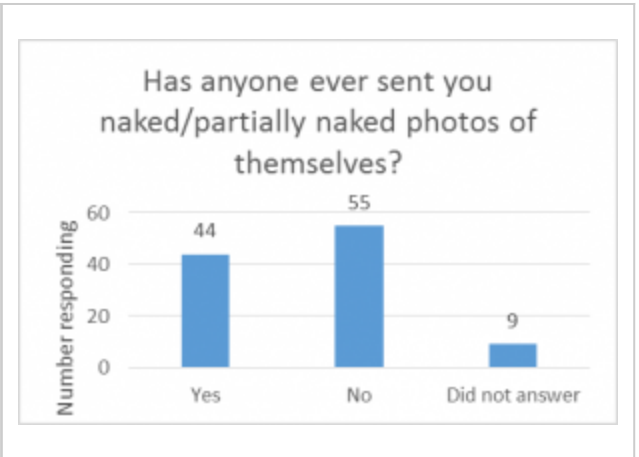
The Online Safety subgroup highlights conferences and e-safety toolkits which the members are responsible for sharing with their organisations.

What we are worried about

The number of completed and returned multi-agency training needs questionnaires was very low, so understanding of workforce training needs around online safety has been difficult to establish.

The Safeguarding Children Board multi-agency training programme does not have a bespoke training course that focuses on online safety.





There is no universal health representation on the Online Safety subgroup which poses a risk in terms of effective dissemination to the children's workforce.

The pace of change in the online world brings a challenge to the LSCB. Even when settings and practitioners receive current guidance and have good tools to use with children and young people, the speed with which the online world changes means that often agencies cannot embed learning quickly enough.

What needs to happen

The multi-agency training needs questionnaire will be sent out again, with the aim of increasing the number of responses. The questionnaire responses will be analysed and presented to the Workforce Development subgroup to enable a better understanding of need.

This table demonstrates range of responses of need so far:

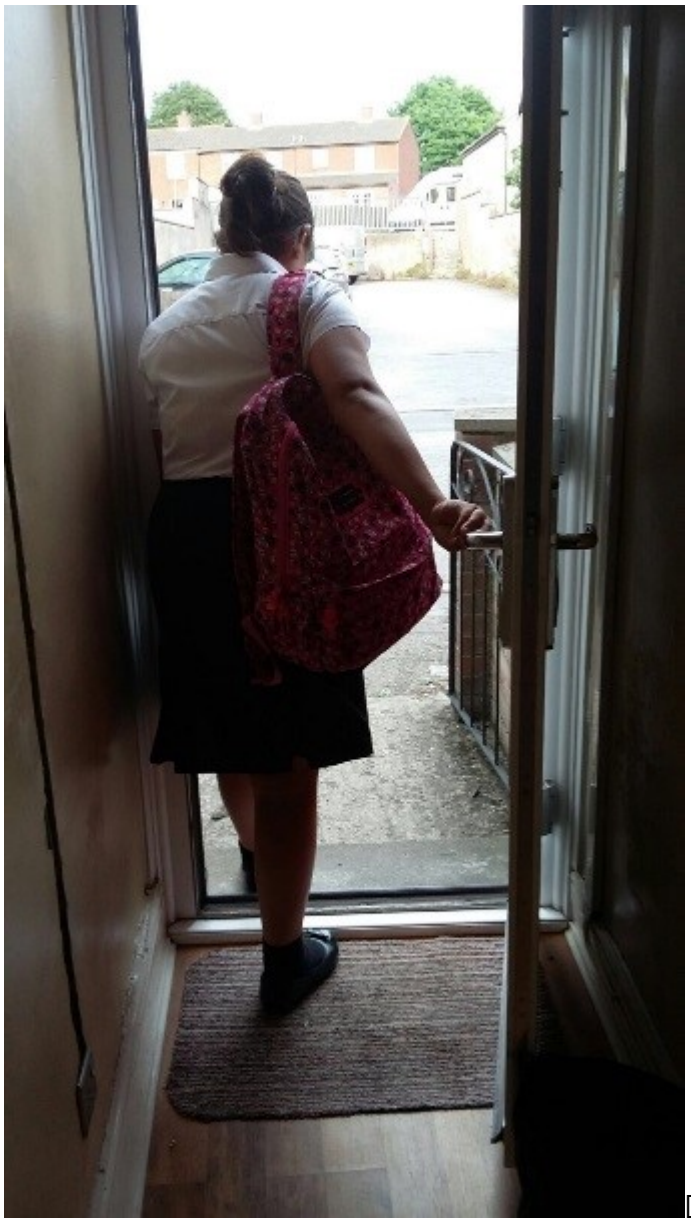
The multi-agency training programme will be enhanced by the addition of a new training session. There will be a pilot initially of the South West Grid for Learning 'Digital Policing' course.

Evaluation data will then help to determine whether this training is the right session to be included in the LSCB training offer.

The Online Safety subgroup will identify a universal health representative.

Children missing from home, care and education

What has worked well

 During 2016-17 the subgroup has continued to build upon its quantitative (data) report and its qualitative (narrative) report to gain a comprehensive understanding of South Gloucestershire's children and young people who go missing.

This information has allowed for the identification of specific groups of young people, areas where mispers gather and schools who have a higher number of mispers. This has enabled targeted intervention and support.

Every South Gloucestershire young person who goes missing is offered an independent return home interview. Whilst this offer is not always taken up, it is an opportunity for the young person to talk about what made them go missing and for support to be identified if appropriate.

A risk management proforma has been produced to ensure that when a young person has a significant misper episode, or three or more missing episodes, a plan is put in place to manage the missing episode and to try to reduce missing episodes in the future.

Updated guidance around responding to missing children and young people has been produced.

Schools are now sent every misper report for young people on their role so that they are aware of what has happened for that young person.

The police receive a copy of the RHI to inform their response to any future episodes.

What we are worried about

- We don't have a comprehensive understanding of our return home interviews in terms of timeliness of RHIs, reasons they are not taken up and impact of the RHI.
- Timeliness of police notifications to ART of all mispers has been of concern over the year although signs are positive that this is improving.
- There has been a significant increase in children and young people being electively home educated (EHE). This can increase a young person's vulnerabilities and they can be largely 'unseen'.
- There has been an increase in repeat mispers.
- There is an increasing number of children who go missing in South Gloucestershire who are looked after by other local authorities and we have no information about them.

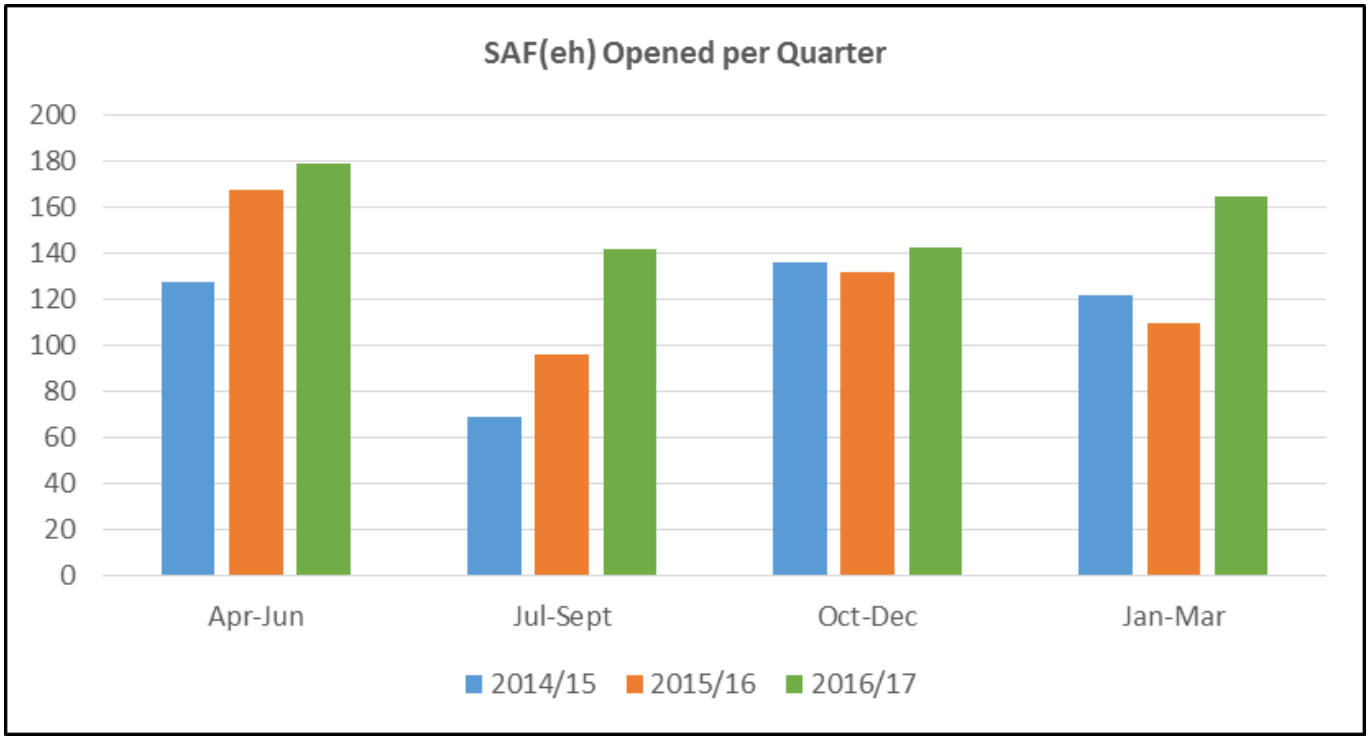
What needs to happen

- Further work will be undertaken to provide more information from the RHIs.
- Links with the ELE team will be made to explore the issues of both missing and CSE.
- The CSE subgroup and the Missing from Home, Care and School subgroups are merging.
- Continued challenges will be made to placing LAs about the need to notify us of their out of authority placements.
- Young people are producing leaflets/business cards containing useful information to give to young people who go missing.
- Links will be made with the anti-social behaviour team to share information about hotspots for increased awareness and monitoring.

Early help

Single assessment framework for early help (SAFeh)

In the last year the numbers of SAFeh submitted has increased by 24%, from 506 to 629. This follows an increase of 11% in the preceding year and continues to be encouraging. It is likely to reflect an increasing number of cases being stepped down to SAFeh from social care. However Ofsted observed that a significantly low number of requests for help into ART had no SAFeh. At this time the likely reasons for this are unclear, and continues to be a key line of enquiry.



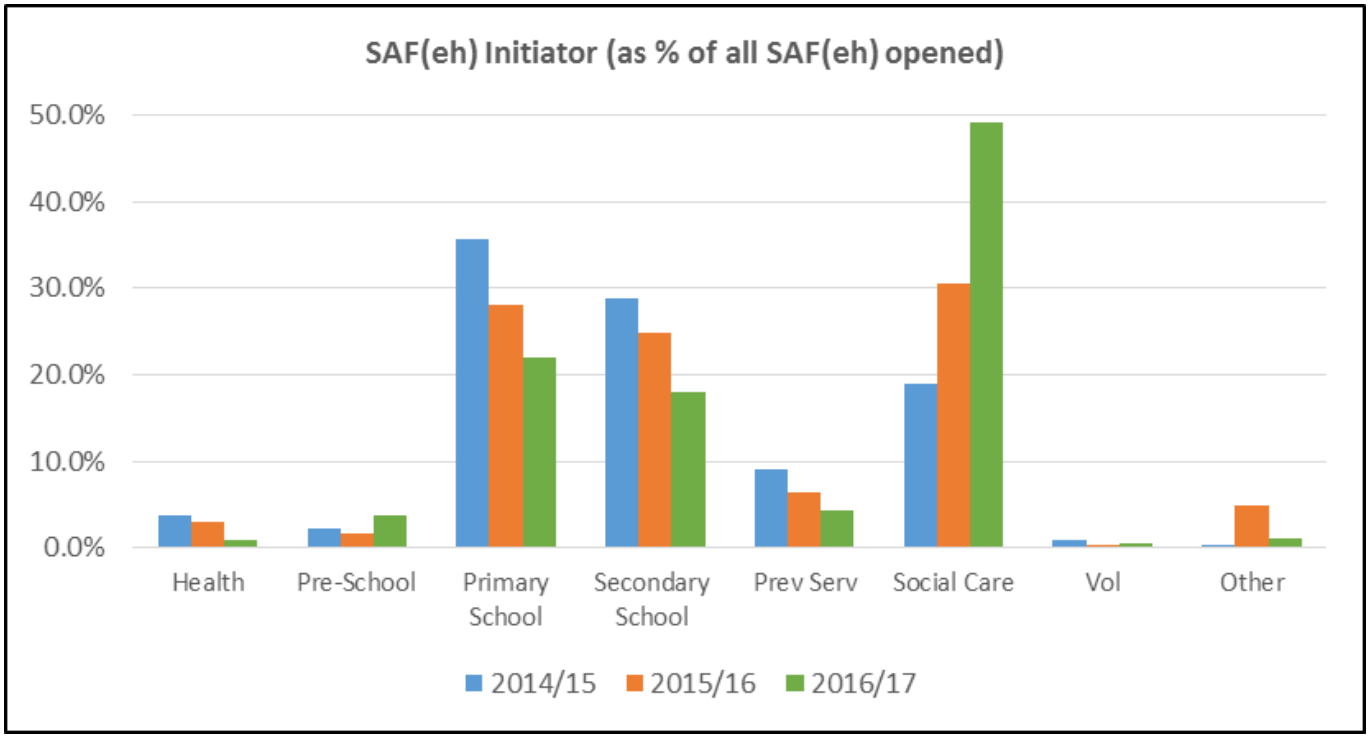
SAF (eh) opened in period					
	Apr - Jun	**Jul - Sept**	**Oct - Dec**	**Jan - Mar**	**Total**
2014/15	128	69	136	122	455
2015/16	168	96	132	110	506
2016/17	179	142	143	165	629

SAFeh initiators:

There has been a further increase in the number of SAFeh requests initiated by social care with this being the second year where an increase has been noted. Such SAFehs account for

approximately half of all those initiated and in numerical terms represent a doubling over the year from 155 to 308. At an initial view all of the other major initiators of SAFeh have continued to decline. This is most pronounced with regard to primary schools, where over the two years they have slipped from initiating over a third of all SAFeh begun, to less than a quarter. However in numerical terms over the year all initiators of SAFeh, other than social care, accounted for 321 in 2016/17 compared to 351 the preceding year.

As detailed above, the number of SAFeh being initiated by social care has significantly increased, and this continues to positively reinforce the success of the two early help partnership workers (EHPW).



SAF (eh) Initiator (as % of all SAF(eh) opened)								
	Health	**Pre-school**	**Primary school**	**Secondary school**	**Prev serv**	**Social care**	**Vol**	**Other**
2014/15	3.8%	2.3%	35.7%	28.8%	9.0%	19.0%	1.0%	0.4%
2015/16	3.0%	1.6%	28.1%	24.9%	6.5%	30.6%	0.4%	4.9%
2016/17	1.0%	3.8%	22.1%	18.0%	4.3%	49.1%	0.6%	1.1%

In South Gloucestershire we have been successful in encouraging most schools to use the SAFeh as part of their common business and delivery process and the way they offer support to families. This is demonstrated by schools continuing to be the largest initiator after social care, with 40% commenced by either primary or secondary schools.

Universal health services, pre-schools and the voluntary sector accounted for a total of 21 SAFeh initiations in the year, this being similar to the previous year. These three sectors are being

encouraged to use SAFeh more frequently, and several actions are in place to continue this work.

The early help offer in South Gloucestershire includes council delivered services known as preventative services. This includes family and young people's support teams, children's centres, co-ordination of families in focus (troubled families) and the Youth Offending Team. Partner organisations also provide early help including midwives and health visitors, infant mental health, schools, speech and language, school nursing, sensory support, young carers support, youth centre provision, GPs, Job Centre Plus, leisure facilities and community centres.

What has worked well

Early help partnership workers (EHPW) have successfully supported practitioners from all agencies to initiate and problem solve SAFeh to improve outcomes for children and their families.

EHPWs specifically support the Access and Response Team (ART) and locality social workers to ensure a smooth transition in stepping down cases from social care.

Multi-agency cluster meetings based around schools successfully problem solve around 'stuck cases' and identify various gaps in knowledge and training, arranging to address them through workshops and presentations.

What we are worried about

The recent Ofsted report commented that:

> The Board has not ensured that the effectiveness of early help has been properly evaluated.

There are also concerns about the capacity of partner agencies and settings to maintain their commitment to early help processes in the context of reduced resources. For example, reduced funding to voluntary agencies and schools.

Inconsistencies between agencies about what early help is, and when SAFeh is required

What needs to happen

The Early Help Strategy (2015-17) will be updated in the context of the Early Help Review commencing in the summer of 2017, and is due to report in November 2017.

All agencies need to develop a joint vision about when early help within a single agency needs to be shared as part of SAFeh. This would improve the common business and delivery pathway as a more universal approach.

Local authority designated officer (LADO)

Working Together to Safeguard Children 2015 requires local authorities to have in place a designated officer to be involved in the management and oversight of allegations against people who work or volunteer with children.

"The designated officer provides advice and guidance to employers and voluntary organisations on how to deal with allegations against people who work with children; liaises with the police and other agencies to monitor the progress of cases and ensures that they are dealt with as quickly as possible, consistent and with a thorough and fair process".

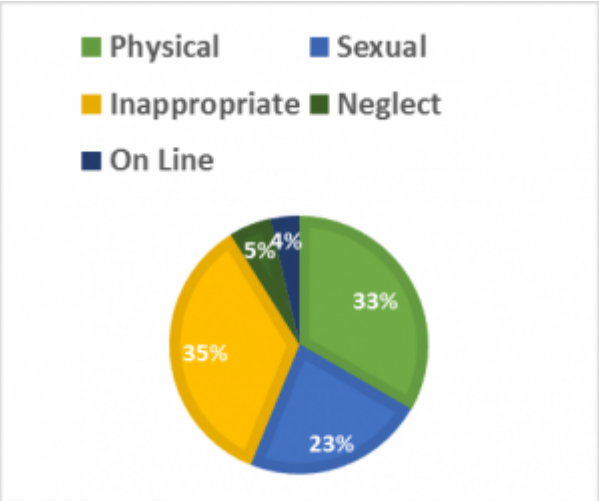
The LADO should be alerted to all cases where it is alleged that a person working with children has:

- behaved in a way that has harmed or may have harmed a child
- possibly committed a criminal offence against a child or related to a child
- behaved towards a child in a way that indicates they may pose a risk of harm to a child

Keeping Children Safe in Education (DfE March 2015) introduced the requirement for head teachers to advise the LADO of any situations where a 'waiver' to a disqualification by association is being sought. Other employers also contact the LADO in these situations and a record is maintained. There have been only two notifications this year.

In addition to specific allegations of abuse, the LADO is receiving an increasing number of enquires and requests for advice and guidance from professionals and the non-statutory sector working within South Gloucestershire.

The LADO received 58 referrals over this year, fewer than the previous twelve months.



Education and care staff account for 68% of referrals.

There has been an increase in allegations against foster carers.

The number of allegations against taxi and bus drivers has also increased. This is likely to be as a result of increased awareness of CSE.

The allegations management process allows for a number of possible outcomes:

- Substantiated
- Unsubstantiated
- Unfounded
- Malicious.

The Department for Education (DfE) has altered the outcome 'unfounded' and replaced this with 'false'. In agreement with the DfE the South West LADO Group have agreed to the continued use of the outcome unfounded. The definition for this is 'this indicates that the person making the allegation misinterpreted the incident or was mistaken about what they saw. Alternatively they may not have been aware of all the circumstances. For an allegation to be classified as unfounded, it will be necessary to have evidence to disprove the allegation'. This is very different from 'false' which implies that the person making the allegation has been untruthful.

What needs to happen

- The introduction of the Mosaic IT system will provide the opportunity to improve the LADO recording to include recording of safeguarding enquiries and advice and will provide more systemic management information
- LADO procedures need to be updated and to include information leaflets for those making an allegation and those against whom an allegation is made
- The LADO needs to establish links with the groups and organisations providing services to local communities to ensure they understand their safeguarding responsibilities and the role of the LADO
- Establish regular safeguarding meetings with Eastwood Park Prison Mother and Baby Unit

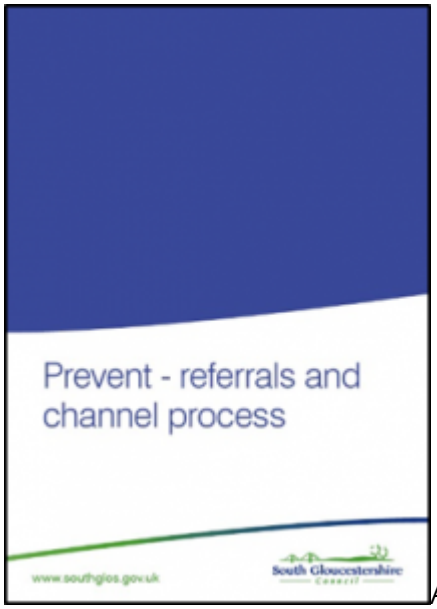
Preventing radicalisation

Radicalisation involves persuading others of a world view that rejects society and encourages the use of violence to change society.

The Prevent programme is part of the national counter-terrorism strategy and involves identifying individuals being radicalised and drawn into terrorism or violent extremism, and working with those individuals on a voluntary basis, giving them support and guidance to turn them to a different path.

The Counter Terrorism and Security Act 2015 places a statutory duty on local authorities such as South Gloucestershire Council to assess the risk of radicalisation in their local area and to take appropriate action in response to that risk.

At this moment in time (end of the 2016/17 financial year) the national threat level from terrorism is 'Severe', meaning a terrorist attack is highly likely. South Gloucestershire is classed as a low-risk area. As such it receives no Home Office funding to deliver its Prevent work. However that does not mean there is no risk in South Gloucestershire.



A Prevent Board for South Gloucestershire co-ordinates work between key organisations operating locally. There is a formal relationship between the Prevent Board, the Local Safeguarding Children Board and the Safeguarding Adults Board which includes the council's head of safeguarding being a member of the Prevent Board. The Prevent Board's

detailed annual report is presented each year to the Local Safeguarding Children Board and the Safeguarding Adults Board.

In the previous year the local focus for Prevent had been largely about ensuring appropriate processes and training were in place. During 2016/17 we built on this, working with local communities in order to raise understanding, and to deal with tensions including those related to faith and race. Key actions in the year included:

- Amending the Channel Panel process to better co-ordinate input from health services
- Meeting with leaders from a range of faiths to discuss how we can work together to improve tolerance and diversity in the community using faith groups as anchors
- Linking to ongoing engagement mechanisms including South Gloucestershire Equality Forum and the South Gloucestershire Race Equality Network
- Establishing a network of key community contacts in Patchway and Filton who are aware of/share information in the community about Prevent
- Extending training in the national Workshop To Raise Awareness of Prevent to a range of voluntary, community and social enterprise sector organisations, with particular emphasis on those working with vulnerable young people
- Verifying that sufficient safeguards and auditing policies are in place to prevent public internet facilities in libraries and One Stop Shops being used for extremism or radicalisation in order to help protect vulnerable individuals
- Trialling the use of the Breakthrough mentoring service as an intervention provider, working with an individual at risk of extremism
- Giving a further 250 council staff detailed (Workshop to Raise Awareness of Prevent) training, bringing the total to 442.

The Ofsted inspection of South Gloucestershire carried out in November/December 2016 concluded that:

"Local professionals, including school staff, have received training in identifying children and young people at risk of radicalisation. The head of safeguarding is a member of the council's steering group for 'Prevent'. A range of agencies refer to the 'Channel' panel, although none have met the threshold for discussion in this forum. Screening by the head of safeguarding ensures that vulnerable children who are referred receive appropriate services. Schools have access to appropriate resources to support them in their 'Prevent' duty."

No resident in South Gloucestershire was identified as being radicalised in 2016/17.

Looking to 2017/18 Prevent priorities will be to:

- Develop a comprehensive and integrated programme to improve community cohesion
- Raise awareness within communities and organisations of lone actors
- Continue monitoring tensions and hate crimes, including extreme right-wing graffiti/stickers on street furniture and walls
- Assess the impact of refugees and asylum seekers housed locally and establish regular communication with them
- Continue roll out of Prevent awareness/WRAP training

- Contribute to a comprehensive regional communications strategy for Prevent to help improve understanding of the process and its reputation.

Learning and improvement

"Local Safeguarding Children Boards should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result"

Working Together to Safeguard Children 2015

Learning Flower design reproduced with permission from City & Hackney Safeguarding Children Board.

Reviews of practice

Serious case reviews and case reviews

South Gloucestershire Safeguarding Children Board has not undertaken any serious case reviews during 2016-17.

The Board continues to have oversight of serious case reviews undertaken nationally and a quarterly list of summaries of learning from these is included within the Board Performance Report.

There have been three multi-agency case reviews undertaken by the Serious Case Review subgroup on behalf of the Board. For each of these a summarised learning brief has been produced and circulated to Board members for wider dissemination in their organisations and agencies. They are also published on the Board website.

Case summary: Chloe

Chloe was aged 13 at the time this review was undertaken. She is a young person who had been subject of a child protection plan and at the time had recently been accommodated under an interim care order (ICO) due to concerns that the child protection plan was not keeping her safe. Chloe was frequently going missing and there was concern about her mental health and risk of child sexual exploitation (CSE). The period of the case review was very time specific. The review was undertaken as it was felt there could be learning for the police, children's social care and health to improve communication, joint working and planning for children in situations of particular crisis.

The family provided their views for this review.

Areas for improvement/concerns within the time frame of the review

The police did not feel that they, or the plan for Chloe, was safely containing her as she was repeatedly missing and sometimes would run within moments of being returned. This resulted in Chloe spending time on police premises as the police did not agree, on occasion, to follow the social care plan for her and return her to her placement.
Different parts of the police force dealt with different aspects of Chloe's case and not all information was shared amongst the different departments. Officers of the police force are not always aware of social care legal terminology, which meant that at times, police action taken was against the order of the family court.
Procedures were not followed regarding the missing episodes, in particular the need to hold risk management meetings; they appear to have been overlooked due to the ongoing 'crisis' and care planning that social care were trying to implement.

Senior managers were not always called upon at times when they should have been regarding decisions about where Chloe should reside after missing episodes.
The management of Chloe in one placement, following a number of missing episodes, lacked consideration and thought about the impact on others in the placement.
A suitable placement for Chloe was delayed due to the lack of a mental health assessment and it was not possible to get CAMHS to provide this.

Good practice/positives within the case

Communication between the Police Safeguarding Team and the Social Care Team was good.

All decisions made by parties had Chloe's best interests at heart.

Chloe had been engaged in school until the making of the ICO and the school had adapted her timetable to meet her changing needs.

The police response to reports of missing episodes was good. Information regarding possible CSE concerns was also able to be obtained and was being investigated.

Recommendations

There were a number of recommendations for the police regarding ensuring the right and up to date information about vulnerable young people was recorded on the right systems so it is accessible to communication and response staff. In order that this is effective, police and social care need to; ensure the timely sharing of written information regarding strategy meetings and actions; and the police need to understand social care terminology and legal duties relating to family court orders. All of these factors being in place should lead to better collaborative working relationships.

Police and social care need to understand from CAMHS (AWP) who to escalate accessing a MH assessment out of hours and how to escalate this if they are not getting the response they need.

Social care need to do some work with their commissioning team about better arrangements for working together and reduction in paperwork when secure placements are needed in an emergency; also to decide who searches for these placements.

Out of hours work: 1) Social care need to identify an ‘on call’ consistent manager should similar situations arise in the future so there is consistent oversight of decision making and all necessary information shared will be up to date. 2) EDT to look into having access to legal advice 3) social care need to ensure a system of free flowing essential information and decisions about cases, so these can be adhered to out of hours.

Missing Protocol: this needs to be reviewed and updated to ensure that there is a standard format for risk management meetings and clear guidance about when they should be considered as well as when a missing episode warrants a strategy discussion.

Consideration of a bespoke school attendance plan in similar situations; for Chloe, allowing her to come in for short hours each day at least meant she was seen daily by someone in the professional network.

Learning Brief Thomas Age 9

Background

Thomas is a nine year old boy diagnosed with an Autistic Spectrum Disorder when he was six by a community paediatrician. Both children's social care and school have supported the family in times of crisis since then.
Thomas has been assaulting his mother and his brother on a regular basis over recent months.

Incident

Police were called to Thomas's home address where he had assaulted his mother and was threatening to self-harm.
After consultation with other agencies the Police Officers detained him under Section 136 of the Mental Health Act. Due to a
lack of capacity at Bristol's place of safety Thomas was taken to Swindon's place of safety.

What Worked Well?

- Excellent Support from School for parents and to all agencies
- Excellent communication between South Glos EDT & Swindon EDS allowing effective information sharing
- Good practice attempts to engage father
- Positive use of police at an early stage
- Thomas was assessed very quickly in Swindon
- Completion of the assessment in Swindon rather than transfer him back to Bristol was a child centred decision
- Police officers were very professional and tried every option before 136

Update

- ✓ Training for Social Work Team Managers re CAMHS referral processes May 17
- ✓ Additional training for GPs and Social workers about pathways for mental health and information needed in a CAMHS referral Feb 17
- ✓ Link to Resolution of Professional Differences Policy is provided with this Briefing (overleaf)
- ✓ System Wide S136 review has demonstrated there are an adequate number of places for the population. In peak time, children are given priority. Chair's representation not required.
- ✓ Cross Boundary Agreement picked up the CYP 136 group, operating procedure is in place
- ✓ Good work report has been completed

Recommendations

- Pathway for referral to CAMHS to be clearer – so professionals know who will refer – if child is known to Social Care, they will lead on referring
- Better understanding for professionals about information needed in a referral to CAMHS
- Better understanding of pathways available to parents and professionals in relation to mental health support
- All agencies involved with a child should consider convening a multi agency meeting at the earliest opportunity (TAC, CinN, Core Group, LAC meeting)
- Improved knowledge needed about the policy 'Resolution of Professional Differences' especially for schools
- SGSCB Chair will make representation to the CCG about the lack of local bed space
- Police providing advice about a young person's behaviour should only be used as a temporary measure in liaison with the lead professional for the child.
- Consider a cross boundary agreement when a child is taken to a bed outside home local authority so that the assessment takes place there, rather than the child being moved
- Good work report for the police who dealt with Thomas

Concerns

- Difficult to get an appointment with CAMHS
- GP who made referral to CAMHS had never met Thomas and referral was lacking in detail
- No multi agency meeting was held
- Child Protection procedures were not followed when appropriate
- Lack of holistic assessment
- No integrated Health team for Thomas either pre or post 136
- Resolution of Professional Differences policy not used to escalate problems
- Lack of local bed space for Thomas when 136 was taken out

South Gloucestershire SAFEGUARDING CHILDREN BOARD

Learning Brief
Ben Age 18 months

Background

Ben and his brother were living with grandparents as their mother was a heroin & crack user, who initially lived with the boys and her parents, and then left, resulting in care proceedings to decide the best place for the children to live. There was considerable disagreement as to whether the grandparents were the best carers for them long term. The court required further assessments take place and during this time Ben was found in the garden pond. Subsequently the grandparents were granted a Special Guardianship Order to care for the boys.

Incident

In September 2015, Ben was found at the bottom of an 8ft deep garden pond at his grandparents house. The family thought he had been missing for 15 minutes. Despite a very poor initial prognosis of life and the belief that he would have suffered significant brain damage if he survived, he made a miraculous recovery.

What Worked Well?

- The family placement social worker identified the pond as a risk and twice advised the grandparents to cover it
- The Children's Hospital has robust safeguarding systems in place, and communication was good between the social worker and the ward.
- The Social Worker and Health Visitor both discussed risks with the Grandparents (for example the dangers of co-sleeping)

How do things look today? (June 2017)

- ✓ Ofsted, The Family Justice Board, Social Care & Legal Services all report positive collaboration between Social Workers and the Legal Team.
- ✓ HHJ Wildblood has given feedback through the Ofsted Inspection and subsequently that he is highly satisfied with the quality of work presented in court from South Gloucestershire.
- ✓ There is a 2 Day Court Skills Training in place. This case is referenced in training
- ✓ The legal team provide training re. Connected Carer Assessments. The entire Family Placement Team has been trained since this incident.
- ✓ Although Ben was not placed, but lived with his grandparents under a private arrangement, a Health & Safety form must be completed in order for a child to be placed.
- ✓ CHIP are creating a targeted campaign around pond safety

Findings

- Is the opportunity for collaborative working between the local authority legal team and children's social care used to the best effect and to agree the most effective tactical approach to take the case through court proceedings and how best to present the evidence to achieve the desired outcomes?
- The priority given to a child's pre-existing relationships in placement decision making easily leads to assumptions in those connected carers assessments where children are already living that health and safety standards are guidance rather than requirements. This increases the likelihood that any risks, such as an uncovered pond, will not be addressed.
- It is appropriate that family and friends assessments are conducted by the Family Placement Team but not all practitioners in the Family Placement Team in South Gloucestershire have been provided with the skills and support required, meaning these complex assessments for court are likely to be of variable quality.
- The expertise of health staff at a regional children's hospital supports relevant communication and collaboration in a crisis situation, enabling an effective multi-agency response.

Concerns

- The Social Worker and Health Visitor did not know about the pond. When it was identified, requests to cover it were seen as a request not a requirement.
- The family placement team social worker had never undertaken this type of assessment before and for a variety of reasons did not have the usual level of management oversight.
- The safety plan relied on continued support to the grandparents from Social Care and this was an unrealistic aspiration when compared to previous lack of co-operation with the Local Authority
- Requesting immediate removal of the children at court had various negative consequences. Legal advice prior to court suggested that the threshold to remove them had not been met and the planning leading up to court did not effectively explore all possible outcomes of the decision

South Gloucestershire SAFEGUARDING CHILDREN BOARD

Voice of the child

"If you get involved and speak up for what you believe in – change can happen" (Member of Youth Board)

Earlier in this report you will have read about the conference conducted by young people as a result of their online safety survey.

Eden Blazey, 15, was presented with a Police and Crime Commissioner Pride Award. He is chair of the Youth Board and led the group of young people who delivered the Online Safety Conference.

On receiving this award Eden said:

"I am gracious to have the opportunity for the work we are doing locally to be recognised. I am determined to support and run projects that make young people's lives better"

Young people have been involved in creating posters that will be used in a CSE campaign in schools. The Board have listened to their comments received as part of this consultation, to ensure the publicity is authentic and gives messages young people want to be shared.

"If you feel someone is not safe, tell someone, it's not snitching".

External learning

Children's services

Ofsted raising standards improving lives	**Inspection of services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of the Local Safeguarding Children Board (Inspection Date: 21 Nov – 15 Dec 2016. Report published Feb 2017)**

Children's Services in South Gloucestershire and the Safeguarding Children Board were judged to be inadequate at this inspection.

Key messages: children's services

- Leaders have not ensured that children with disabilities receive a safe service that meets their needs and protects them from harm
- Quality assurance systems, improvement plans and the analysis of performance information have been only partially effective
- Child protection thresholds are not consistently applied across the partnership and this has left some children at risk of harm
- The response to care leavers at risk of sexual exploitation is weak
- The analysis of, and response to, the risk of child sexual exploitation for individual children is inconsistent and confusing
- Children are not seen quickly enough for return home interviews
- Not enough children have their needs assessed by an early help assessment
- Privately fostered children are not properly assessed and their needs are not appropriately managed
- Care plans for looked after children are not always clear
- Social workers do not have sufficient understanding of domestic abuse

Key messages: SGSCB

- SGSCB has not sufficiently monitored and evaluated the effectiveness of frontline practice
- The Board has not sufficiently challenged or influenced practice weaknesses in relation to the identification of significant harm for children
- The Board has not had any oversight of the safeguarding practices of the mother and baby unit at the local prison

As a result of this inspection a comprehensive improvement plan is in place to address all of the recommendations made and this is monitored by an Improvement Board with an independent

chair. The SGSCB receives regular updates and the board business plan reflects the priorities for change identified.

Sirona Care & Health

Sirona Care & Health were inspected in October by the CQC – a full inspection of 37 people throughout our services for one week and with unannounced visits in the further two weeks. Overall children's services were rated as Good.

Key messages included:

- There was a positive culture around incident reporting which helped promote learning and service improvement for children and staff said they received feedback from reported incidents when this was appropriate and were told what actions were taken
- There were some outstanding examples of the planning for transition being undertaken
- The provider encouraged innovative practice. One of the school nurses had developed an app to help young people make informed choices regarding sexual health and contraception
- We had feedback and comments from children and families that was positive about the staff they received a service from. People told us that staff took the time to explain and ensure they understood the care and treatment they were involved in providing
- There were numerous examples of staff engaging with the users of services to gain feedback and use this information to influence service development.

There were shortfalls including:

- There were some shortfalls in the safeguarding training updates being completed by some teams
- We saw examples where staff were not following the required infection control protocols
- There were shortfalls in the systems for storing of medication used by the sexual health nurses working in the schools.

Frontline intelligence

Training evaluation

All practitioners attending the LSCB Inter Agency Child Protection and the Advanced Inter Agency Child Protection training complete a Smart action plan alongside the usual evaluation form.

Three months after the training a sample of five action plans is chosen from each course and the practitioners and their managers are contacted by email or by phone and are asked a series of follow up questions. This is part of a five part evaluation plan and helps to inform the Board of the effectiveness of the training programme.

Action – "I plan to review all processes and procedures currently in use with the staff at school and to evaluate effectiveness, putting in place any changes needed"

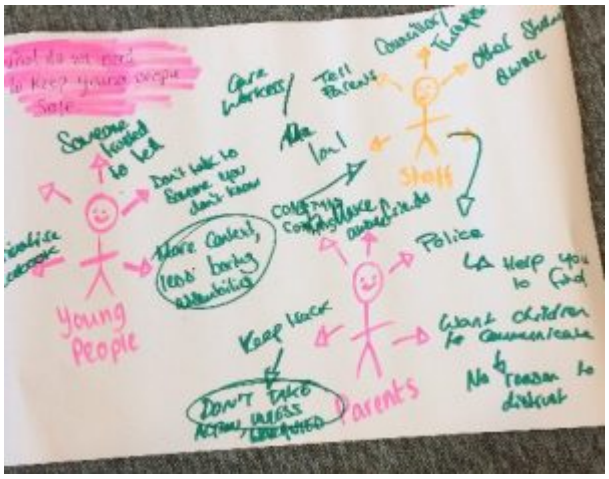
Impact on practice – "Staff more aware of procedures and have a safeguarding toolkit. Everyone takes responsibility for their role around safeguarding. Safeguarding question into interviews"

Practitioner Forum

The SGSCB plans to launch a Practitioner Forum within 2017-18. This forum will include practitioners from a range of agencies and will be used to help the Board hear the voice of frontline practitioners.

The formal arrangements for this group will be established, along with terms of reference to ensure effectiveness of the group. This plan is included in the 2017-18 business plan for SGSCB.

Direct work with young people



As well as hearing the voice of practitioners the SGSCB continues to seek the views of young people and families. This helps to inform practice and ensure arrangements are effective.

2401 Referrals

540 Re-Referrals

1111 Strategy Discussions

275 Initial Child Protection Conferences

186 Children with CP Plan

11.8% have a disability

1547 Domestic Abuse Notifications

179 Looked After Children

64,749 Children and Young People under 19

1077 Child in Need

181 open SAFeh

328 Children discussed at MARAC

196 Children reported missing

21 recorded CSE crimes

58 referrals to the LADO

244 Child Protection Crimes

Auditing

Section 11 auditing

Section 11 of the Children Act 2004 place duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

In South Gloucestershire the Section 11 Audit for 2016-17 was undertaken across four local safeguarding children board areas with a combined survey issued to partners. The LSCBs that collaborated for this audit were South Gloucestershire, Bristol, Bath & North East Somerset and North Somerset.

Organisations that responded:

Avon Fire and Rescue	Youth Offending Service (YOS)
Avon and Wiltshire Mental Health Partnership (AWP)	Royal United Hospitals Bath (RUH)
Community Rehabilitation Company (CRC)	North Bristol Trust (NBT)
Public Health	University Hospitals Bristol (UHB)
Clinical Commissioning Group (CCG)	Barnardo's
Vinney Green Secure Unit	Avon and Somerset Constabulary
Safe and Strong Communities	Integrated Children's Services
South Gloucestershire and Stroud College	Sirona Care & Health
South West Ambulance Service	Cafcass
British Transport Police	

Submissions show considerable variation in length and detail provided, and in low grades without actions and assertions with lack of evidence. This is not altogether surprising as there are many variations in agencies such as role and scope, funding and resources and stages of organisational development. Organisations who did not respond have been followed up.

Questions posed to organisations for self-audit centred on the following themes:

1. Senior management commitment to the importance of safeguarding and promoting

children's welfare
2. A clear statement on the agency's responsibilities towards children is available for all staff
3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
4. Service development takes account of the need to safeguard and promote the welfare of children and, where appropriate, the views of children and families
5. There is effective training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families
6. Safer recruitment procedures including vetting procedures and those for managing allegations are in place
7. There is effective inter-agency working to safeguard and promote the welfare of children
8. There is effective information sharing.

Following analysis of both the Section 11 audit submissions, and accompanying action plans, the four LSCBs have agreed to focus in particular on 'Effective Inter-Agency Working' for the coming year. This will take the form of an inter-agency walkabout peer review.

Partners undertake section 11 audits, including themed audits for training and child sexual exploitation, on a regional basis. Following robust challenge by the board, all agencies returned their audits. These have been analysed, with themes feeding into the Child Sexual Exploitation and Training subgroup action plans. All schools responded to their annual section 175 audit. Further changes have been made in order to increase rigour in self-assessment and to ensure greater attention to the Board's priority areas, such as female genital mutilation and child sexual exploitation
South Gloucestershire Ofsted Report 2017

Multi agency auditing

The Quality Assurance subgroup of South Gloucestershire Safeguarding Children Board (SGSCB) conducts quarterly thematic multi-agency deep dive case audits.

For 2016-17 these were:

Children subject to a strategy discussion and subsequent Section 47 enquiry (May 2016)

The aim of the audit was to ascertain whether there were good multi-agency standards for managing strategy discussions and subsequent Section 47 enquiries considering:

- Compliance with legislation, national and local guidance
- Good process and practice
- Deficiencies in process and practice, including efficacy of multi-agency working
- Impact and outcome

Themes and conclusions

The audit team identified that the four reviews of case files held the potential to shed light on particular areas of practice across the child protection system in South Gloucestershire.

Key strengths identified

- Thoughts and feelings of children were considered
- Appropriate decision making
- Effective information sharing

Key lessons for professionals

- Use and include appropriate risk assessment tools (eg. DASH & SERAF)
- Make sure recommendations from strategy discussions are ‘Smart’
- Follow the Resolution of Professional Differences Policy (Escalation) where responses are deficient
- Make use of the Signs of Safety model
- Ensure information gathered at strategy discussions is integrated into records so it is visible to professionals working with the child
- Ensure key partner information is gathered for strategy (especially health) and that decisions are fed back appropriately

Children who have been missing from home, school or care (July 2016)

This audit reviewed the records of four children who had been reported missing from home or care. The purpose of the audit was to assess the effectiveness of the multi-agency response to children who are reported missing. It followed significant work by the Missing from Home, Care and School subgroup of the Safeguarding Children Board in implementing a robust and consistent response to South Gloucestershire's missing children in line with statutory and good practice guidance. The aim of the audit was to identify whether the following standards had been met in the cases reviewed:

1. Is the child appropriately referred as missing to the police?
2. Are partner agencies made aware of every missing episode and the child's return?
3. Have the police carried out a safe and well check?
4. Has a return interview taken place? Has this included the completion of the SERAF? (Sexual Exploitation Risk Assessment Framework). Are all agencies considering CSE when dealing with the child who has gone missing? Are they completing a SERAF?
5. For repeat mispers, is a multi-agency risk management meeting held? Are all relevant partners invited and do they attend? Is there a clear plan to try to reduce the missing episodes? Is the reason for going missing established or attempted to be established?
6. Is there clear management oversight of children who go missing, particularly when considered serious or high risk?
7. Are all members of the family and friends network, including fathers and partners included in any subsequent assessments?
8. Is the 'voice of the child' considered by all? Is this clearly recorded?
9. Are other necessary processes followed, for example for a looked after child is the independent reviewing officer (IRO) always informed when a child goes missing, are child protection processes followed, is there enhanced monitoring by partners?
10. Is there a clear plan for the child that everyone is aware of?

Themes and conclusions

The key finding from auditing the four records was that for children who frequently go missing each missing episode was dealt with as a separate isolated incident and the links to joining episodes together was not made. There was limited evidence that the underlying reason for going missing was established or attempted to be established by dealing with each episode in isolation.

Key strengths identified

- Three out of four cases showed appropriate referrals to police
- Good use of a multi-agency risk management meeting and relevant partners were invited and attended
- The 'voice of the child' appears to have been considered well and clearly recorded in records in all of the cases and there is a good example of Child Two's feelings about his father which

resulted in a male Breakthrough mentor being put in place for him
- Evidence of clear management oversight of children who go missing, particularly when considered serious or high risk by preventative services when conducting return home interviews.

Key lessons for professionals

- Ensure key partner agencies are informed when a child goes missing
- Consider the risk of child sexual exploitation when a child goes missing
- For young people at risk of going missing, good attendance in education is critical and schools need to be robust in their challenges to ensure this happens
- None of the cases audited were concerning a looked after child – always ensure information is shared with the independent reviewing officer when a looked after child goes missing
- Police should consistently undertake safe and well checks even when the child is found with a friend or relative

Children subject to a child protection plan transferring from one service to another (September 2016)

Context for case file review

This audit reviewed the records of four children who were the subject of child protection plans and transferred from one service to another during the preceding 12 months. The aim of the audit was to ascertain whether there were good multi-agency standards for managing the children's transfer from one organisation to another, whether there was a good handover between professionals, and that the correct information was shared, enabling the new professional to be aware of the risks for the child.

Themes and conclusions

The audit team identified that these four reviews of case files held the potential to shed light on particular areas of practice across the child protection system in South Gloucestershire. The audit team prioritised four findings for the SGSCB members to consider.

Key strengths identified

- Some very good practice identified in transition from primary to secondary school including the secondary school attending core groups from before the child moved schools, a named professional at the secondary school being allocated to provide extra support and a handover of detailed notes and analysis of emotional wellbeing from the school nurse to the new school.
- Good practice by CAMHS for one of the cases, where a variety of strategies were used to try

and engage the child and appropriate referrals were made.

Key lessons for professionals

- Professionals should always consider the voice of the child and record the child's wishes and feelings even when the child is non-verbal
- Child protection conference chairs should ensure that when children will be transitioning from one service to another, the transfer is discussed during conferences and that the transfer forms part of the child protection plan
- All professionals should ensure that when sharing information with other professionals this is done in written form and also recorded in the child's record
- Children's social care should ensure that when an unborn child is to be the subject of an initial child protection conference, this conference is a specific separate conference to any review conference being held in relation to their siblings.

Children subject to a child protection plan transferring from CAMHS (child and adolescent mental health service) to adult mental health (February 2017)

Context for case file review

For this audit, records of four children who were the subject of child protection plans and transferring from CAMHS to adult mental health during the preceding 12 months were reviewed. The aim of the audit was to ascertain whether there were good multi-agency standards for managing the children's transfer from one organisation to the other, whether there was a good handover between professionals, and that the correct information was shared, enabling the new professionals to be aware of the risks for the young person.

Themes and conclusions

Key strengths identified

- Some very good practice by one young person's care coordinator and evidence that the young person responds well to her, is learning to understand her vulnerabilities and is doing well
- Good practice identified with information shared between school health nurse, school and GP and appropriate referrals made.

Key lessons for professionals

- All organisations to review their own internal safeguarding training to ensure it includes

guidance on the Mental Capacity Act for 16 to 17 year olds and provide feedback to the Board

- Professionals should assess the mental capacity of young people according to the Mental Capacity Act guidance
- Professionals should explore the use of SAFeh for young people with mental health concerns, especially when CAMHS threshold is not met or CAMHS support is refused
- Police to review their process for obtaining consent from young people in relation to sharing information with other organisations and agencies to ensure this is obtained from the outset of any episodes of police involvement
- The children's social care 0-25 team must undertake an audit of assessments in order to identify and provide assurance to the Board on their robustness.

Single agency auditing

Barnardo's BASE Project Audit 2016(Barnardo's Against Sexual Exploitation)

The Regional Assistant Director undertook an audit of BASE's activity in South Gloucestershire which involved sampling supervision minutes, team meeting minutes and case files.

Recommendations were

- Review template for issues of culture and identity
- Review assessment template to ensure it is proportionate and consistently used
- Review support arrangements to staff as recent growth has left some staff concerned about being supported given the emotional impact of the work.

The outcome of the audit was good, with no major risks identified.

Young Person Drug and Alcohol Service Audit 2016

This was an audit of 12 case files. Some were concerning long term intervention, some short term and some with complex needs of safeguarding issues.

Recommendations included

- Include summary of resources/interventions used as well as a record of concerns
- Timely write up of notes
- Ensure consistent use of risk/harm definitions
- Use of supervision for case file reviews.

Bristol Children's Hospital A&E Department Audit 2016

Non mobile baby injuries audit of practice

Recommendations included

- Dissemination of messages to staff via 'message of the week' proved very effective
- Staff to specifically document when baby is seen fully undressed

- Include any injury to a baby – not just falling off things
- Ensure letters to primary care are clear and include mechanism of injury.

South Gloucestershire Specialist Drug and Alcohol Service Audit 2016

Reviewing consent; parental status; domestic abuse; risk assessments.

Recommendations included

- Review consent for all client records
- Ensure all clients who have children or are in contact with children have a parental risk assessment completed
- Provision of training for completion of DASH when there are concerns about domestic abuse
- Ensure risk assessments are kept up to date and reviewed.

Diocese of Bristol February 2017

Audit undertaken by Social Care Institute for Excellence (SCIE) of the safeguarding arrangements in place. South Gloucestershire Anglican churches fall within this diocese.

Recommendations included

- Each case file needs to have clearly standardised sections, one of which should be for case notes which record all activity undertaken
- Risk assessments need to be undertaken in line with national guidance (Risk Assessment for Individuals who may Pose Risk to Children or Adults 2015), taking into account that this guidance is in the process of being updated.
- The quality and effectiveness of safeguarding agreements need to be reviewed, to ensure they are based on an up to date and fit for purpose risk assessment.
- More reliable and consistent support to survivors to be pursued.

Child death overview panel (CDOP)

The child death overview panel (CDOP) identifies effectively the learning arising from child deaths. The annual report is thorough and analytical, identifying learning for the board. The CDOP has taken action at a local, regional and national level to drive changes, for example by lobbying ministers about the importance of personal health and social education to help children to understand safeguarding risks. (Ofsted)

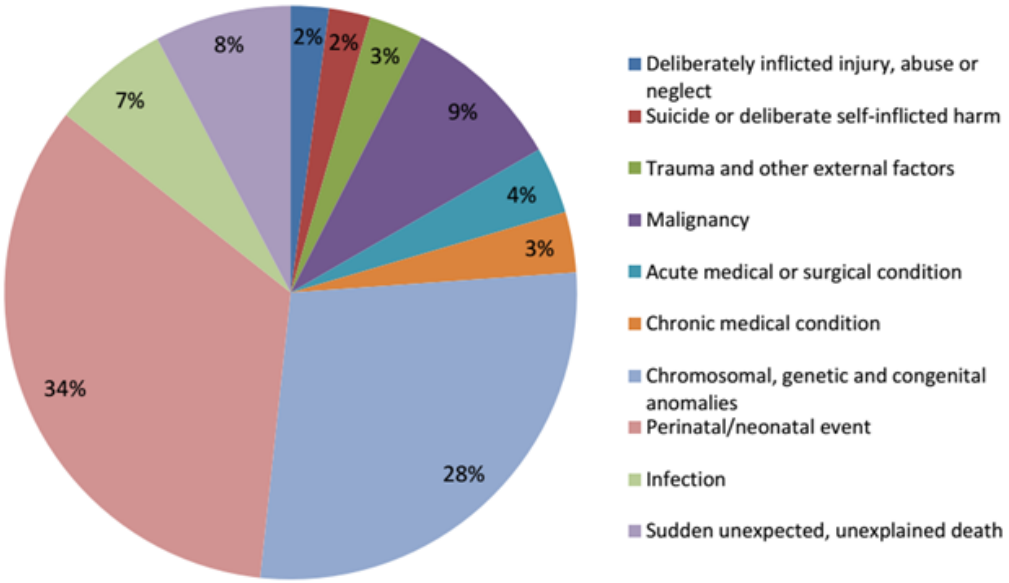
Since April 2008, Local Safeguarding Children Boards in England have had a statutory responsibility for child death review processes. The relevant legislation is enshrined within the Children Act 2004, and applies to all young people under the age of 18 years. The processes to be followed when a child dies are currently outlined in Working Together to Safeguard Children 2015.

The overall purpose of the child death review process is to understand how and why children die, to put into place interventions to protect other children and to prevent future deaths.

In the area of the former county of Avon, four neighbouring LSCBs (Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset) have come together to form a single West of England (WoE) CDOP.

557 child deaths were notified to the West of England Child Death Enquiries Office between 1 April 2012 and 31 March 2017. Of the 102 notified deaths in 2016-17, 18 were resident in South Gloucestershire.

Notifications by category of death over the period 2012-17



Themes emerging from aggregate review of cases at CDOP during the year 2016-17

Group A Strep infection

CDOP has reviewed four cases in the last two years where the cause of death has been Group A Streptococcal sepsis. The panel has scrutinised these cases in detail and challenged local protocols when appropriate and will continue to contribute to national guidance regarding detection of sepsis.

Inequalities of healthcare provision

This year, CDOP wrote to the Children's Health Commissioner responsible for one of the LSCB areas as the panel felt that they had identified a theme of inequalities of healthcare provision across the West of England area despite the best efforts of professionals on the front line providing services. Two areas where this issue was highlighted are:

- The level of specialist paediatric pre-hospital critical care available in one part of the region varies by time of day; there are also regional variations in services provided and CDOP felt this may have affected the care available in one case reviewed
- In rare cases, the local district general hospital provides services via its emergency department to children in extremis, where transfer to a specialist paediatric hospital would not be possible. CDOP was informed that this means that the emergency department staff at the local hospital may lack in confidence and familiarity in dealing with these scenarios. CDOP was aware that the local hospital staff receive advanced paediatric life support (APLS) training and appropriate refreshers, however without regular patient contact the panel felt this may result in a level of de-skilling. The importance of this issue was sharply illustrated by one of the cases discussed at CDOP.

A response was received from the Children's Health Commissioner confirming that provision of paediatric services from the local hospital is currently under review including looking at ways to improve the availability of paediatric clinical expertise and paediatric upskilling of staff.

24/7 end of life care for children

This year has seen a number of children die as the result of life-limiting conditions. It was recognised by CDOP that there is a shortage of paediatric palliative care trained clinicians in the community. This has an impact on the level of support and care that families receive as there is no weekend or out of hours service provision. This is despite the agreed availability of funding to 'spot purchase' a package of end of life care for a child. Families can choose to be at the hospital or the hospice but they do not have a full choice of place of care at the time of their child's death.

CDOP prepared a report entitled 'End of Life Care at Home' at the request of commissioners to help with scoping the need for this service and informing possible models that could be

considered.

Co-ordination of care for children with the most complex medical conditions and disabilities

CDOP reviewed a number of cases where children had accessed care from a number of different services within the local hospital trust to meet their complex health needs. During review of these cases it was highlighted that there can be difficulties co-ordinating care for these children and in one case the family of the child performed this role. CDOP recognised the important role that parents can play in co-ordinating such matters but felt this was not an appropriate measure to be relied upon.

Provision of 'Care of Next Infant Scheme'

This has continued to come to light through case reviews following sudden infant death syndrome (SIDS) and other SUDIs. This year CDOP has supported the training for community neonatal nurses to provide this programme and coordinated the input required from other professionals including neonatologists, health visitors and the children's emergency department.

Future priorities and challenges

The UK ranks 15 out of 19 Western European countries on infant mortality and has one of the highest death rates for children and young people in Western Europe. Each UK government is challenged to develop a child health and wellbeing strategy as well as adopting a 'child health in all policies' approach. There are a number of specific recommendations for the England government regarding reducing the number of child deaths including:

- Funding health visiting and home safety equipment schemes which educate and equip parents and carers to keep their children safe, with a focus on water safety, blind cord safety and safe sleeping
- Road safety features with a suggested introduction of graduated driving licences for novice drivers and 20mph speed limits in built-up areas
- Development of integrated health and care statistics.

Working Together guidance is being revised to complement legislative change with the upcoming Children and Social Work Act 2017. Working Together will continue to set out principles of the child death review process but will also signpost to more detailed guidance which will clarify arrangements and improved standardisation across areas. WoE CDOP team are contributing in this process at a high level through consultation meetings and drafting guidance. The process as it is run in WoE continues to be held in high esteem nationally. Under the new Act, responsibility for the CDR process is likely to pass from LSCBs to CCGs. There is likely to be a requirement for a child death review meeting in every case which we already carry out in WoE. With some changes to CDOP configuration, regionalisation is anticipated, and once again our CDOP has been asked to contribute options to this revision. One task of the designated doctor is maintaining and improving quality of child death review meetings. This is done through ongoing training and service

development. All partner agencies need to be involved in this, and this year has seen specific training to hospice and sub-speciality paediatric teams, and multi-agency training on the rapid response process.

Feedback and presentation of data to the four LSCBs has been done on an annual basis through presentations at the boards as well as sharing this annual report. In 2016, a small number of specific cases were presented to enable a more thorough understanding of the child death process and provide examples of how CDOP tries to affect change and generalise learning from specific deaths. CDOP has taken the lead in development of written information for parents on the different processes which may follow a child's death. CDOP has also contributed to the new bereavement pathway at the local trust. We are lucky to have such a stable and dedicated team in the child death enquiries office who, together with our partner agencies, enable this significant body of data and learning to be brought together and presented in this report. There is a responsibility to families to optimise learning from child deaths, but the framework and the changes ahead hopefully provide an ongoing opportunity to do this to the best of everyone's ability.

Vinney Green Secure Children's Home

"Young People say they feel safe. They speak positively of staff and live in a home where their individual needs guide the care they receive"
Ofsted: Jan 2017

Safeguarding

The Head of Secure and Emergency Services is a qualified social worker and the safeguarding lead within the unit. All staff receive safeguarding training delivered by the Head of Secure and Emergency Services and a member of South Gloucestershire Council's workforce development team. This year there were three specific areas concentrated on:

- Child sexual exploitation (CSE)
- Radicalisation
- Panorama programme about Medway STC – lessons to be learnt

Following the programme, we focused on the 'culture' at Vinney Green, in recognition that the staff at Medway did not wake up one morning and think 'let's be abusive today'; it was a slow process of standards slipping, poor practice becoming the norm, and staff becoming collusive with each other. As part of the safeguarding training we discussed our legal duty to report.

Restrictive physical intervention (RPI)

All staff are trained in diffusion techniques and the use of restrictive physical intervention (RPI) measures if they are required to respond to incidents of aggressive or violent behaviour. The unit has a restraint minimisation strategy in order to reduce levels of restraint and to ensure that the use of restraint falls within national minimum standards i.e. that this is only used in order to prevent injury to the young person or others, to prevent a serious breach of security or to prevent serious damage to the fabric of the building. If RPI measures are required to manage these extreme levels of behaviour staff will use the minimum necessary force for the shortest period of time and will ensure the young person is given appropriate levels of counselling and support immediately after the incident. All incidents of restraint are reviewed using the unit's CCTV system and are monitored by the local authority designated officer (LADO) as part of our safeguarding procedures.

The number of recorded incidents increased from 404 to 468. The number of RPI increased minimally from 272 to 273 throughout the year. This equates to an increase of almost 0.4%. Overall, this means that 58.3% of all significant incidents resulted in a RPI compared to 67.3% the previous year.

The number of recorded assaults between young people decreased marginally from 80 in 2015/16 to 79 in 2016/17. However, assaults perpetrated by young people against staff halved from 68 in

2015/16 to 34 in 2016/17. Overall, assaults decreased by 41 episodes over the year.

In respect of RPI recording, Vinney Green continues to record any time that hands are laid on a young person. During the year 2016/17, 52 young people were involved in one or more episodes of RPI, out of the cohort of 101 residents during the year. Therefore, 48.5% of all young people admitted to Vinney Green during the year did not have an episode of RPI during their stay. Due to the fact that we only house 24 young people at a time, the data can be very hard to interpret reliably as one very violent young person (male or female) can completely skew the data.

The full data relating to incidents and RPI is given below:

	Cohort		**Number of Incidents**		**RPI Episodes**		**Proportion of Incidents resulting in RPI**		**Proportion of RPI by Gender**	
	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17	15/16	16/17
Male	68	84	302	416	201	240	0.666	0.577	2.96	2.86
Female	21	17	92	52	71	33	0.772	0.635	3.38	1.94

Safeguarding Children Board

The Head of Secure and Emergency Services is a member of the South Gloucestershire Safeguarding Children Board, and annually four policies, along with a copy of the annual review are submitted to the Board for review:

- Missing young people
- Searches
- Restraint minimisation
- Safeguarding

This year the policies went via the Policy and Procedural subgroup and appropriate updates were made. The Board also have overview of the LADO's inspection of the CCTV and the unit's annual report and Regulation 45 Report.

Reportable incidents

There were eight notifiable incidents during the year. Due to the small number it is not appropriate to speak about each individually for confidentially reasons. However, one is still ongoing and the other seven have all been investigated alongside the LADO and HR to a satisfactory conclusion. Ofsted and the YJB are notified appropriately.

0-25 service

The 0-25 service moved from the council's Adult's Services to become part of the Integrated Children's Services in August 2016.

0-25 Improvement Board/Governance Board

The 0-25 Improvement Board was set up in September 2016 in order to oversee improvement to the service. This board is chaired by the Director for Children, Adults and Health and provides the necessary scrutiny and support for the improvement needed within the service. The 0-25 Improvement Board deals with everything related to the 0-25 service apart from the performance of the children's social care team which is reported to the Governance Board, (also chaired by the Director for Children, Adults and Health). The two boards have direct oversight and governance of the 0-25 service development plan.

Staffing

2016/17 was a difficult year for the 0-25 service in terms of recruiting permanent staff, the children's social care team in particular. The service manager, team manager and senior practitioner were all interim agency workers, as was the vast majority of the social work team itself.

Recruitment and retention of a permanent workforce in the 0-25 service is the main priority for 2017/18.

Ofsted inspection and performance

The Ofsted inspection in November and December of 2016 confirmed the significant weaknesses in the service. The 0-25 service struggled to improve performance during 2016/17 across the social care and SEND teams. For example, performance data at the end of March 17 showed poor performance in terms of Education, Health and Care Plans (EHC plans) completed in timescale, as well as single assessments completed within timescale.

At the end of March 17:

- 46% of LAC visits were completed within timescale
- 16% of Child In Need (CIN) visits were within timescale
- 9% of CIN reviews were held within the 12 week timescale.

The Open to Review (OTR) case management system did not work effectively in 2016/17 and was criticised during the Ofsted inspection in December 2016. The pace of change in the early part of the year for the OTR system was too slow and became an immediate priority for the new service

manager who started in April 2017. The first quarter of 17/18 has seen significant improvement in this area of work.

The implementation of Signs of Safety (SoS) – the ICS case work model – was significantly delayed due to the other pressures for the service. The SoS model was not recognised within the children's social care team as the model to which all social workers and managers should be working. A priority in 2017/18 will be firmly embedding the model within the team.

Since April, the 0-25 service is developing a culture of internal challenge and improvement; managers and front line social workers are beginning to understand departmental expectations of them in terms of performance which has led to a significant improvement in performance in the first quarter of 2017/18 and there is a service improvement plan in place which incorporates the Ofsted report requirements.

Safeguarding

Safeguarding vulnerable children has always been a priority for the 0-25 service, however the Ofsted inspection identified weaknesses in child protection practices in the children's social care team, particularly relating to the OTR system.

Since April 17, three locality child protection social workers and the locality social care service manager have joined the team on secondment, which has added significant safeguarding experience to the 0-25 service.

Child Injury Prevention Group (CHIP)

South Gloucestershire CHIP Child Injury Prevention Group

The vision of this group is to reduce the risk of injury to children aged 0-19 in South Gloucestershire whilst encouraging them to lead active and fulfilling lives. The group is multi-agency including representation from South Gloucestershire Council's safeguarding manager, public health and wellbeing division, trading standards, early years, road safety, children's centres, health visiting, Avon Fire and Rescue Service and many more, all working collaboratively to reduce childhood injury by improving children's safety within their environment and encouraging safe behaviours.

The year 2015/16 saw some key achievements for the group such as the development of a two year Child Injury Prevention Action Plan. This plan has been developed to identify the important work delivered by the group against which to monitor effectiveness, identify future priorities and build on the added value and direction that the group currently provides. The introduction of CHIP newsletters to be published every six months enable key messages, knowledge and guidance to be disseminated to all child and health care professionals working with children and young people. The group participated in the delivery of the annual, national Child Safety Week by raising the issue and promoting the importance of injury prevention with professionals and other partners across the area.

This group aims to address health inequalities caused by injury through the delivery of the home safety equipment scheme (criteria based). This scheme provides safety gates; window, door and cupboard locks; fireguards and blind cord cleats for those families that evidence tells us are more at risk of injury. Referral is made by health visitors and children's centres to the Public Health and Wellbeing division for eligible families and appropriate equipment is fitted.

The CHIP group meets quarterly, if you would like to become a member or for more information please contact:

Amanda Preddy on 01454 864672 or amanda.preddy@southglos.gov.uk.

Priorities for the coming year

Our vision for safeguarding in South Gloucestershire is that children and adults thrive, reach their full potential and live their lives safe from harm (violence, abuse, neglect, exploitation). To achieve this vision we will work together and with local communities to improve outcomes and to ensure South Gloucestershire is a place where safeguarding is everybody's business. (SGSCB & SGSAB Vision 2016)

Strategic priority one

To ensure there is effective multi-agency action to identify, assess and reduce the risk of child sexual exploitation.

Strategic priority two

To actively seek to capture and act upon the voice of those affected by safeguarding concerns.

Strategic priority three

To ensure that children within the 0-25 service receive an appropriate and timely response in relation to safeguarding concerns.

Strategic priority four

To challenge and assure the quality of safeguarding practice in South Gloucestershire.

Strategic priority five

To ensure that the processes of the Board are rigorous and effective and are evaluated for their impact on outcomes for children.

Key messages

We have included some key messages for the different stakeholders involved in safeguarding children in South Gloucestershire.

www.southglos.gov.uk/safeguarding

Safeguarding children is everyone's responsibility - If in any doubt - speak out

Call South Gloucestershire Council on 01454 866000
Or 01454 615165 out of hours and at weekends
If a child is in immediate danger – please call 999 and ask for police assistance

Children and young people

- Nothing is more important than making sure you are SAFE and well cared for
- As adults sometime we think we always know best…we don't…and that's why your voice is so important
- This is about you and we want to know more about how you think children and young people can be better protected
- We want to talk to you more often and we want to know the best way to do this…please help
- If you are worried about your own safety or that of a friend, speak to a professional you trust or call South Gloucestershire Council on 01454 866000 or speak to ChildLine 0n 0800 1111
- If you or a friend are in immediate danger, please call 999 and ask for police assistance

Parents and carers

- Public agencies are there to support you and prevent any problems you are having getting worse…don't be afraid to ask for help
- Tell us what works and what doesn't when professionals are trying to help you and your children
- Make sure you know about the best way to protect your child and take time understand some of the risks they can face
- You'll never get ahead of your child when it comes to understanding social media and IT – but make yourself aware of the risks that children and young people can face at thinkuknow.co.uk/parents

The community

- We all have a role to play in protecting children and young people. All children have a right to be SAFE and should be PROTECTED from all forms of abuse and neglect.

You don't have to be absolutely certain about whether a child is being abused. If you have a feeling that something's not right talk to South Gloucestershire Council on 01454 866000 (01454 615165 out of hours and weekends) If a child is in immediate danger call 999 and ask for police assistance

- Spotting the signs a child is being abused or neglected can be difficult. On our website we have highlighted some of the signs to look out for http://sites.southglos.gov.uk/safeguarding/category/children/i-am-a-parentcarer/
- If you are concerned about a child, you should report it. Information is usually gathered from many sources and individual reports form one part of a bigger picture
- In 2014/15 more than 400,000 children were supported because someone noticed they needed help

Frontline staff and volunteers working with children, young people and their families

- Ensure that the safeguarding and welfare of the child is central to all that we do and is of the highest quality
- Families in South Gloucestershire should be treated with respect, courtesy and honesty
- Families should receive a consistent service. Be proactive in identifying and responding to the changing needs of our local community
- Be familiar with SGSCB A Child's Journey of Need threshold document and use when necessary
- Ensure inspirational, confident, ambitious and influential leadership that contributes to positively changing the lives of local children
- Ensure you undertake effective and continuous learning that improves your practice
- All workers should engage in professional challenge when required
- Use your representative on SGSCB to make sure your voice is heard
- Professionals should email accessandresponse@southglos.gov.uk*

*Do not send personal data via an unsecured email. If required, send a request for access to the secure portal to this address before proceeding.

Local politicians

- You are leaders in your local area. Do not underestimate the importance of your role in advocating for the most vulnerable children and making sure everyone takes their safeguarding responsibilities seriously
- Councillor Jon Hunt is the lead member for children and young people and has a key role in children's safeguarding, so does every other councillor
- You can be the eyes and ears of vulnerable children and families…Keep the protection of children in the front of your mind

Chief executives and directors

- You set the tone for the culture of your organisation. When you talk, people listen – talk about children and young people
- Your leadership is vital if children and young people are to be safeguarded
- Understand the capability and capacity of your front-line services to protect children and young people – make sure both are robust
- Ensure your workforce attend relevant SGSCB training courses and learning events
- Ensure your agency contributes to the wok of the SGSCB and give this the highest priority. Be Section 11 compliant
- Advise the SGSCB of any reorganisational restructures and how these might affect your capacity to safeguard children and young people

The police

- Robustly pursue offenders and disrupt their attempts to abuse children
- Ensure officers and police staff have opportunity to train with their colleagues in partner agencies
- Ensure the voices of all child victims are heard, particularly in relation to listening to evidence where children disclose abuse
- Ensure a strong focus on MAPPA and MARAC arrangements

Headteachers and school governors

- Ensure your school/academy/educational establishment is compliant with Keeping Children Safe In Education (DfE 2015)
- You see children more than any other profession and develop some of the most meaningful relationships with them
- Keep engaged with the safeguarding process and continue to identify children who need early help and protection

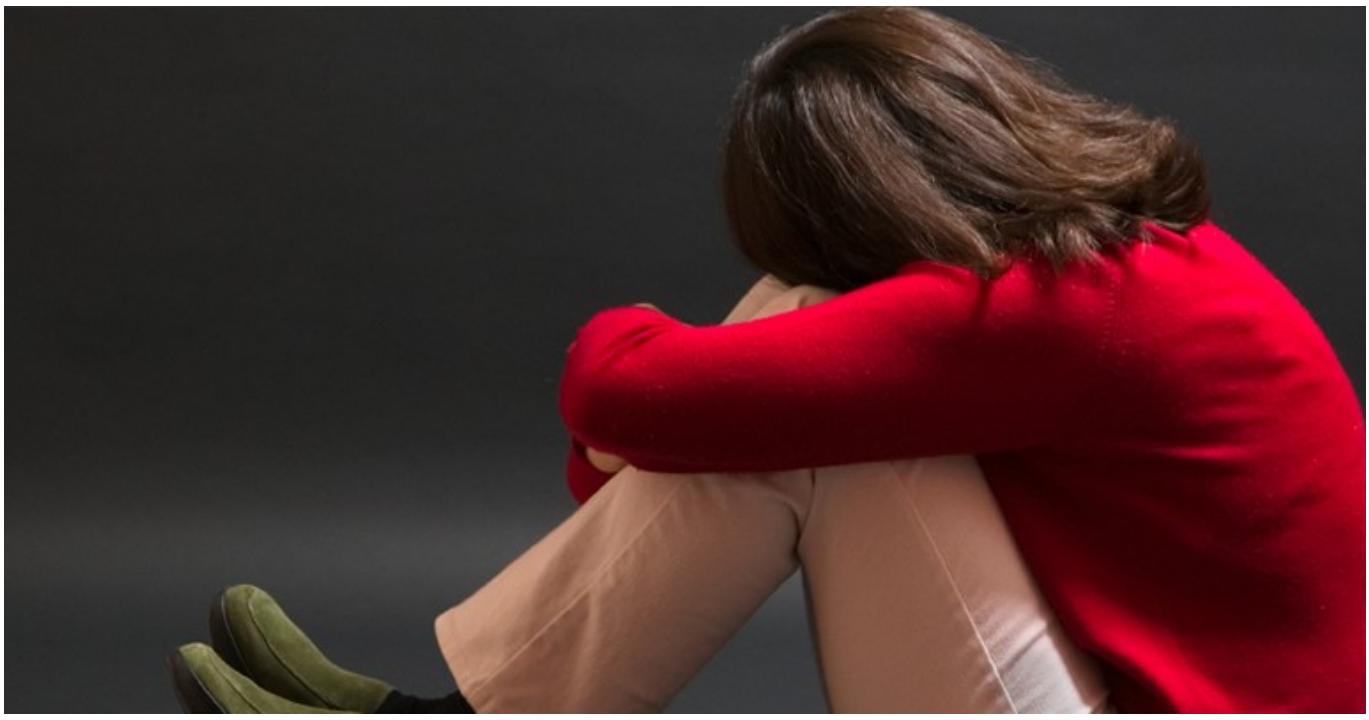
Clinical commissioning groups

- CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations
- Discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children

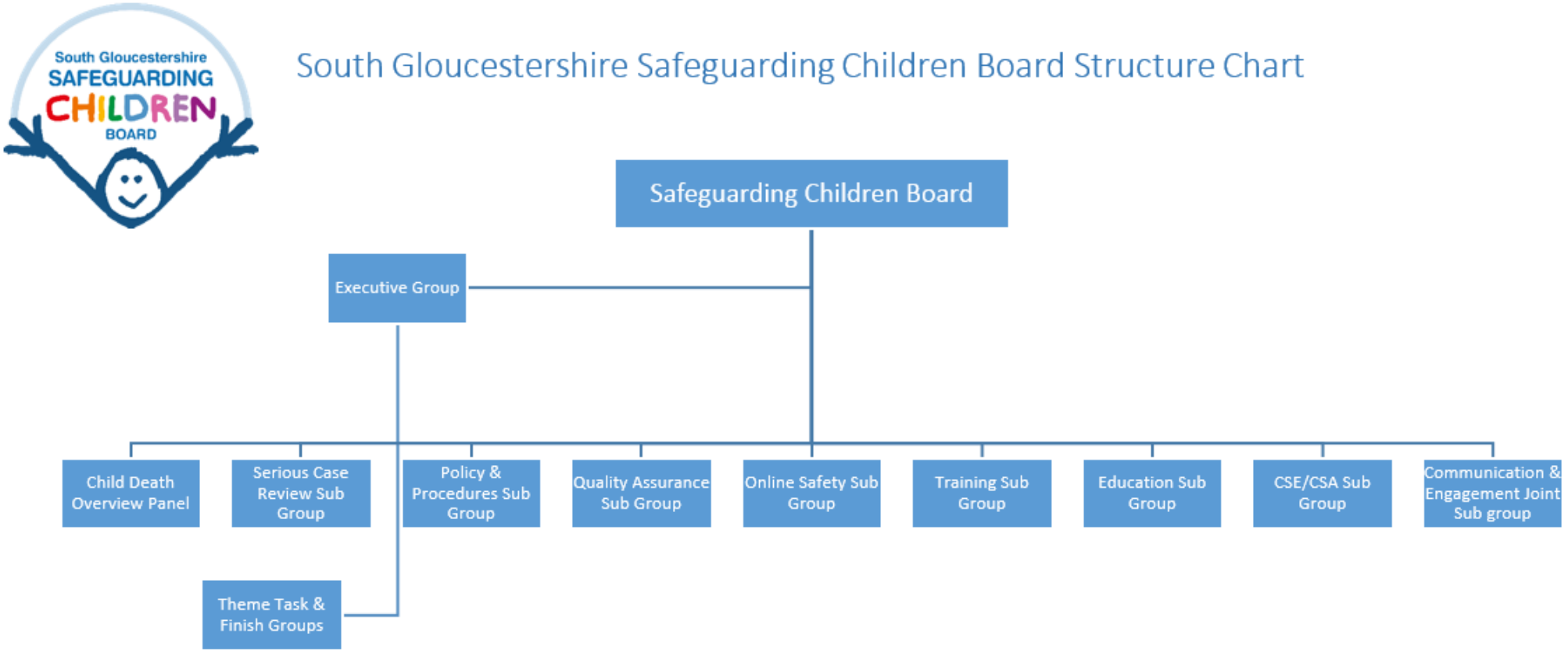
The local media

- Communicating the message that we all have a role to play in protecting children from abuse is crucial – you can help us to do this positively
- With your help, we can create a new social norm around reporting and tackling the barriers that stop people taking action
- This could take the form of encouraging and reassuring people that we all have a role to play in protecting children from abuse, not leaving it to others to report and helping the public to understand the signs to spot

If in any doubt – speak out



Appendix one: SGSCB structure chart



Appendix two: Constitution of South Gloucestershire Safeguarding Children Board

1. Purpose and Objectives
    - The South Gloucestershire Safeguarding Children Board (SGSCB) is the statutory multi-agency body established by South Gloucestershire Council in accordance with the Children Act 2004 and the statutory guidance set out in Working Together to Safeguard Children 2015.
    - The core objectives of the Board as set out in the Children Act 2004 (S14) are:

- to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.
    - In order to fulfil its statutory function under regulation 5 of the Local Safeguarding Children Boards Regulations 2006 an LSCB should use data

and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter3 of Working Together 2015;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.
    - The Board must work closely with the Children's Trust Board and the Health and Wellbeing Board and must hold these bodies to account in driving forward improvements in the safeguarding of children and young people and the promotion of their welfare.
    - The Board will maintain an awareness of the Prevent programme and will:
- ensure Prevent requirements to identify and respond to people at risk of being drawn into terrorism are appropriately and proportionately built into local safeguarding processes.
- periodically review local activity and outcomes with the Prevent Group to improve the understanding and awareness of local risks.

2. Terms of Reference
    - To develop policies and procedures for safeguarding and promoting the welfare of children and young people in South Gloucestershire, with particular reference to:

- action to be taken where there are concerns about a child's safety or welfare, including thresholds for identification of need and intervention;
- training of persons who work with children or are in services affecting the safety and welfare of children;

- the recruitment and supervision of persons who work with children;
- investigation of allegations concerning persons who work with children;
- the safety and welfare of children and young people who are privately fostered;
- co-operation with neighbouring authorities and their Safeguarding Children Board partners;
- the development of local protocols for matters such as the resolution of professional differences of views and for participation in child protection and other related conferences;

- To communicate 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.
- To monitor and evaluate the effectiveness of what is done by the Local Authority and Board partners, both as individual agencies and collectively, to safeguard and promote the welfare of children and young people and to advise them on ways to improve their practice, including:

- the development of self-evaluation tools and monitoring their use and effectiveness;
- the development and use of quality audit processes
- the scrutiny of physical restraint in secure estate settings;
- the development of means for challenging practice to drive forward improvements;
- the scrutiny of performance data
    - To produce and submit to the Children's Trust Board and the Health and Wellbeing Board an annual report on the effectiveness of safeguarding and promoting the welfare of children in the local area which:
- provides a rigorous and transparent assessment of the performance and effectiveness of local services;
- identifies areas of weakness, the causes of those weaknesses and the action being taken to address them;
- identifies other proposals for action;
- provides lessons from reviews undertaken;
    - To influence the planning and commissioning of services for children and young people in South Gloucestershire to ensure that they take safeguarding and promoting the welfare of children into account.
    - To ensure that there are effective arrangements for collecting and analysing information about the deaths of all children in the area and specifically to identify:
- Any case giving rise to the need for a review (regulation 5(1)(e))
- any matters of concern affecting the safety and welfare of children in the area;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

and to ensure there are effective arrangements for ensuring a co-ordinated response by the authority, their Board partners and other relevant persons to the unexpected death of a child.

- To undertake reviews of serious cases where abuse or neglect of a child is known or suspected, or where a child had died or has been seriously harmed and there is concern as to the way in which the Local Authority, the Board partners or other relevant persons have worked together to safeguard that child.

- To put in place arrangements to ensure that the voice of children and young people, families and the community are taken into account.
- To ensure lay members operate as full members of the Board.
- To maintain a local Learning and Improvement Framework, which is shared across local organisations who work with children and families, which enables them to be clear about their responsibilities, to learn from experience and improve services as a result.
- To undertake any other activity that the Board considers to be conducive to the achievement of its objectives.

3. Legal Status and Decision Making
    - The SGSCB is a statutory body in its own right and will agree an annual business plan to guide its work.

- The SGSCB will present an annual report to the Children's Trust Board and the Health and Wellbeing Board.
- The SGSCB will establish such sub committees as are appropriate at any time and will review their operation annually. The Board may delegate decision making as appropriate to sub committees.
- The SGSCB will scrutinise the Children and Young People Plan and any other relevant needs assessments and plans to ensure that the safeguarding and promotion of the welfare of children and young people are being appropriately addressed.
- The SGSCB will be able to make recommendations as appropriate to the Children's Trust Board, the Health and Wellbeing Board and any other relevant decision making bodies regarding policy, practice and resources associated with the safeguarding of children and young people and the promotion of their welfare.

4. Membership
    - The Board shall be chaired by a person who is independent of the partners represented on the Board and organisations which deliver services to children and young people in the area. The Chair will be appointed by the Chief Executive and a panel of partners and lay members and will be accountable to the Chief Executive. The period of office for the Chair will normally be three years. The Board shall also appoint a Vice Chair from within its membership, normally for a period of three years.
    - The membership of the Board will include named representatives of all relevant agencies as set out in the Children Act 2004 and the statutory guidance Working Together 2015 as follows:

- Independent Chair
- Participant Observer Member – Executive Member for Children's Services South Gloucestershire Council
- Director for Children Adults and Health, South Gloucestershire Council
- Head of Integrated Services for Children and Young People, South Gloucestershire Council
- Head of Safeguarding, South Gloucestershire Council
- Safeguarding Policy and Practice Manager, South Gloucestershire Council
- Representative of Avon and Somerset Constabulary as nominated by the District Police Commander

- Director of Public Health, South Gloucestershire Council
- Designated Nurse for Safeguarding Children
- Designated Doctor for Safeguarding Children
- Named GP for Safeguarding Children
- Representatives of North Bristol and University Hospitals Bristol NHSF Trust and Avon and Wiltshire Mental Health Partnership Trust as nominated by the respective Chief Executives of the Trusts
- Clinical Commissioning Group Nurse Director and Head of Quality and Safeguarding
- NHS England, Director of Nursing and Quality
- Representative of National Probation Service as nominated by the Chief Executive of the Service
- Representative of Community Rehabilitation Company as nominated by the Chief Executive of the Service
- Representative of CAFCASS as nominated by the Chief Executive of the Service
- The Governor of Eastwood Park HMP or their nominated representative
- Head of Vinney Green Secure Unit
- South Gloucestershire Youth Offending Service Manager
- Head of Safer Stronger Communities, South Gloucestershire Council
- Representative of the main Housing Provider in South Gloucestershire as nominated by the Chief Executive of the Service
- Head of Legal, Democratic and Property Services, South Gloucestershire Council or his/her nominated representative
- 2 lay members appointed by the Board
- Representative of South Gloucestershire Primary and Special Schools as nominated by the Heads Executive
- Representative of South Gloucestershire Secondary Schools as nominated by the Secondary Heads Group
- Representative of Further Education as nominated by the Principals of Filton and City of Bristol Colleges
- Head of Education, Learning and Skills, South Gloucestershire Council
- At least one faith representative
- At least 2 Voluntary Sector representatives
- Representative of South West Ambulance Service
- Chairs of the SGSCB Sub Groups (if not members in another capacity)
- Representative from Sirona Care and Health

Associate Members

- Representative of the Crown Prosecution Service
- Representative of Avon Fire and Rescue Service

- Board members will be able to nominate one substitute to attend meetings in his/her absence
- The Board may co-opt other members as appropriate on the recommendation of the Executive Sub Committee.
- Officers from the Board partners will be available to offer advice and guidance as required.

5. Sub Committees
    - In order to undertake the range of work which shall be reported on an annual basis to the full Board, the Board has identified the following sub groups:

- The SGSCB Executive Sub Committee
- The West of England Child Death Overview Panel
- The SGSCB Serious Case Review Sub Group
- The SGSCB Policy and Procedures Sub Group
- The SGSCB Quality Assurance Sub Group
- The SGSCB Training Sub Group
- The SGSCB Online Safety Sub Group
- The SGSCB Education Sub Group
- The SGSCB Child Sexual Exploitation/Child Sexual Abuse Sub Group
- The SGSCB Missing from Home, Care and School
    - In addition, the Board may establish themed groups, some of which will operate on a task and finish basis. These groups are subject to annual review.
    - The SGSCB also has linkages to other groups established on a sub regional/regional basis, in particular the Avon and Somerset Consortium, co-ordinated by the Avon and Somerset Constabulary, and the South West Child Protection Shared Procedures Group.

6. Convening and Conducting Meetings
    - The Board shall meet at least four times per year with additional meetings and development days to be arranged as agreed by the Board.
    - The Chair will be an independent person as described in 4.1 above.
    - The Board should aim to reach its conclusions by consensus, but, in the absence of consensus on any matters requiring decision, the Chair shall have a casting vote.
    - All members of the Board will be expected to sign the SGSCB Memorandum of Understanding confirming their acceptance of their responsibilities in respect of the Board and their own organisation.
    - Secretariat and legal support will be provided by South Gloucestershire Council to include:

- Co-ordination of agenda preparation;
- Convening of meetings of the full Board, the Executive Sub Committee and any Serious Case Review Panels;
- Publication of agenda and supporting papers at least five days prior to the meeting;
- Taking of minutes;
- Monitoring and progressing actions agreed by the Board.
    - The meetings of the SGSCB are not open to the public.
    - An annual record of attendance by organisation will be published and the Chair will raise any non attendance greater than 25% with the relevant organisation.
    - Any dispute resolution will be undertaken in accordance with the policy for the Resolution of Professional Differences of Opinion adopted by the Board.

7. Funding

- A specific pooled budget for the Board will be agreed each year and reported in the Annual Report and the Business Plan. It is expected that the statutory partners named in the Children Act 2004 will make a contribution to the pooled budget.
- In addition, both the statutory partners and other Board members will be expected to make a contribution in kind through their participation in Board and sub group meetings, and other activities arranged by the Board.

Appendix three: Memorandum of understanding for members of the South Gloucestershire Safeguarding Children Board

Chapter 3 of the statutory guidance Working Together to Safeguard Children 2015 sets out the responsibilities of local safeguarding children boards and the statutory membership.

This includes the following statements in respect of members of an LSCB :

- Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to:
    - speak for their organisation with authority
    - commit their organisation on policy and practice matters
    - hold their own organisation to account and hold others to account
- All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

This memorandum of understanding sets out the South Gloucestershire Safeguarding Children Board's expectations for members. The members shall, for the purpose of this memorandum of understanding, include the organisation and the individual representing the organisation who are defined as statutory board members and member organisations ('board member').

Each board member will agree to accept the following responsibilities which shall commence immediately and will thereafter work diligently in accordance with the terms of reference of the Board and the duties placed on each member of the Board and their employing organisation in accordance with 'Working Together to Safeguard Children 2015'.

Commitment to the purpose and objectives of the Board

In order for the Board to operate effectively, Members must be committed to the collective purpose, ethos and aims of the Board. This means to:

- Develop and deliver a local safeguarding board in accordance with the range of roles and statutory functions as set out in the Children Act 2004 and Working Together to Safeguard Children 2015'.
- Work effectively and efficiently so as to ensure the Board meets its statutory objectives which are to co-ordinate what is done by each person or body represented on the Board for the

purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by each such person or body for those purposes.

This includes:

- regular attendance at the Board and any subgroups
- Completion of Section 11 Audits in a timely way
- Support achievement of the priorities that have been agreed by the Board in its business plan
- Ensure that confidential information is not shared beyond the Board without the permission of the chair

Promote and support the objectives of the local safeguarding board

In order to ensure the work of the Board is effective, each board member shall be a champion for safeguarding children and young people. This means that:

- Each member shall scrutinise vigorously the arrangements in place within their own organisation in respect of working with children and young people to ensure that the arrangements are fit for purpose, and be ready to share this with the Board when required.
- Each member shall take such steps as are necessary within their individual organisation to promote improved arrangements where they deem appropriate.
- Each member shall promote effective communication, both within their own organisation and with other partner organisations/agencies.
- Each member shall promote the work of the Board within their individual organisation and disseminate relevant documentation and information as appropriate so as to raise greater awareness of the issues relating to the safeguarding of children and young people amongst a wider community.

This includes:

- Contributing to and dissemination of newsletters
- Regular promotion of learning and development events
- Dissemination of policies, research and learning from case reviews
- Promoting the Board website and use of South West Child Protection Procedures website.

This Memorandum of Understanding is signed by:

Name:
Organisation:
Signature
Date:

and received by the Head of Safeguarding

Name: Catherine Boyce
Date:
Signature

Appendix four: Board membership and attendance

Agency	Name	Role	Attendance Includes predecessor where applicable
Independent Chair	Amy Weir		100%
South Gloucestershire Council	Councillor Jon Hunt	Lead Member for Children & Young People	50%
	Lynn Gibbons	Public Health Consultant	75%
	Kathryn Birtles	Education Advisor (Early Years)	100%
	Catherine Boyce	Head of Safeguarding	100%
	Helean Hughes	Head of Education, Learning & Skills	100%
	Holly Magson	Workforce Development Advisor	50%
	Sonya Miller	Head of Integrated Services	75%
	Peter Murphy	Director for Children, Adults & Health	100%
	Deborah Rodney	Policy & Practice Manager	50%
	Karen Moore	Legal Services Manager	75%
	Alison Sykes	Interim Head of Vinney Green Secure Unit	75%
	Sarah Taylor	Safeguarding Board Business Manager	-
	Robert Walsh	Head of Safe Strong Communities	100%
	Steve Waters	Youth Offending Team Manager	75%
Avon Probation Service (CRC)	Rachael Cragg	LDU Team Leader, BGSW CRC, Probation	50%

Agency	Name	Role	Attendance Includes predecessor where applicable
Avon Probation Services (NPS)	Jayde O'Brien	NPS Probation, Team Leader	75%
South Gloucestershire Clinical Commissioning Group	Lindsey Mackintosh	Designated Doctor Safeguarding Children	100%
	Lisa Harvey	Deputy Nurse Director, Designated Nurse Safeguarding Children	100%
	Kate Mansfield	Named GP for Safeguarding Children	75%
	Anne Morris	Nurse Director, Head of Quality & Safeguarding	50%
Primary School	Tim Ruck	St. Stephen's Infant School	75%
Secondary School	Rhian Priest	Principal, Bristol Technology &Engineering Academy	25%
Lay Member	Karl Stephenson	Lay Member	75%
	Janice Suffolk	Lay Member	75%
Avon Fire & Rescue Service	Neil Liddington	Assistant Chief Fire Officer, Service Delivery	0%
CAFCASS	David Gee	Service Manager	100%
South Gloucestershire & Stroud College	Emma Jarman	Vice Principal & Designated Safeguarding Lead	0%
Faith Sector	Adam Bond	Diocesan Safeguarding Advisor	25%
AWP	Jon Peyton	Head of Safeguarding Children	100%
South Western Ambulance Service NHS Foundation Trust	Sarah Thompson	Safeguarding Named Professional	25%

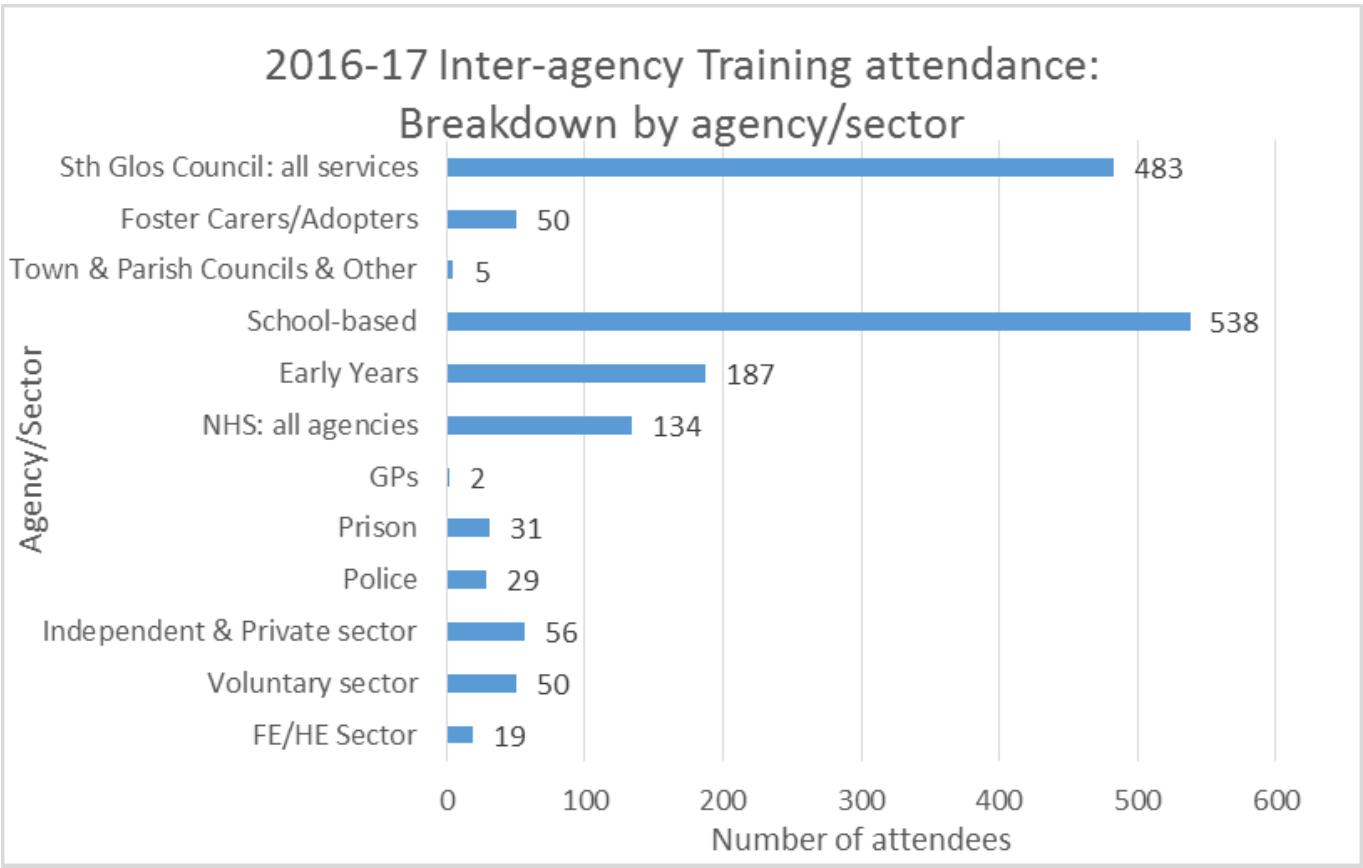
Agency	Name	Role	Attendance Includes predecessor where applicable
Deputy Representative North Bristol NHS Trust	Maria Hennessy	Head of Nursing & Governance in the Community Child Health Partnership	75%
University Hospitals Bristol	Carol Sawkins	Named Nurse Safeguarding Children	100%
HMP/YOI Eastwood Park	Suzanne Smith	Head of Safety & Equalities	25%
Survive	Sarah Telford	Chief Executive	75%
Barnardos	Duncan Stanway	Assistant Director	100%
Avon & Somerset Constabulary	Mark Evans	Detective Superintendent	100%
Merlin Housing	Paul Coates	Director of Housing & Communities	0%
Sirona	Jill Chart	Named Nurse for Safeguarding	100%
Soldiers, Sailors, Airman & Family's Association (SSAFA)	Julie Jones	Personal & Family Support Worker	25%

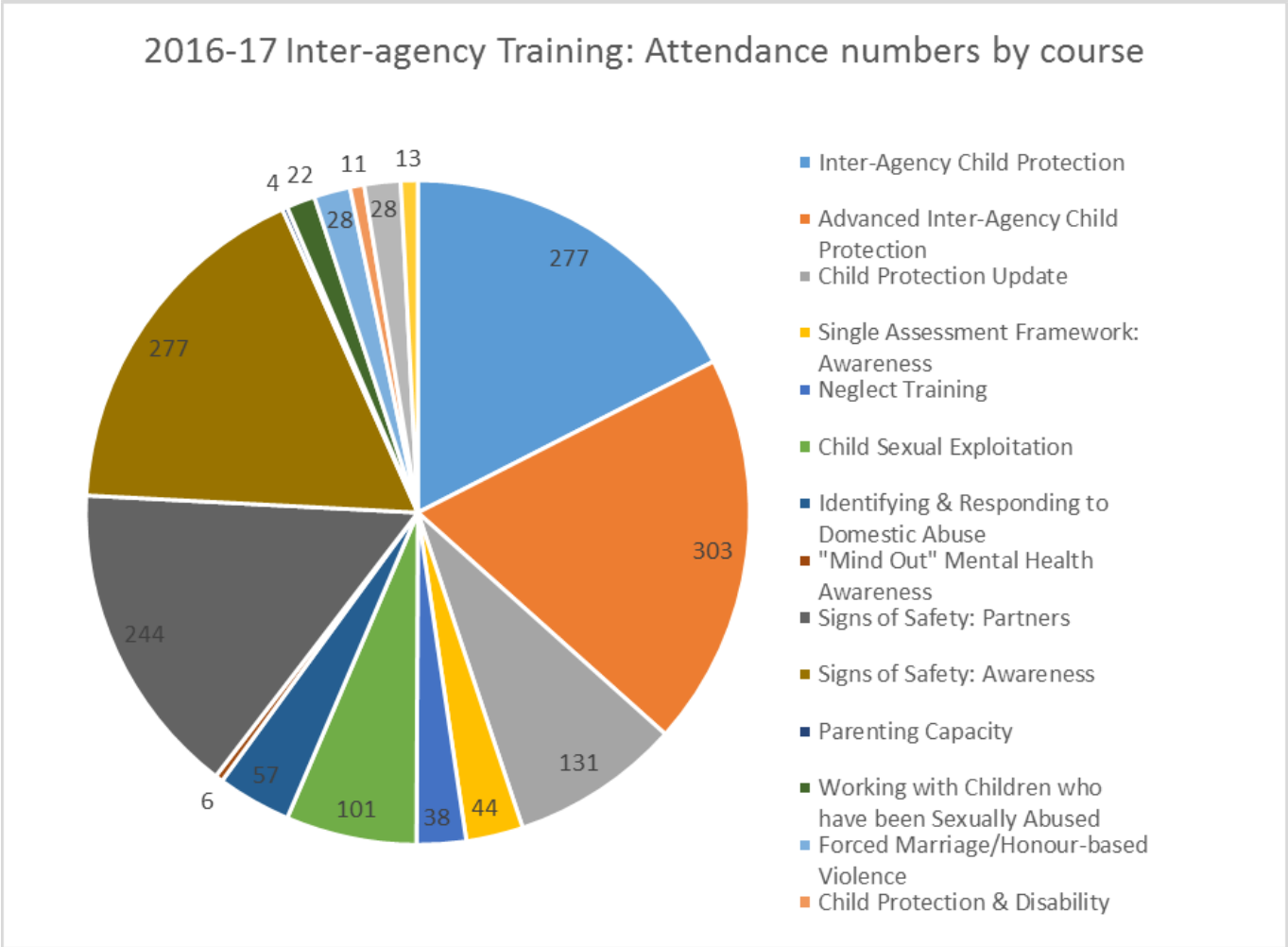
Appendix five: Financial report

South Gloucestershire Council Children's Safeguarding Budget 2016-17		
Source of funds		
2016 - 2017 Safeguarding contribution	**Budgeted contribution**	**2016-17 Final outturn**
	£	**£**
2015-16 Carry Forward	**£55,000.00**	£55,000.00
Avon and Somerset Police	**£7,342.00**	£7,342.00
Avon and Somerset Probation	**£523.00**	£523.00
CAFCASS	**£550.00**	£550.00
AWP Mental Health Trust	**£1,777.00**	£1,777.00
Department for Children and Young People	**£72,950.00**	£72,950.00
NHS South Gloucestershire	**£31,940.00**	£31,940.00
Totals	**£170,082.00**	**£170,082.00**
Application of funds		
2016 - 2017 Budget plan	**Budgeted expenditure**	**2016-17 Final outturn**
	£	**£**
Pay		
Safeguarding Policy and Practice Manager	£30,900.00	£23,159.56
Strategic Safeguarding Manager	£26,680.00	£26,680.00
Administration	£3,700.00	£3,678.00
Independent Chair -SCB	£26,060.00	£15,543.84
Non pay		
Child protection training	£43,360.00	£50,651.00
LSCB conference	£5,300.00	£5,300.00
Administrative support	£6,400.00	£6,885.34
Case reviews	£30,000.00	£5,925.00
Night time economy work (Barnardos)	£5,500.00	£5,417.00
Chrysallis service (SW Grid For Leaning)	£1,500.00	£1,576.00
Child death review (Bristol University)	£5,000.00	£5,500.17
Publications/procedures (BANES)	£3,000.00	£3,020.48
Income generated from training	-£17,318.00	-£55,254.39
Totals	**£170,082.00**	**£98,082.00**
Carry forward to Safeguarding Board 2017 - 2018		**£72,000.00**

Appendix six: SGSCB inter-agency training data

Course title	Attendance	Attendance	Attendance	Attendance
(number of courses delivered, 2016-17)	**2016-17**	**2014-15**	**2013-14**	**2012-13**
Inter-Agency Child Protection (13)	277	193	274	190
Advanced Inter-Agency Child Protection (14)	303	238	132	148
Child Protection Update (7)	131	94	132	115
Single Assessment Framework: Awareness (3)	44	36	145	68
Neglect Training (Toolkit) (3)	38	19	106	n/a
Child Sexual Exploitation (8)	101	116	72	49
Identify & Respond to Domestic Abuse (6)	57	63	35	25
"Mind Out" Mental Health Awareness (1)	6	28	53	n/a
Single Assessment Framework: Update (0)	0	4	111	34
Parenting Capacity (1)	4	21	37	36
Working with Parental Challenge & Hostility (0)	0	11	47	37
Child Sexual Abuse (2)	22	9	37	21
Forced Marriage/Honour-based Violence (3)	28	9	26	43
Child Protection & Disability (1)	11	8	22	20
FGM Awareness (3)	28	33	n/a	n/a
Signs of Safety: Partners (11)	244	n/a	n/a	n/a
Signs of Safety: Awareness (12)	277	n/a	n/a	n/a
Other: ABE, CSE Train Trainer etc	13	25	52	36
Annual total	**1584**	**907**	**1281**	**822**


2016-17 Inter-agency Training attendance:
Breakdown by agency/sector
Sth Glos Council: all services
Foster Carers/Adopters
Town & Parish Councils & Other
School-based
Early Years
NHS: all agencies
GPs
Prison
Police
Independent & Private sector
Voluntary sector
FE/HE Sector
483
50
5
538
187
134
2
31
29
56
50
19
Agency/Sector
0
100
200
300
400
500
600
Number of attendees


2016-17 Inter-agency Training: Attendance numbers by course
277
303
131
44
38
101
57
6
244
277
4
22
28
11
28
13
Inter-Agency Child Protection
Advanced Inter-Agency Child Protection
Child Protection Update
Single Assessment Framework: Awareness
Neglect Training
Child Sexual Exploitation
Identifying & Responding to Domestic Abuse
"Mind Out" Mental Health Awareness
Signs of Safety: Partners
Signs of Safety: Awareness
Parenting Capacity
Working with Children who have been Sexually Abused
Forced Marriage/Honour-based Violence
Child Protection & Disability

South Gloucestershire Annual Safeguarding Children Board Conference

Domestic Abuse: protecting the next generation

"Good mix of professional and expertise. Workshops were great, more of these needed"

"Excellent conference, one of the best I have attended recently. Extremely relevant, very well organised and brilliant speakers"

"Really useful practical examples of work that could be done with young people"

SGSCB STRATEGIC PRIORITIES AND BUSINESS PLAN 2017-2018

Our vision for safeguarding in South Gloucestershire is that children and adults thrive, reach their full potential and live their lives safe from harm (violence, abuse, neglect, exploitation). To achieve this vision we will work together and with local communities to improve outcomes and to ensure South Gloucestershire is a place where safeguarding is everybody's business

SGSCB statutory responsibilities identified in 'Working Together to Safeguard Children 2015', include:

- Co-ordination & Effectiveness
- Serious and Child Death Review
- Training
- Performance and Quality Assurance
- Learning and Improvement

Ongoing activity of SGSCB is undertaken by the following Sub-Groups

- Executive
- Training
- Policy & Procedures
- Communications
- Quality Assurance
- On-Line Safety
- Serious Case Review
- Missing from Home, Care and School
- Child Sexual Abuse/Sexual Exploitation
- Child Death Overview Panel
- Education

STRATEGIC PRIORITY 1:

To ensure there is effective multi agency action to identify, assess and reduce the risk of child sexual exploitation

1. To ensure the seraf is a useful tool to assist practitioners in identifying the risk of CSE
2. To rewrite and relaunch the multi-agency CSE guidance
3. To ensure the South Gloucestershire workforce is appropriately trained in CSE
4. Develop performance reports, both data based and qualitative, to enable multi-agency oversight of CSE in South Gloucestershire
5. Undertake a LSCB mapping exercise in order to assess the understanding of the local response to CSE
6. Develop and implement a risk assessment model/pathway for all high risk children, to include those at risk of CSE
7. To work towards the merging of the missing from home, care and school and CSE sub groups.

STRATEGIC PRIORITY 2

To actively seek to capture and act upon the voice of those affected by safeguarding concerns

1. To undertake a focussed piece of work to look at how the board can ensure the 'voice of the child' impacts on board business and effectiveness
2. To actively pursue how the Quality Sub Group can seek feedback from family members, including the child/young person on each case subject to multi-agency audit

STRATEGIC PRIORITY 3

To ensure that children within the 0-25 service receive an appropriate and timely response in relation to safeguarding concerns

1. To develop a disabled children safeguarding plan in line with national research and guidance recommendations
2. To review the LSCB training offer to ensure disabled children are integrated into all training courses
3. To establish a regular reporting process of improvement actions taken and progress made
4. To establish a performance data set that would enable the Board to provide oversight and scrutiny of the 0-25 service and its practice

STRATEGIC PRIORITY 4

To challenge and assure the quality of safeguarding practice in South Gloucestershire

1. To actively participate in the Avon and Somerset wide Section 11 thematic audits
2. To ensure the effectiveness of early help services is properly evaluated
3. Establish links with Eastwood Park Prison mother and baby unit to ensure that these babies are safeguarded and that their welfare is promoted
4. Increase challenge and scrutiny of practice relating to children who are privately fostered
5. Scrutinise multi agency understanding of Female Genital Mutilation including how agencies should respond in cases where it is suspected and to ensure that advice and expertise is available
6. To strengthen the remit of and response to the Quality Assurance Sub Group and their findings
7. To continue to have oversight and scrutiny of:

- Corporate parenting
- FGM/honour based violence/forced marriage
- Vinney Green Secure Unit
- EDT
- Elective home education/missing from education
- CDOP
- ART/MASH (and the application of the threshold matrix)
- Children in detention after charge
- Marac
- Lado
- Complaints
- Children in secure and custody

STRATEGIC PRIORITY 5

To ensure that the processes of the Board are rigorous and effective and are evaluated for their impact on outcomes for children

1. To take full account of the findings of the Alan Wood Review of LSCBs on behalf of the DfE and how these are represented in the Children's Bill
2. To build on the strategic relationships with other boards/committees to share the key priorities for safeguarding children and young people in South Gloucestershire.
3. To enable the Board to work in an efficient and purposeful way where there is shared responsibility and challenge and understanding of the member role
4. Further review the multi-agency data set to ensure that it contains sufficient information to judge the effectiveness of services, particularly in relation to child protection practice
5. Strengthen the usefulness of the annual report by more closely evaluating what the Board has achieved against its key priorities
6. To ensure the Board is a 'learning Board' that demonstrates professional curiosity
7. To consider how the board can consult with and receive feedback from member organisations' frontline practitioners

South Gloucestershire Safeguarding Children Board (SGSCB) is the key statutory body overseeing multi-agency safeguarding arrangements across South Gloucestershire. It is governed by the statutory guidance in Working Together to Safeguard Children 2015.

Our vision for safeguarding in South Gloucestershire is that children and adults thrive, reach their full potential and live their lives safe from harm (violence, abuse, neglect, exploitation). To achieve this vision, we will work together and with local communities to improve outcomes and to ensure South Gloucestershire is a place where safeguarding is everybody's business.

Contact South Gloucestershire Safeguarding Children Board by email: sgscb@southglos.gov.uk. You can also contact the Safeguarding Boards Business Manager on 01454 863136.

Information about the board for professionals and the public is available on the dedicated South Gloucestershire Safeguarding Board website at www.southglos.gov.uk/safeguarding