Buckinghamshire

BSCB

Safeguarding Children Board

Buckinghamshire Safeguarding Children Board

Annual Report 2015-16

Contents

Thank you to Jed, Iris and Darcy for drawing pictures for this report.

Foreword

Welcome to the 2015/16 Annual Report for the Buckinghamshire Safeguarding Children Board (BSCB). I am very pleased to present the achievements of the Board over the past year in relation to its key statutory duties and the Board's priority themes, agreed in consultation with children and young people and with agency partners on the basis of learning from outcome data, multi-agency audits and from reviews of children's cases. The report also sets out the remaining challenges we face and the work we need to do to deliver fully on our priorities.

I hope you will agree that the report shows the Board is in a very different place than it was this time last year. Significant progress has been made to get basic systems, processes and governance arrangements in place including more robust quality and performance information to enable partners to more effectively challenge and support each other in the collective interest of safeguarding Buckinghamshire children. I am pleased also at the progress that has been made to involve children and young people in the work of the Board and to contribute their thinking on priorities. Examples include the children and young people's version of our 2014/15 annual report, their imaginative contributions to the new BSCB website and the e-safety ambassadors based across our schools.

Strong progress has continued to deliver the remaining recommendations from the 2014 Ofsted inspection and to be able to evidence some strong improvements in agency practice. These include:

- The development of the Early Help Panel process, which is providing coordinated, multi-agency early help and support for children and families;
- The development of a multi-agency dataset, which is giving the BSCB increased visibility of performance data and opening up new lines of enquiry and challenge;
- Stronger relationships with the other strategic partnership boards operating in Buckinghamshire, which has facilitated effective joint working.

In the Spring this year we updated our self-assessment of the Board's progress under the Ofsted criteria and there was partnership agreement that the Board was no longer inadequate under any of the standards and is moving up the 'Requires Improvement' rating with an expectation of achieving good by the end of 2016. All of this will of course be subject to ratification by Ofsted when they re-inspect us.

I would like to say a big thank you to all the agency partners represented on the Board, for their hard work and joint ownership of the challenges and opportunities we face. Also to our Sub Group chairs, and to the BSCB team who have given their all to support and drive the Board's improvement.

Fran Gosling-Thomas - BSCB Independent Chair

1 Our County and Our Children

Buckinghamshire is a county of contrast, with a predominantly rural north and a more urban south. Just over half a million people live in the county, in approximately 200,000 households.[1] Each year around 6,000 babies are born. The current child population is[2]:

0-4 years	33,264	5-9 years	34,940
10-14 years	32,481	15-19 years	31,436

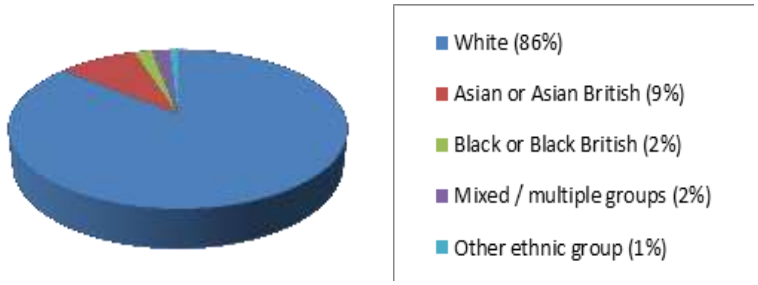
The ethnic profile of Buckinghamshire (figure 1) is broadly similar to that of England and Wales, with the majority of the population of White ethnic origin (86% in 2011[3]). Of these 5.3% are of non-British white origin. The largest non-white ethnic group is Asian, accounting for 8.6% of the Buckinghamshire population (England & Wales 7.5%). Over 60% of the county's Muslim population is in Wycombe district area. The age structure in the non-white population is very different, with a much younger population compared to the white population. Children from minority ethnic groups account for 20.9% of all children living in the area, compared with 21.5% for England as a whole.

In primary schools 16.8% of children and young people speak English as an additional language (national average: 20.1%). In secondary schools the figure is 15.7% (national average: 15.7%).[4]

Deprivation

Buckinghamshire is the second least deprived county in England.[5] Across the county, 86% of lower layer super output areas (LLSOAs) rank among the least deprived half in England, and more than a third rank in the least deprived decile. Buckinghamshire has much better educational attainment than the national average, a highly skilled workforce, and lower levels of

Figure 1: Buckinghamshire Population by Ethnicity (2011 census)



[1] 2011 Census. Available from: www.ons.gov.uk/census/2011census
[2] Mid-year Population Estimates 2015. Available from: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool
[3] 2011 Census
[4] 2016 data from Local Authority Interactive Tool. Available from:www.gov.uk/government/publications/local-authority-interactive-tool-lait
[5] 2015 Indices of Multiple Deprivation. Available from: www.buckscc.gov.uk/community/research/deprivation/

poverty and unemployment. These and other favourable socio-economic circumstances contribute to the better health and wellbeing of the Buckinghamshire population compared to nationally. However, the high level of affluence and traditionally low unemployment rates across the county as a whole disguise pockets of deprivation:

- Whilst no part of Buckinghamshire falls into the most deprived decile in England on the index of multiple deprivation, three LLSOAs in Aylesbury Vale fall into the second most deprived decile.[6]
- Compared to other Local Enterprise Partnership areas, Buckinghamshire ranks as least deprived on the health, education, skills and training domains. However, it ranks 17th most deprived (out of 39) on barriers to housing and services. This reflects local challenges such as low incomes in relation to local housing costs, household overcrowding and homelessness as well as distance from services in more sparsely populated areas. On the barrier to housing and services domain, 8% of our LLSOAs are among England's most deprived decile.[7]
- 15% of Buckinghamshire children under 16 are living in poverty (25% for the UK as a whole).[8]
- The proportion of children entitled to free school meals is 6.5% in primary schools (the national average is 14.5%) and 4.8% in secondary schools (the national average is 13.2%).[9]

The impacts of deprivation are felt from the earliest years:

- Children living in the mot deprived areas of Buckinghamshire are more likely to be underweight at birth and die in the first year of life than those living in the least deprived areas;
- At the end of the first year of primary school, 41% of those living in the least deprived areas have a good level of overall development, compared to 69% in the least disadvantaged areas;
- Children and young people from more disadvantaged areas have higher admission rates to hospital for a range of conditions including chest infections and asthma, injuries, self-harm and substance misuse; [10]
- There is a strong link between levels of deprivation and the likelihood of children having contact with Children's Social Care. Local analysis indicates that children in deprived areas are 2.5 times more likely to be on a child protection plan than the Buckinghamshire average. [11]

[6] As reference 5
[7] As reference 5
[8] Child Poverty Map of the UK (October 2014). Available from: www.endchildpoverty.org.uk/images/ecp/Report_on_child_poverty_map_2014.pdf. Figures calculated after the deduction of housing costs.
[9] 2016 data from the Local Authority Interactive Tool.
[10] Buckinghamshire Director of Public Health Annual Report 2014. Available from: www.buckscc.gov.uk/media/2672362/1405_Bucks_Council_Report_FINAL_v2.pdf
[11] Customer Segmentation presentation (June 2014) Buckinghamshire County Council Research Team

2 The Journey through Children's Social Care

The Front Door: Contacts, Referrals and the Multi-Agency Safeguarding Hub (MASH)

Contacts and Referrals

The **First Response** team provides the **'front door'** or entry point to Children's Social Care and Early Help. Reviewing the contacts that come into First Response, the conversion rate to referrals, where they come from and what happens to them in terms of outcomes for the child gives a picture of service demand. The factors which influence referral levels are multiple and complex. For example national media coverage and the complex responses across agencies and the general public to events such as the 2010 report into the death of Peter Connelly (Baby P), the 2013 guilty verdicts in the Oxford child sexual exploitation trials and the findings of the serious case review into the death of Daniel Pelka also in 2013. Changes in local authority responsibilities, partnership relations and structural changes across a number of organisations have all had an impact in recent years.

2014 saw a huge increase in **referrals** in Buckinghamshire which was not reflected across statistical neighbours or nationally. To a large extent this was due to a temporary change in process where all contacts to Children's Social Care were progressed to referrals.[12] Children's Social Care is now differentiating between contacts and referrals once more and data for 2015 (figure 3) shows that across the year as a whole our referral rates are now coming back into line with those of our statistical neighbours and have fallen back below rates for the South East and England as a whole. As work around referrals and thresholds continues we expect referrals to remain more consistently around this level.

The monthly breakdown for 2015/16 (figure 4) shows that referral rates have fluctuated during the year, with some levelling out from October 2015. The fluctuation of referrals is seasonal, with known peaks at the end of June, early July and in December. This is consistent with school holidays. In addition, the number of referrals has increased due to an improved understanding of the thresholds of intervention across the partnership, improved service delivery by Children's Social Care and changes in demographics.

The **conversion rate** between contacts and referrals has been an area of concern. The 2014 Ofsted report found a poor understanding of thresholds across partners. This was contributing to high levels of contacts to Children's Social Care that did not meet their threshold and which therefore were not converted to a referral.

[12] 'Contacts' are any contact that is made with First Response in relation to a concern about a child. Only those that meet the threshold for a statutory response or statutory intervention from Children's Social Care will become a 'referral'. Those that do not meet the threshold (level 4 on our Thresholds document) will be passed to the Early Help Panel (level 3) or signposted to other services or to information (levels 1 and 2).

Figure 3: Rate of Referral to Children's Social Care (per 10,000 children under 18)

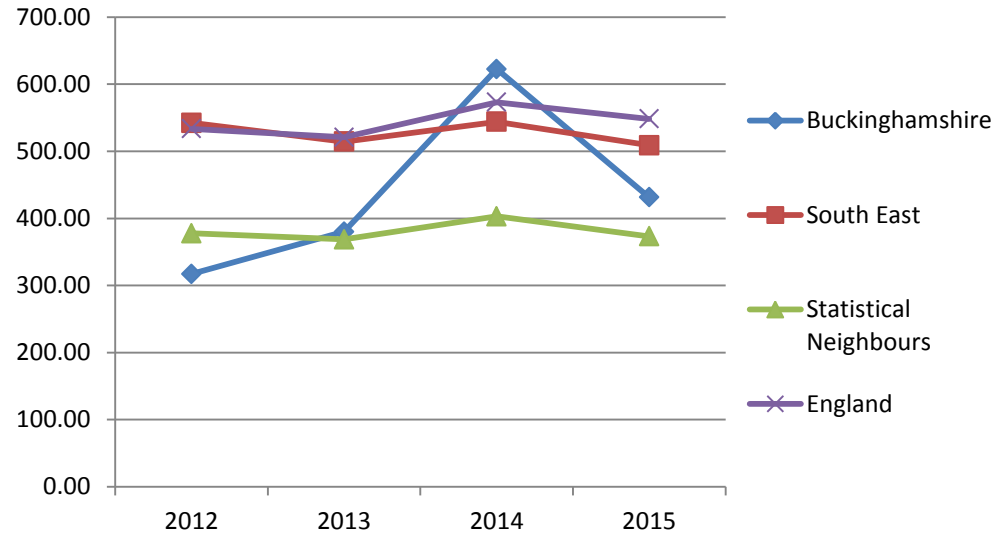


Figure 4: Buckinghamshire Rate of Referral to Children's Social Care (per 10,000 children under 18)

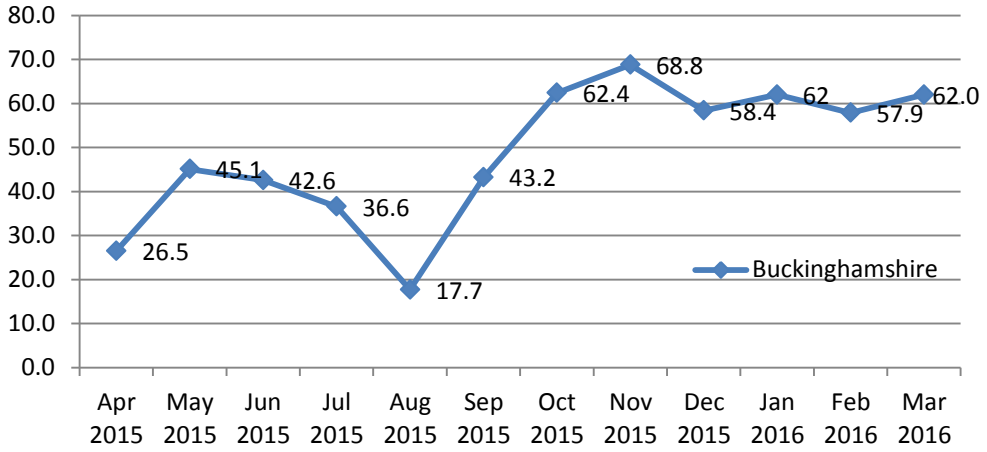


Figure 5: Outcome of Contacts to Children's Social Care

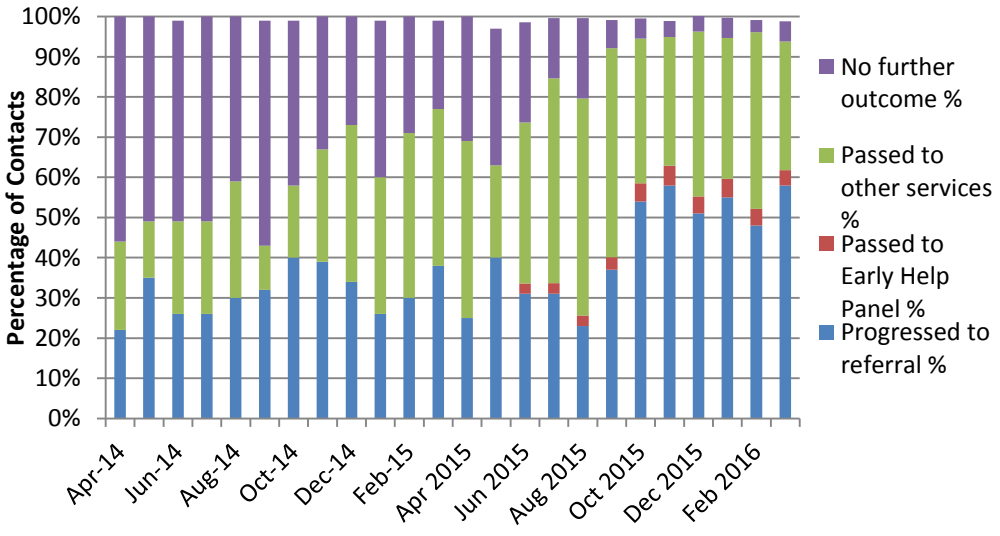
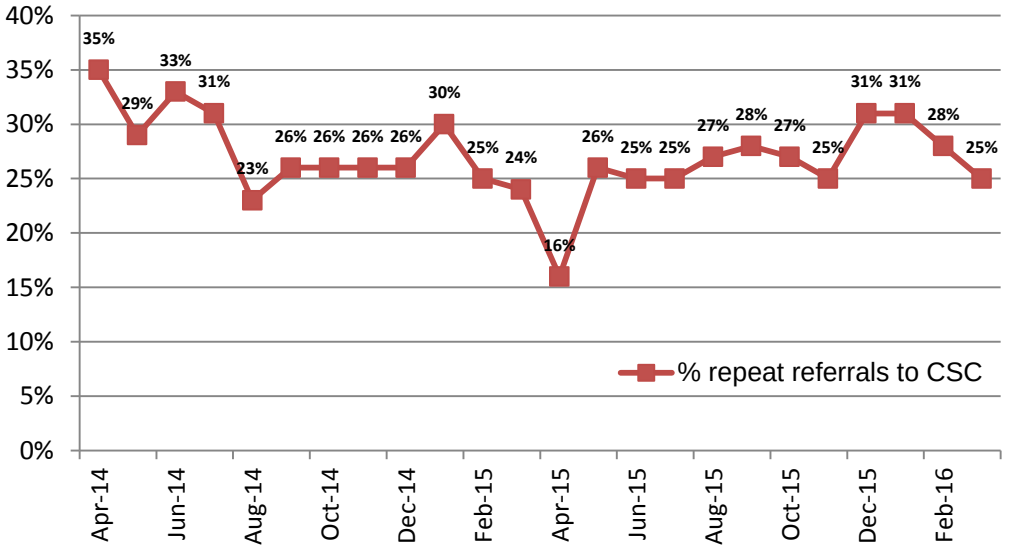


Figure 6: Rate of Referral to Children's Social Care

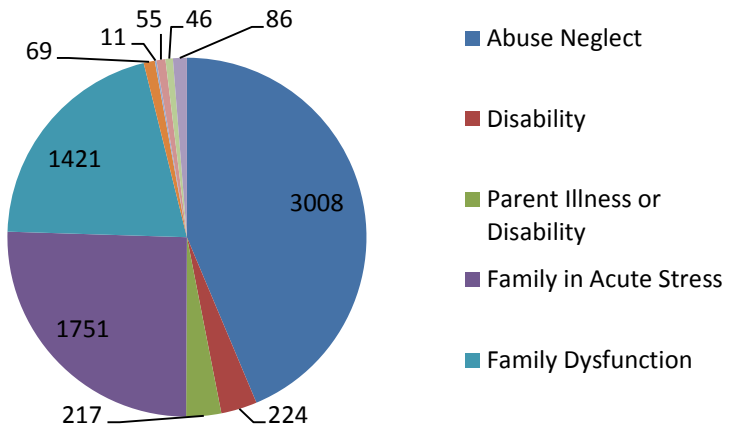


There are now signs of an improving picture, in particular:

- Auditing within Children's Social Care and by the BSCB is showing an increased understanding of thresholds across partners;
- A significant decrease in the number of contacts with No Further Action (figure 5);
- An upwards trend in the conversion rate over more recent months (with schools now at 75% and an average of 50% across the rest of partners)(figure 5);
- Referrals at level 3 starting to be passed over to our new Early Help Panel process for a coordinated early help response (figure 5).

This reflects significant and ongoing work to implement a coordinated, multi-agency Early Help approach (see Section 3) and improve knowledge of thresholds and the single referral pathway across the partnership. Over the next 12 months we expect this improvement to continue as this work is embedded further.

Figure 7: Reason for Referral to Children's Social Care



Other improvements at this early stage of the child's journey are also evident including increased **speed of decision making** around contacts and improved **feedback to partners** on the outcomes of referrals.

The rate of **re-referral** to Children's Social Care (figure 6) remains high. This is an area for further improvement over the next 12 months so that the needs of more children are met the first time. Analysis of re-referrals has highlighted the following as key factors; some system challenges, issues relating to a lack of consent for Children in Need, the partnership response to Domestic Abuse, more than one agency making the same referral, and changes in the family circumstances leading to an escalation of concern by the original referrer.

As last year, the highest number of contacts and referrals came from the Police (30% or 4762 contacts and 27% or 1874 referrals). Schools accounted for the second highest number of contacts and referrals (16% or 2599 contacts and 24% or 1648 referrals). Abuse / neglect is the highest reason for referral at 44%. The next highest reasons were family in acute stress (25%) and family dysfunction (21%) (figure 7).

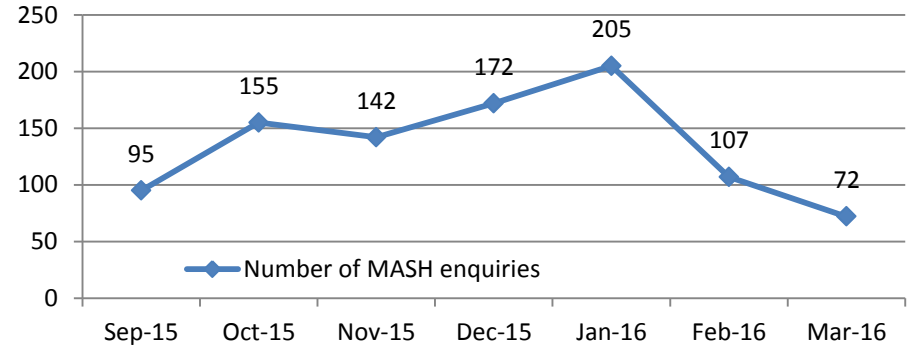
Multi-Agency Safeguarding Hub (MASH)

The MASH, established in August 2014, enables real time information to quickly be gathered from partners to help make the right decision about the correct course of action for a child after a contact to Children's Social Care. A number of agency representatives are co-located in the MASH (Children's Social Care, Police and Health) and additional partnership engagement is provided from 'virtual' members.

The last 12 months has seen continued **strategic and operational commitment** from partners to support the MASH and this has driven a number of successes including:

- Co-location in Aylesbury Police Station (including Adult Social Care);
- Recruitment of more permanent Children's Social Care staff to the MASH;
- Good collaboration and responses from partners;
- Partnership working to develop the 'perfect strategy meeting';
- Good attendance at strategy meetings from Health, Police, Children's Social Care and increasingly schools, resulting in joint decision making and management of risks to the child;
- Improved timeliness of decision making.

Figure 8: Number of MASH Enquiries excluding Section 47s (data only available from September 2015)



There have been fluctuations in the number of enquiries in MASH. This is due in part to staffing and system challenges. Recent external and internal audits have highlighted that there are too many children's circumstances being considered when there is a clear indication that an assessment is required. Further work is being done to make the process 'leaner'. This includes considering IT solutions as well as an auditing day to walk through all of the referrals in real time to understand the impact of MASH.

Assessing Need and Providing the Right Help and Support

Once a child has been referred to Children's Social Care, an assessment is undertaken to decide the most appropriate course of action. The number of assessments completed within the statutory 45 day timescale increased overall during the year, with some variation (figure 9). This remains an area for further improvement.

The number of Section 47 enquiries (undertaken where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm) has increased over the course of the year (figure 10). However, the conversion rate from Section 47 enquiry to Initial Child Protection Conference needs further review. The conversion rate in an effective system would be around 60-65% so further work needs to be undertaken to understand current performance.

Children in Need (CIN)

Compared to both statistical neighbours and national, Buckinghamshire had lower rates of **children in need** (CIN)(figure 11), although numbers have become much more closely aligned with our statistical neighbours over the last 2 years. This alignment reflects continued adjustments to thresholds and scrutiny of all stages of the child's journey through Children's Social Care as we move away from the challenging local situation that was reflected in the inadequate Ofsted rating in 2014.

Figure 9: Percentage of Assessments Completed within 45 Working Days

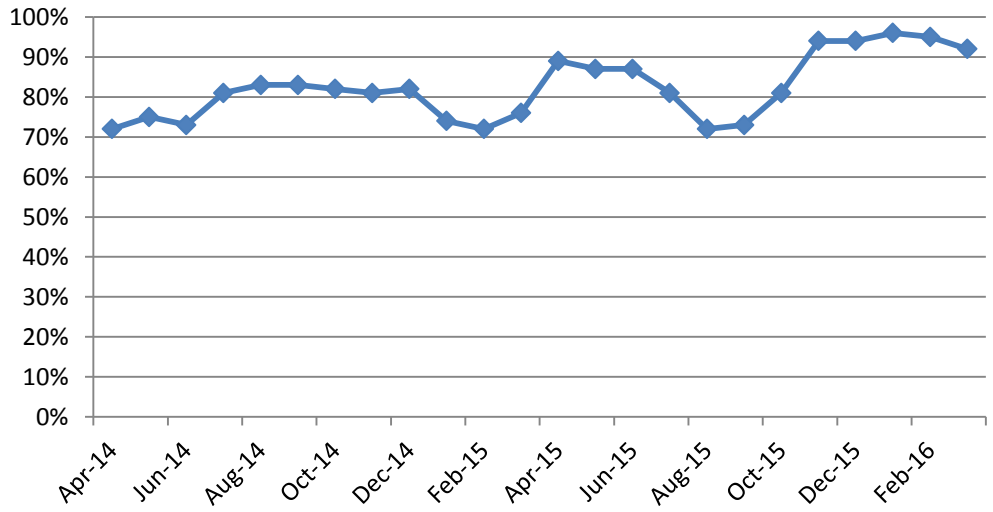


Figure 10: Number and Outcome of Section 47 Enquiries

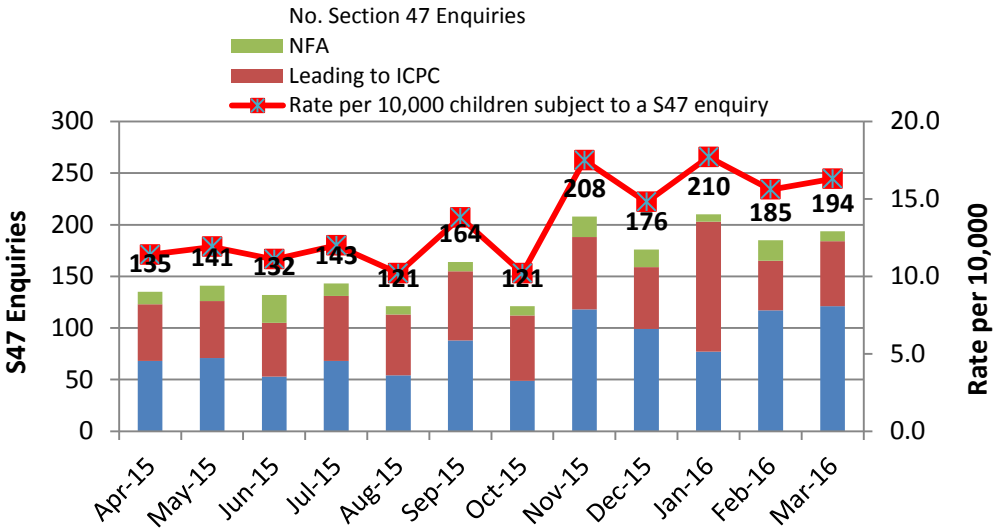


Figure 11: Children in Need 2009-2015 (rate per 10,000 children under 18)

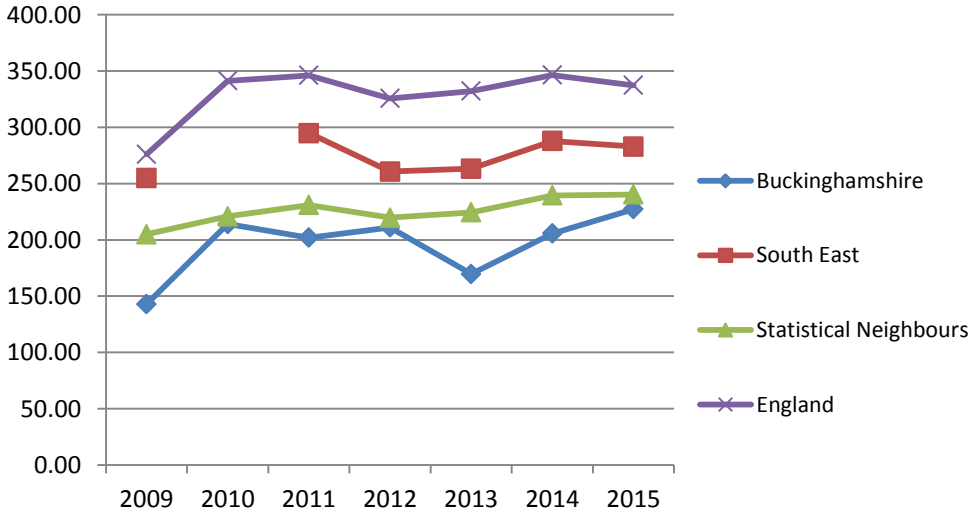
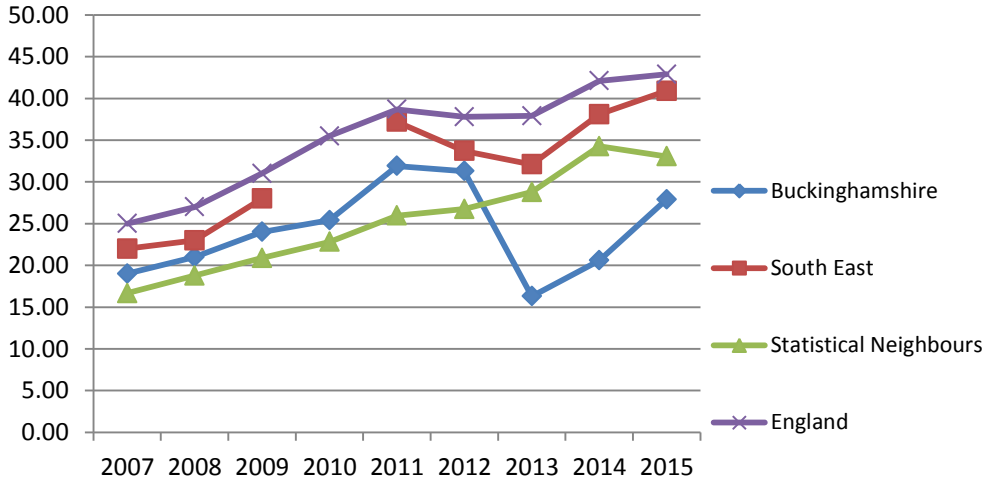


Figure 12: Children with a Child Protection Plan (per 10,000 children under 18)



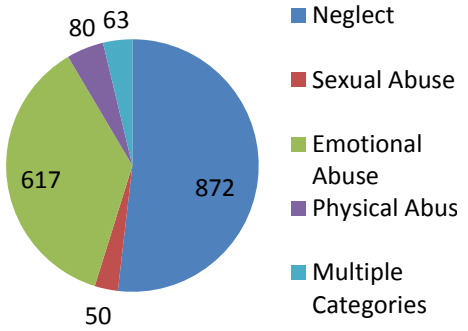
The findings from our Serious Case Reviews for Baby K (published August 2015) and Baby M (not yet published) suggested that CIN remains a particular area of challenge with inconsistent levels of service being provided. Children's Social Care have recognised these challenges and started work to drive improvement. However, this remains a key area for further work over the next 12 months. This will include a re-design of the service with dedicated CIN teams to drive up performance.

Children with a Child Protection Plan

Data shows the rate of children with a **child protection plan** in Buckinghamshire becoming more aligned with statistical neighbours (figure 12). As with Children in Need, this is a positive reflection of the work around thresholds and scrutiny across the child's journey. We expect rates to stabilise further in line with our statistical neighbours over the next 12 months once the legacy of the previous performance has worked through the system, and with a more coordinated approach to Early Help.

Neglect was the most frequent category of child protection plan, followed by emotional abuse (figure 13).

Figure 13: Category of Child Protection Plans 2015/16



Some of the key areas of challenge relating to this aspect of the child's journey have been:

- Ensuring good quality plans;
- Ensuring plans are owned, driven forward and where necessary challenged by all partners involved;
- Ensuring children are involved in their journey and that their voice is heard.

Significant work is being undertaken in this respect including, towards the end of the financial year, the roll out of a new model for Child Protection Conferences (Strengthening Families Model). Over the next 12 months the Board will be keen to review the impact of these improvements and will seek evidence of improved outcomes for children and young people. Performance is now good in relation to the length of time children are subject to Child Protection plans.

Children Looked After

Our rates of **children looked after** (figure 14) have become more comparable to our statistical neighbours over the last few years, but remain lower than rates for the South East or national. Given the relative prosperity of Buckinghamshire compared to other areas, this is to be expected.

At March 2016, 463 children were being looked after by the local authority. Of this number:

- 52% lived outside the local authority area and 57% were placed further than 20 miles from home. 83 lived in residential care. This figure remains high compared to other areas;
- 195 lived with an agency foster carer and 83 with a Local Authority foster carer;
- 7 were in independent living;

- 24 lived with parents;
- In the last 12 months there have been 38 adoptions - an increase from 30 adoptions in 2014/15;
- 20 new foster carers were identified this year (a reduction from the 30 identified last year). However, 19 stopped being foster carers within the same timeframe.

The key challenge continues to be a **lack of placements** for looked after children within Buckinghamshire. There may be good reasons for placing children at distance from home. However, this can potentially increase their vulnerability and makes contact with birth families and other networks more difficult. Although there is significant work underway to try and improve this, there are unlikely to be any short term improvements and this remains an area of risk. During the next 12 months additional work will also be required to ensure we can take an increased allocation of unaccompanied asylum seeking children.

Private Fostering

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. In such situations the Local Authority must be notified so that they can check on the suitability of the placements and ensure other advice and support is provided.

During the last 12 months, the Local Authority has undertaken considerable work to increase awareness around private fostering, but this has not had a significant impact on the number of private fostering notifications (figure 15). This is an area for further monitoring and over the next 12 months the Board will work with the Local Authority to try and increase awareness further.

Figure 14: Children Looked After (rate per 10,000 children under 18)

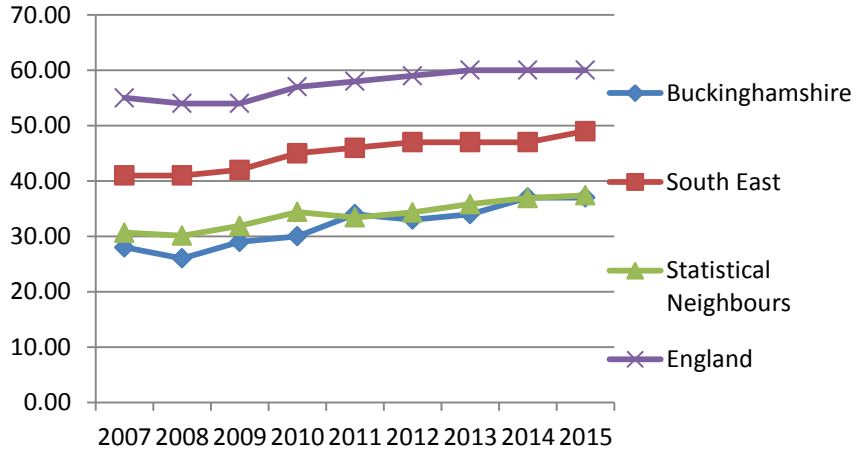
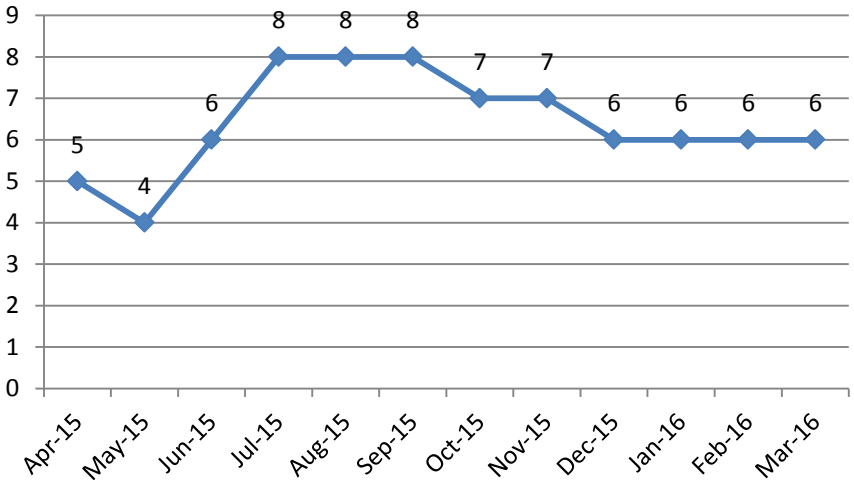


Figure 15: Number of Children Privately Fostered at Month End



3 Our Board

The Children Act 2004 requires all local authority areas to establish a Local Safeguarding Children Board (LSCB). LSCBs are multi-agency partnerships which are responsible for coordinating local arrangements to safeguarding and promote the welfare of children and ensuring that these arrangements are effective.

The Buckinghamshire Safeguarding Children Board (BSCB) has membership from across both the statutory and voluntary sector and a full list of members can be found at appendix 2. The main Board is supported by 9 Sub Groups which also draw their membership from across agencies in Buckinghamshire that work with children and families. A structure diagram for the BSCB, including all of the Sub Groups is included at appendix 1.

The BSCB is funded through contributions from each of the partner agencies. The contributions from each partner agency for the 2015/16 year can be found at appendix 3.

The BSCB meets every two months and focuses its attention on areas of safeguarding challenge or concern and the implementation of the BSCB Improvement and Development Plan. It considers how agencies work both individually and together to safeguard and promote the welfare of children.

Responsibilities

The BSCB is responsible for[13]:

- Developing policies and procedures for safeguarding and promoting the welfare of children;
- Raising awareness within communities and organisations of their responsibility to safeguard and promote the welfare of children and supporting them to do this;
- Monitoring and evaluating the effectiveness of the Board and its partners both individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- Participating in the planning of local services for children in Buckinghamshire;
- Undertaking reviews of serious cases and child deaths and advising the authority and their Board partners on lessons to be learned.

The BSCB, other than the part-time presence of an Independent Chair and a small project team, has no existence other than as a collective unit. Strong multi-agency working from across our partners is therefore vital to achieving the BSCB priorities and ensuring that children in Buckinghamshire are effectively safeguarded.

[13] The duties and responsibilities of LSCBs are set out in full in Working Together to Safeguard Children (2015). Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Business Planning and Priorities

Every year the BSCB holds an annual business planning day to consider progress made against the priorities set in the previous year and to determine new ones. Priorities are driven by developments and needs arising both nationally and locally. For 2015/16 the Business Planning day was held in January 2015. At this point the Board developed a new Improvement and Development plan for 2015/17. This focused on the areas for improvement identified by Ofsted in their inspection report published in August 2014 and other local priorities identified by Board partners.

Given that the Board, along with the local authority services for children in need of help and protection and children looked after and care leavers received an Ofsted rating of inadequate at the 2014 inspection, this year has seen a continued focus on driving improvement. Whilst at the time of writing this report, the Board has yet to be re-inspected by Ofsted, it is hoped that this report provides positive evidence of improvement whilst at the same time making it clear that there are still a number of areas which required further work and development.

Priority 1

Early Help & Thresholds

Priority 2

Child Sexual Exploitation

Priority 3

Child's Voice & Journey

Priority 4

Neglect

Priority 5

Increasing the Impact & Effectiveness of the Board

Compliance with Statutory Functions

Vision and Values

Our Vision

"A strong and shared safeguarding culture across partners ensures every child and young person in Buckinghamshire grows up safe from maltreatment, neglect and harm. Children and their parents receive the right help and support when they need it, leading to better outcomes for children and young people."

Our Values

- ✓ We will be honest and clear about the difference we are making for children and young people
- ✓ We will respectfully challenge each other to ensure we are making a difference
- ✓ We will all take responsibility for helping each other to improve outcomes for children and young people
- ✓ We will value difference to help us to improve
- ✓ We will look to hold to account rather than to blame
- ✓ Everything we do will benefit children and young people in Buckinghamshire
- ✓ We will be courageous
- ✓ We are all in it together – as a Board we accept collective responsibility for our performance

Lay Members

Working Together 2015 requires all LSCBs to have two Lay Members. This year saw both of our long-standing Lay Members stand down from their role. We recognise the important contribution that both of these Lay Members have made to the Board over the last few years. They were able to bring to the Board their own knowledge and experience to help challenge and inform the Board.

The BSCB is currently recruiting new Lay Members and looks forward to welcoming the different perspectives and voices they will bring to the Board.

4 Our Performance: Early Help and Thresholds

Our Aim

Partners are fully engaged in the delivery of the Early Help Strategy so that children and their families have timely access to appropriate help and support.

Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life. Effective early help relies on local agencies working together to:

- Identify children and families who would benefit from early help;
- Undertake an assessment of the need for early help;
- Provide targeted early help services to address the assessed needs of a child and their family, which focuses on activity to significantly improve outcomes for the child.

The Board's Early Help Sub Group, which continues to attract strong multi-agency attendance, has a key role in monitoring the effectiveness of early help across agencies. At a **strategic level** key developments this year include:

- The development of an **Early Help data dashboard**, which is starting to help the Early Help Sub Group and the Board have better visibility of how well Early Help is working locally. This is monitored at each sub group, with notable trends and 'red flag' areas of concern presented at each BSCB meeting.
- The Board has driven a sustained and tailored **communication and awareness raising** campaign around Early Help and Thresholds across the partnership including:
  - The publication of a Buckinghamshire **Early Help Strategy** in November 2015.
  - The publication of a revised **Thresholds document** in September 2015 which incorporated feedback from a partnership consultation at the end of the last financial year. Laminated, colour copies have been distributed to partners to encourage them to display the document within their workplace.

  - The development of a suite of resources to support agencies to embed an understanding of Early Help and thresholds. This includes a **referral flow diagram** and **wallet cards** setting out the action professionals should take if they are concerned about a child.

- A revised **Multi-Agency Referral Form (MARF)** in February 2016 to create better alignment to the revised Thresholds document.
- Tailored awareness raising training with a number of agencies (see storyboard on p18 for example).
- Supporting partners to disseminate key messages on Early Help and Thresholds through their own channels such as websites and training.

"An area of much improvement" **(Board feedback on Early Help as part of our self-assessment against the criteria for a good LSCB)**

By the end of the year there was good emerging evidence of improved knowledge and confidence around thresholds. A Peer review of Children's Safeguarding Services conducted by the Local Government Association in October reported good evidence of the Thresholds document being displayed within partnership settings and identified the partnership working around the development of the Thresholds document as a strength. Also in October 2015, the Home Office review of gang activity in High Wycombe found that our Threshold Document is underpinned by an evidence base, draws on practitioner knowledge and replaced a previous system that was not working. Partners are accessing the Thresholds document more often, with the Threshold page on the BSCB website featuring in the top 10 pages since July 2015. There is also early evidence from Children's Social Care and BSCB auditing of increased knowledge and understanding of thresholds. **This provides a strong base on which we will need to build further over the next 12 months.**

- The Board has sought to **raise public awareness** around reporting safeguarding concerns, recognising the important role that we all have in protecting children. We worked together with the Buckinghamshire Safeguarding Adults Board to develop a **short commercial** to encourage people to report concerns. This has been made available in public settings such as GP surgeries, and a number of agencies are using it as part of their staff induction. The commercial was screened in the Eden Centre, High Wycombe for 7 days during August 2015. 307 of the people who viewed the commercial during this time provided feedback on the impact of the advert, which we used to help us develop our approach for future use.
  - **294** (96%) said that the commercial improved their knowledge;
  - **12** (4%) said it did **not** improve their knowledge; of these **2** said they were already aware, and **2** that they did not want to get involved at all;
  - **286 (93%)** said that they **would** feel confident in reporting safeguarding concerns;
  - *'After watching I would report it' (public quote).*

  Later in the year we supported the national Department for Education campaign to raise public awareness around reporting and have updated our website in line with this campaign.

Storyboard: Collaborative working with Thames Valley Police on Early Help and Thresholds

Why did we seek improvement?

In March 2015, the BSCB ran a survey to understand knowledge and use of the Thresholds document. This identified that there was work to be done across the partnership to embed the Thresholds document. However, responses suggested that knowledge and usage within Thames Valley Police needed particular attention.

As our Early Help processes were developing at the same time, there was a good opportunity to work with the Police to ensure that all front line officers understand Early Help processes and consider this when dealing with vulnerable families in the course of their everyday work.

What did we do?

- The BSCB worked collaborative working with TVP to develop a tailored presentation on Early Help and Thresholds;
- A pilot training day was delivered by an Area Commander, supported by Early Help trainers;
- 3 members of Thames Valley Police were trained to deliver the presentation across front line and neighbourhood officers (approx. 300 people);
- Thresholds documents and wallet cards were distributed at each training event;
- The Thames Valley Police trainers visited First Response and Family Resilience Service, to improve their understanding of the process. This informed their training and strengthened the links between agencies.

Evidence of impact and outcomes?

- There has been an improvement in the number of appropriate contacts and referrals from Thames Valley Police;
- There was positive feedback from those who attended the training, for example one trainer fed back: *"One of the officers came over and thanked us for delivering something that would benefit them";*
- Thames Valley Police report that that staff have an increased level of understanding of the Thresholds document and Early Help processes, including understanding that there may be occasions when it is appropriate for them to act as a lead agency through the Early Help Panel process;
- Thames Valley Police are engaging well in the Early Help Panel including acting as one of the rotating panel chairs.

Next Steps?

- Continue to monitor the level of appropriate contacts and referrals from Thames Valley Police;
- Develop a version of the Thresholds document that is more portable for outreach/mobile workers, including Police Community Support Officers (PCSOs);
- Ensure training continues as new staff come in to Thames Valley Police;
- Consider how to embed appropriate use of the Outcomes Star (see p21) within Thames Valley Police.

At an **operational level** key developments have been:

- The introduction of a **single 'front door'** or point of contact for those that have a concern about a child. This was a recommendation made by Ofsted during their visit in summer 2014 and has helped ensure there is a simple route available for professionals to contact Children's Social Care around those cases at level 3 and 4 of the Thresholds document.
- The development of the multi-agency **Early Help Panel** for children and families requiring coordinated, multi-agency early help support at level 3 of the thresholds document. Again, this responded to a finding from the 2014 Ofsted visit that although we had a good range of Early Help services available in Buckinghamshire, there was no coordinated system in place to respond to those children who did not meet the threshold for statutory provision led by Children's Social Care. Referrals at level 3 are taken to the panel, which identifies a lead agency to coordinate the support which is required for the whole family. Tailored plans are created for each family which aim to strengthen protective factors and mitigate against risk factors.

Evidence of Impact and Effectiveness: The Early Help Panel

Since the first panel in June 2015 through to the end of the financial year, there has been good evidence of partners working effectively together to help embed this new process and overcome any teething problems. **The BSCB acknowledges the considerable amount of work contributed by partners to set up and embed this process.**

- For the early panels, a high proportion of cases did not meet the Level 3 threshold. This caused some frustration for panel members who were unable to use the panel to concentrate effectively on those families who did meet the threshold. However, whilst work needs to continue on improving the quality of referrals, there has been significant improvement in the level of appropriate referrals (figure 16).
- A wide range of agencies are taking on the Lead Agency role, demonstrating good ownership and partnership working. Buckinghamshire County Council's Family Resilience Service has been the lead agency in approximately 60% of cases. This is as expected given that they are the only service set up to work with children and families of all ages across a range of issues (figure 17).
- There has been regular attendance at panels from most agencies, with work underway to plug any identified gaps in attendance.
- From June 2015 – March 2016, 340 families had their needs discussed at the Early Help Panel. The average number of problems identified per family is over 5, with the following the most common issues for families, as identified by agencies at the point of referral: behavioural problems, mental health, parenting, domestic abuse, family relationship breakdown and school attendance.

Figure 16: Early Help Panel Threshold Decisions (by Threshold level)

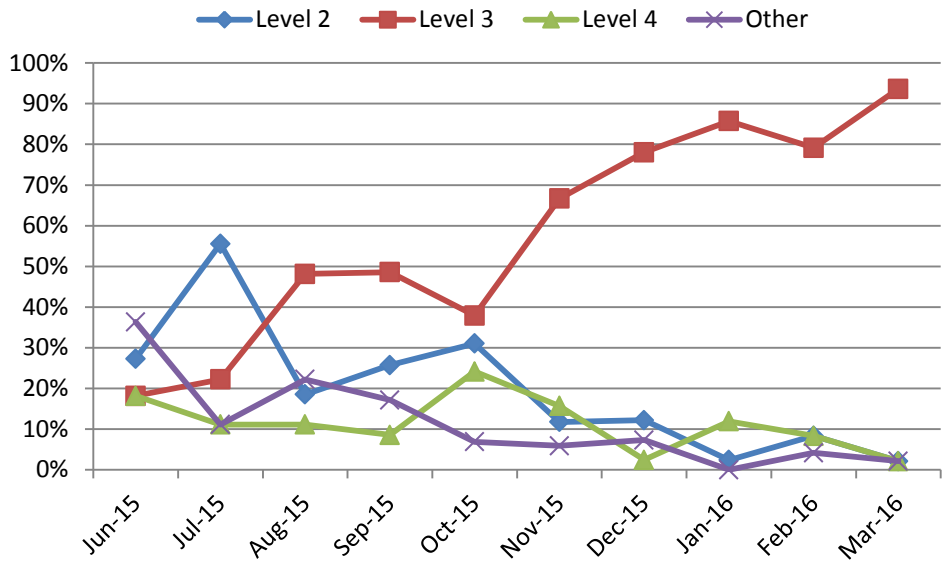


Figure 17: Early Help Panel Lead Agencies September 2016 – March 2016

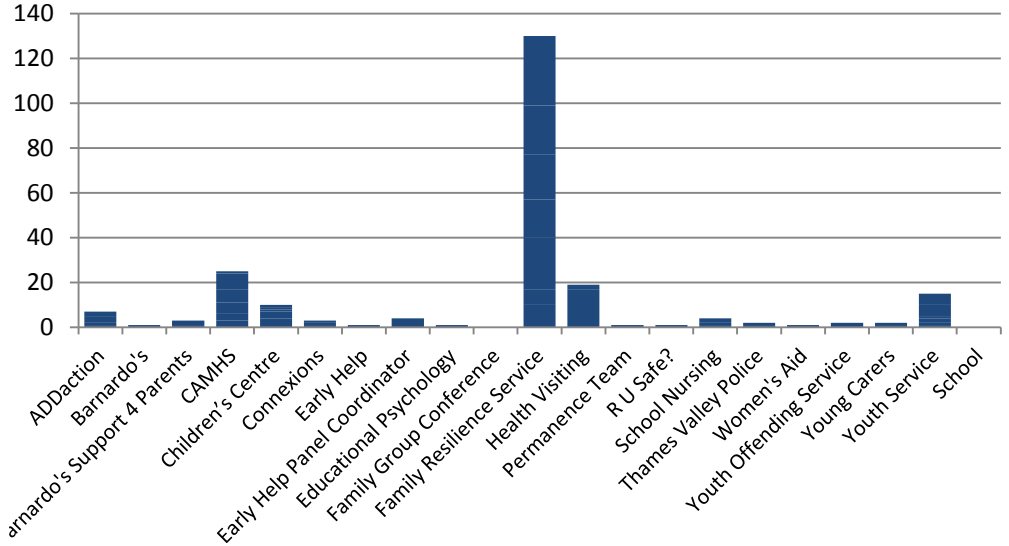


Figure 18: Rates of persistent absence at state funded primary and secondary schools

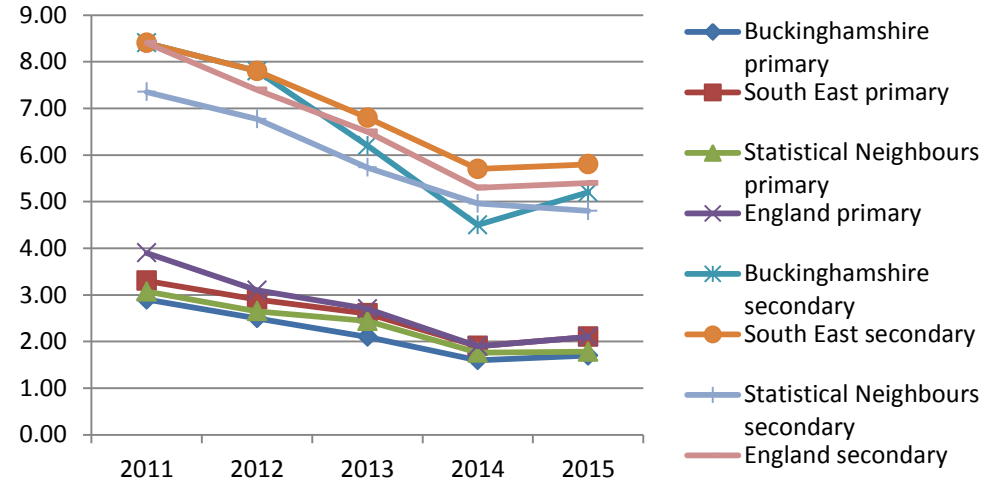
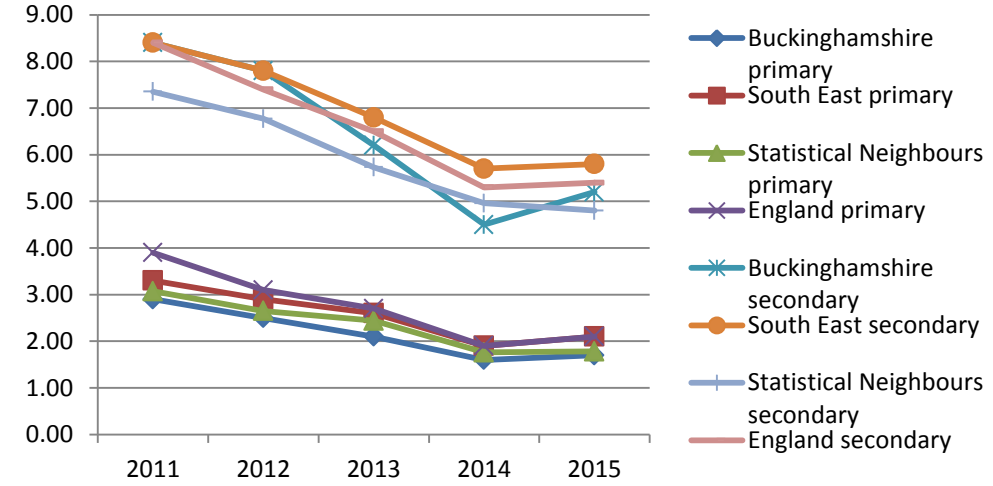


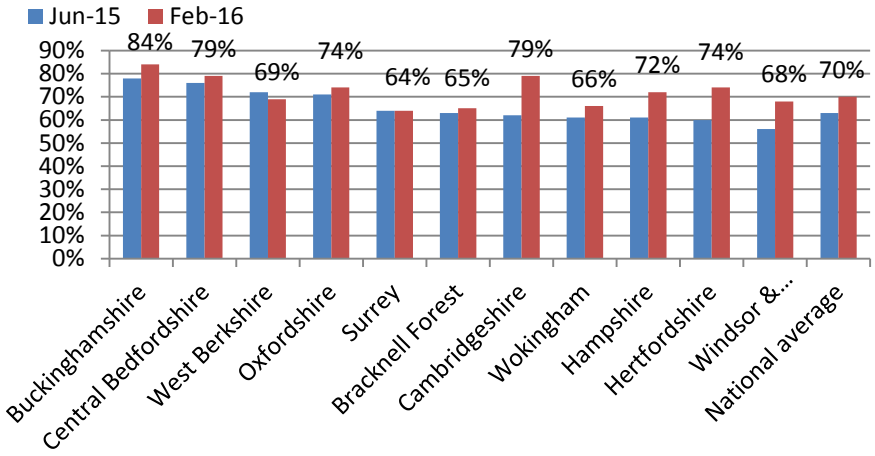
Figure 19: Rates of unauthorised absence at state funded primary and secondary schools



Looking beyond the Early Help Panel, Buckinghamshire has a **wide range of services providing Early Help support**, and our high level indicators for Early Help show that we perform well in comparison to our statistical neighbours in a number of areas.

- There is a high level of take up of targeted, **free nursery provision for 2 year olds** (figure 20). This is supported by a strong brokerage services provided through the County Council which contacts eligible families who have not taken up the offer and provides tailored support.
- Rates of **unauthorised and persistent school absence**[14] (figures 18 & 19) are lower than statistical neighbours and national average at primary and secondary level.
- Buckinghamshire has, on average, lower rates of 10-17 year olds entering the **criminal justice system** for the first time and a lower rate of young people who receive a conviction in court receiving a custodial sentence.

Figure 20: Take up of Early Years provision for 2 year olds in Buckinghamshire compared to statistical neighbours



Next Steps

There has been much progress over the last 12 months, but there is more to do. Over the next 12 months we need to:

- Continue to support **communication and awareness raising** across partners, with an emphasis on partners taking ownership of and embedding key messages within their own agencies;
- Incorporate Early Help into the BSCB **training programme**, in particular ensuring there are sufficient multi-agency early help awareness raising sessions and Family Outcomes Star sessions to meet need across the partnership;
- The BSCB has endorsed the **Outcomes Star** as the partnership early help assessment tool in Buckinghamshire. However, usage is not yet well enough embedded across local agencies; further work is needed to ensure appropriate and effective use;
- Re-run our partnership Thresholds survey and use BSCB audits to further quantify improvements in **knowledge and confidence around thresholds**;
- Further develop our Early Help dataset so that it has a greater focus on the **outcomes** achieved for children, and explore the extent to which Early Help services are meeting need. With increasing pressures on budgets across partners this will be essential if the Board is to effectively challenge and influence service provision.

[14] Persistent Absentees are defined as having an overall absence rate of around 15 per cent or more. This equates to 46 or more sessions of absence (authorised and unauthorised) during the year.

5 Our Performance: Child Sexual Exploitation

Our Aim

Children and young people in Buckinghamshire are effectively protected from sexual exploitation.

Child Sexual Exploitation (CSE) remains a key area of work for the BSCB and our multi-agency CSE Sub Group has continued to drive forward the CSE work plan. At a **strategic level** key developments include:

- The development and launch of a **Buckinghamshire strategy for tackling CSE** in February 2016: Whilst the BSCB is the strategic lead for CSE, the strategy was also signed off by the Health and Wellbeing Board, the Safer Stronger Bucks Partnership Board and the Safeguarding Adults Board in recognition of the role all agencies have in tackling CSE. The strategy has helped ensure there is a shared commitment to tackling CSE at a strategic level and in particular the Board has welcomed the Safer and Stronger Bucks Partnership Board taking ownership of the 'Pursue' strand of the strategy. Information from the CSE Strategy has also fed into the refresh of the Joint Strategic Needs Assessment, which for the first time will include a specific section on CSE.
- The development of a **CSE data dashboard**, which has helped the Board develop a greater understanding of the local profile in relation to CSE. This is monitored through the CSE Sub Group, with notable trends and 'red flag' areas of concern presented at each BSCB meeting.
- The Board ran a CSE **'pop up event'** for professionals in May 2015 which was attended by over 130 delegates. This provided an opportunity to share knowledge and learning around CSE including relating to a recent local serious case review.
- The Board has run two multi-agency **challenge events** to gather evidence around the partnership response to CSE. The first, held in August 2015 influenced the development of the CSE Strategy. The second, held in March 2016 focused on CSE and Commissioning. This considered commissioned CSE services, as well as the way CSE is taken account of in the commissioning of wider services for children and young people.

Our CSE Strategy was launched to coincide with CSE Awareness Raising day on 18th March 2016 and we received positive press coverage. We asked all agencies to sign up to a CSE Promise to show their commitment to working together to deliver the strategy. Each agency received a personalised copy to sign and display in their organisation.

- The decision by the Board to commission a **Serious Case Review** into CSE in Buckinghamshire since 1998 (see p56)
- The BSCB has continued to offer 1 day **multi-agency CSE training**. This remains outside of our training pathway meaning it is open to all professionals regardless of whether or not they have completed one of our level 2 safeguarding courses.
- The Board has supported a range of awareness raising activity. In particular partners have continued to fund the drama production **Chelsea's Choice** so this can be provided free of charge to all secondary schools and have put on 6 **awareness raising evenings for parents and carers**. Partners remain supportive of the **R U Wise to it? campaign** which continues to be developed with children who have been victims of CSE.
- The Board continues to promote the use of the **Aide Memoire** to support professionals to recognise the indicators of CSE. Our Commissioning Challenge event provided good evidence of this being used, in particular across public health services.
- The Board was pleased to hear the findings from a **Buckinghamshire County Council Scrutiny Enquiry** into CSE in November 2015, and welcomed the commitment that Members showed to exploring and further strengthening our local response to CSE.

At an **operational level**, Barnardo's R U Safe continues to provide a frontline CSE Service. The service is commissioned by Buckinghamshire County Council to work with children aged 11-18 years old (or age 21 for those with learning difficulties) who are at risk of or victims of CSE. The work includes outreach, one to one engagement and awareness raising and preventative programmes. A number of other interventions are also available to support children. For example sexual health services are working to deliver preventative outreach where young people are showing inappropriate attitudes towards women, and CAHBS (Child and Adolescent Harmful Behaviour Service), delivered through Oxford Health NHS Foundation Trust provides interventions for young people who are displaying harmful or problematic sexual behaviour.

2015/16 also saw the development of the **Swan Unit** – a multi-agency team including professionals from Thames Valley Police, Children's Social Care, Buckinghamshire Healthcare NHS Trust, R U Safe? and virtual representation from Child and Adolescent Mental Health Services (CAMHS). The unit has a number of specific functions in relation to CSE, primarily assessing risk for new referrals, managing strategy meetings (MACE), providing advice to professionals, undertaking direct work with young people and coordinating low level information in relation to CSE. All new referrals of children to Children's Social Care which involve CSE are now initially managed through the Swan Unit.

Other significant work at an operational level includes the **Hotel Watch** scheme which is now operating across the county to increase awareness and understanding of CSE amongst staff working in hotels, and work through some of our district and county

licencing services to ensure taxi drivers have a good awareness of safeguarding and CSE, and know how to report any concerns. During 2015/16 Barnardo's was also able to run a **Nightwatch** service as part of a pilot funded through the Department for Education. This programme sought to equip those working at night with the knowledge to spot the signs of CSE and have the confidence to report it. The pilot has now ended but partners are working through the Swan Unit to try and secure funding to continue this work. There has also been a good example of **innovation** by Public Health, who have used data from the county's emergency hormonal conception scheme to identify potential CSE victims by searching for patterns in individuals making repeat requests.

Effective information sharing and partnership working is promoted through monthly Multi-Agency Risk Assessment Conference **(M-SERAC) meetings**. These meetings seek to ensure children living in Buckinghamshire are effectively safeguarded and protected from harm in cases where they are or might be victims of CSE and / or they are high risk missing children or children who regularly go missing.

How many children in Buckinghamshire are at risk of or a victim of CSE?

Referrals to R U Safe? have remained steady over the year, with an average of 44.5 referrals per quarter. The total caseload has also remained steady, averaging 91 cases per quarter. There has been a slight increase in both referrals and the active caseload compared to 2014/15 (figure 21). The majority of referrals during 2015/16 came from Children's Social Care (34%) and Education providers (35%). Sexual Health Services (7%) and the Barnardo's Missing Service (7%) were the next two highest referrers. Between January and March 2016[15], 37 children were discussed at Swan Unit Strategy Meetings. An average of 8 new cases were discussed at each monthly M-SERAC meeting during 2015/16 (figure 22).

- **Age:** The majority of R U Safe? clients for 2015/16 were aged 14 (21%) or 15 (24%) and 87.5% of all CSE clients were aged between 13 and 17. The M-SERAC profile is similar; with 21% of new CSE referrals aged 14 and 21% aged 15.
- **Gender:** More females are reported at risk of or victims of CSE. During 2015/16, 90% of referrals to R U Safe? were for females. 92% of the CSE cases discussed at M-SERAC were female, and 100% of the cases that were both CSE and missing were female.
- **Ethnicity:** 79% of R U Safe? CSE clients during 2015/16 were white British. 6% were Asian or Asian British and 5% were Black or Black British (African or Caribbean). 2011 Census data recorded that 78% of the Buckinghamshire population aged between 10 and 19 was white British meaning figures are reflective of the local demographic.
- 25% of R U Safe? clients held **Child in Need** status, 19% were on a **Child Protection Plan** and 12.5% were **Looked After Children**.

[15] Data for the Swan Unit is only available from January 2016.

Figure 21: Barnardo's R U Safe? Number of children referred and number of children on active caseload

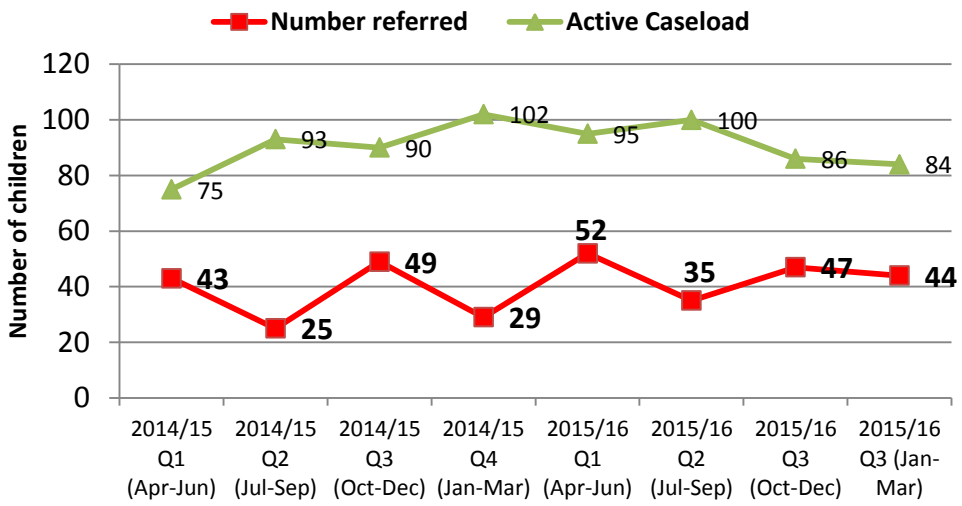
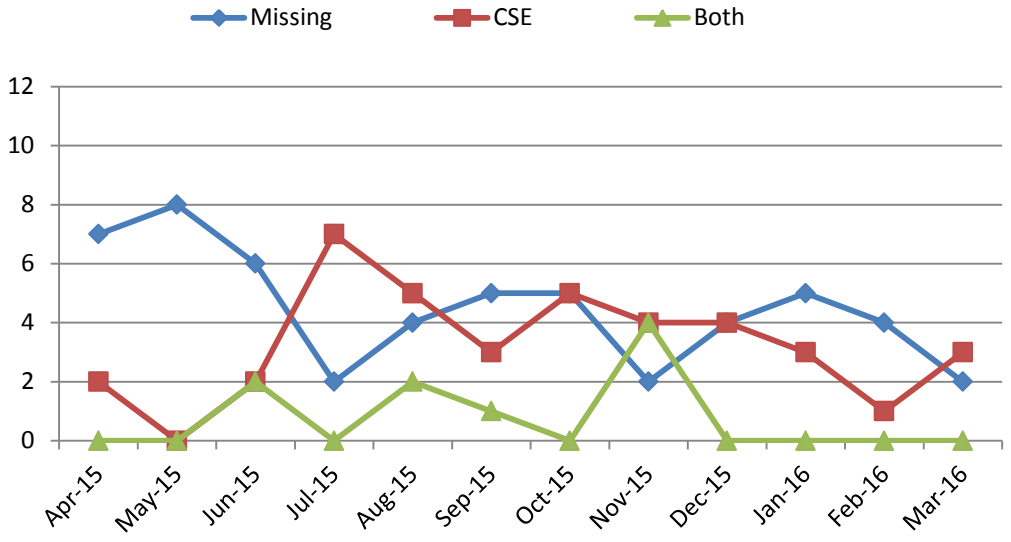


Figure 22: Number and type of new cases discussed at M-SERAC



How effective is our local approach and what outcomes are achieved for children?

- Our CSE Sub Group is chaired by a Service Director from Children's Social Care. It has excellent levels of **partnership engagement** and has driven developments at a strategic level. There is good evidence that the work of the Sub Group has had a positive impact including raising awareness and understanding amongst children and parents.
- There is strong emerging evidence around the **effectiveness of the Swan Unit** (see p27).
- There is good evidence that single agencies continue to achieve **positive outcomes** for children. For example, over the year an average of 89% of children who engaged with Barnardo's R U Safe? demonstrated **knowledge of sexual health strategies** at exit from the service and an average of 73% had **reduced association with risky peers or adults**.
- Initiatives such as Nightwatch and Hotel Watch are producing positive outcomes. For example, following training as part of the Nightwatch scheme we know of **1 referral** by a taxi driver and **3 arrests** being made after concerns were reported to hotel staff.

Evidence of Impact: Chelsea's Choice

*'"I will now make sure I keep all my social media on **private.**"* **(Feedback from school pupil)**

*"It made me **more aware** of the issue and has made me **more careful** on the internet"* **(Feedback from school pupil)**

Staff from **13 secondary schools** fed back their views on the production which was delivered in Autumn 2015. **100%** said the production was a useful way of **raising the issues of CSE and grooming** with their students.

We received **534 evaluations from school pupils**. **79%** said it had **changed their attitude** / opinion towards the issues of CSE and grooming. **98%** said they found what they learned through the play was very **helpful** (68%) or quite helpful (30%). Pupils also indicated a range of ways in which the play had impacted on them including **28%** recognising that they needed to **treat others with more respect** and **24%** saying they would delete all those they had not met face to face from their **online friends** list. In response to a question about whether they were worried about themselves or a friend, 114 pupils said they were. Of these, 59 said that as a result of watching the play they now knew they could ask for help and where to go for this.

Next Steps: We are already planning the next wave of Chelsea's Choice for September 2017. Our planning is taking on board the feedback from both schools and pupils including continuing to ensure this is provided free for all secondary schools and looking at how to supplement the production with classroom sessions.

*"It has **changed my perspective** as to how often it occurs and how easy it is to be fooled."* **(Feedback from school pupil)**

*"I now know that you **shouldn't trust** everything and everyone on the internet."* **(Feedback from school pupil)**

*"It is very detailed and presented well. It shocks enough to get the students talking about it without being too overwhelming. **Very well thought out**."* **(Feedback from teacher)**

Evidence of Impact: CSE Parents Evenings

*"The session was an **eye opener** to me. It made me feel uncomfortable but it is essential knowledge."*

In October 2015, Board partners ran 6 evening sessions to raise awareness of CSE with parents and carers. We received 128 evaluation forms from the **240** people that attended. 76% of respondents said they either knew nothing or were not confident about issues relating to CSE prior to the session**. 100% said their knowledge improved** as a result of the session.

Next Steps: Although those who attended found the session beneficial, the CSE Sub Group wants to think about how to **reach a larger number** of parents, carers and community members over the next 12 months.

*"You have been so **informative** and approachable. Your knowledge is invaluable – thank you for giving up your time in teaching us, informing me and giving me sites to turn to for further information."*

*"The whole panel provided a **positive** picture of joined up working."*

Storyboard: The Multi-Agency Swan Unit

Why did we seek improvement?

The Swan unit was developed in response to findings from a number of high profile **national enquiries** relating to CSE. The aim was to ensure:

- Children at risk of or victims of CSE receive effective and coordinated provision;
- Professionals are effectively supported to work with children at risk of or victims of CSE.

What did we do?

- Set up a **multi-agency team** co-located in Aylesbury Police Station;
- Increased partners to include Education, RUSafe?, 2 permanent CSE specialist social workers, 2 full time Police engagement officers, a full time Detective Sergeant and a Children's Social Care Practice Improvement Manager;
- Improved **IT systems** so all agencies can access their systems from the police station;
- Take referrals from other social care teams so the Swan Unit can **joint work** with the allocated social worker;
- Presented **training** to schools and services on CSE, leading to more appropriate referrals;
- Developed a **Quality Assurance Framework** to provide a methodical way of evaluating the unit.

Evidence of impact and outcomes?

An audit of the Swan Unit commissioned by the BSCB and undertaken in April 2015 found:

- The **practice** of the Swan Unit was broadly very positive, providing a professional, dedicated, effective and balanced service;
- Strategy discussions are producing **good decisions and outcomes** and management decision making and rationales for next steps are effective and visible;
- **Partnership working** is generally excellent at all levels of involvement;
- The **voice of the young person** is being sought, recorded and taken into account in decision making;
- The **outcomes** achieved for young people were well judged, and the advice and information provided was clear and comprehensive.

The journeys of individual children are also providing evidence of positive outcomes. This example relates to a Joint Investigation between a Police Engagement Officer and a Social Worker from Swan Unit.

A 14 year old was reported missing with concerns about her meeting an older male while missing. The child ('A') disclosed being in contact with an older male online and that he had encouraged them to meet him and sent indecent messages. 'A' was supported to explain this to their family, a Video Interview Recording was completed and the perpetrator arrested swiftly. The parents were provided with space to share their thoughts and concerns and given advice and resources to help them understand grooming and keeping their child safe. 'A' was referred to R U Safe? for ongoing awareness raising and counselling. The parents said they were impressed with and grateful for the specialist support they all received at such a difficult time.

Next steps?

- Consider the remit of the unit in relation to **children missing** and other forms of **exploitation**;
- Have a permanent CSE **specialist nurse** to sit in the Swan Unit and include an **Addaction worker** in the strategy meetings;
- **Train** taxi drivers across Buckinghamshire to recognise the signs of CSE and report concerns;
- Swan Unit to undertake regular **auditing and monitoring** activity which will be reported to the CSE Sub Group.

Next Steps

Whilst there is good evidence of an **effective, coordinated approach**, there are a number of areas where we need to do more over the next 12 months.

- We need to do more to ensure our **communication and awareness raising** is effective at reaching all sections of the community including black and minority ethnic communities, and that we can sustain work with those community members who are in a good position to spot and report concerns.
- We need to strengthen our understanding of the link between **CSE and learning disability** and scrutinise whether we have a robust local approach in place in this respect.
- Although we have some strong local services in place, the CSE Sub Group has identified some potential **gaps in provision** for children who are victims of CSE as they become **adults**, and for adults disclosing CSE in their childhood. We will continue to work closely with the Safeguarding Adult Board and the Safer, Stronger Bucks Partnership Board to influence the development of appropriate local provision.
- The CSE Sub Group has identified potential gaps in the support available for **siblings and parents / carers** of CSE victims. We need to look further at how we ensure that families are effectively supported.
- We need to further strengthen our dashboard to ensure it provides increased **evidence around outcomes**, including whether children are being identified and receiving the right help and support as early as possible.
- In response to feedback from partners we need to consider a more **coordinated approach with other forms of exploitation** including radicalisation, human trafficking and modern day slavery, recognising that the signs, vulnerabilities and grooming behaviours across these types of exploitation can be very similar.
- We need to **learn lessons** from the effective, targeted approach to CSE to inform other forms of exploitation.

Tackling Peer-on-Peer Abuse

Since January 2014 the **MsUnderstood Partnership**, led by the University of Bedfordshire, has been working with practitioners in Buckinghamshire to develop contextual and holistic responses to peer-on-peer abuse (peer-on-peer CSE, serious youth violence, harmful sexual behaviour and teenage relationship abuse). A number of successful pieces of work have helped progress our local approach after the last 12 months including:

- The development of a **train the trainer programme** to ensure consistent message on the nature of peer-on-peer abuse across agencies.
- A detailed **case review** of 5 peer-on-peer cases. The learning from the review was shared with over 80 professionals from across Buckinghamshire at a learning event in November 2015. A **series of vignettes** were also produced from the review, which are now being used for training. The review raised specific questions around:
  - The response to the impact of **domestic abuse** on children and young people;
  - The role of the youth service and **community based responses** to neighbourhood based risk;
  - **Peer group** influence and intervention;
  - The influence of **siblings** on young people's vulnerability.

This work identified some examples of **effective and contextual responses** to peer-on-peer abuse in Buckinghamshire including:

- Peers, schools and neighbourhoods involved in assessment processes;
- 1:1 interventions delivered within schools and in partnership;
- Successful outcomes in terms of criminal justice process;
- Services sticking with young people.

Next Steps

We are committed to **continuing this work** when the support from the University of Bedfordshire comes to an end in May 2016. In particular this will enable us to further explore those questions raised through the case file audit.

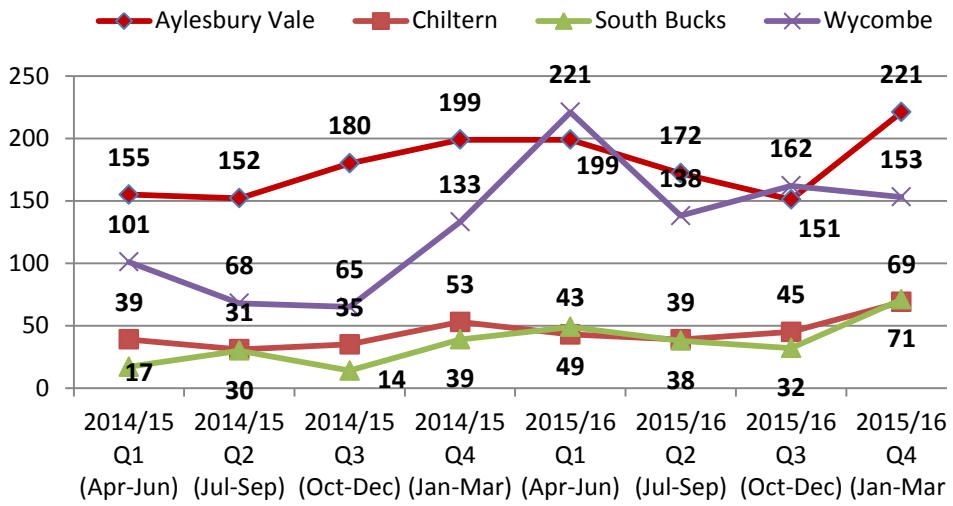
Children Missing

This year the Board has started to achieve greater oversight of the local picture of children missing, through incorporating data into our CSE dataset and receiving reports to the Board. Whilst this has highlighted a number of **local challenges**, there is also evidence of **good practice**.

At an operational level, M-SERAC acts as the multi-agency risk management meeting for both CSE and missing. Combining missing and CSE into a single meeting recognises the link between missing and CSE and facilitates a joined up response.

Barnardo's R U Safe? provides a missing service, including completing return home interviews for children returned from missing episodes**. 68%** of the clients they worked with over the year had a **reduced number of missing episodes** after working with them, and **71%** had **reduced association with risky peers or adults**.

Figure 23: Missing Episodes for Children in Buckinghamshire by District Council (source Thames Valley Police)



Over the last year:

- Aylesbury Vale and Wycombe have higher numbers of missing episodes for children compared to the other districts (figure 23). There was a notable spike in missing episodes in Wycombe District between Oct-Dec 2014 and April - June 2015. This caused a spike in the overall figures for the County and was due to a high number of repeat missing episodes for a single young person.
- **79%** of missing episodes have been for children aged between **14 and 17.**
- **48%** of missing episodes were children from a **white background**, 21% from a mixed or non-white background and in 31% of cases ethnicity was not recorded or not stated. This suggests a disproportionate number of episodes from non-white children.
- Overall **girls** have slightly more missing episodes than boys (**57%** and 43% respectively within the key 14-17 age group).
- Overall the trend over the last few years has been an **increase** in the number of missing children.

Next Steps

When our Board members completed a self-assessment against the criteria for a good LSCB, they identified that good progress had been made around CSE, but that children missing remained an area for development. Over the next 12 months the Board needs to:

- **Improve our dataset** around children missing to further enhance the Board's understanding and oversight of the local picture and to enable more effective challenge;
- Improve our knowledge around **children missing from education;**
- Improve the timeliness of **face to face interviews** for children.

At an operational level, work will continue to look at new solutions to **reduce the number of missing episodes**, focusing on the high demand created through **repeat missing episodes**. There is also a need to ensure we have the right planning and procedures in place to effectively safeguard children who are **placed out of county** and subsequently go missing, as currently this is an area of challenge.

6 Our Performance: Child's Voice and Journey

Our Aim

The BSCB can demonstrate the link between its challenges and service improvements for children and young people.

Understanding the voice and journey of the child continues to be a priority that is reflected across the activity of the Board and all of the Sub Groups. Over the next 12 months we need to seek further opportunities to make sure there are continued opportunities for children and young people to **influence** the activity of the Board.

Female Genital Mutilation (FGM)

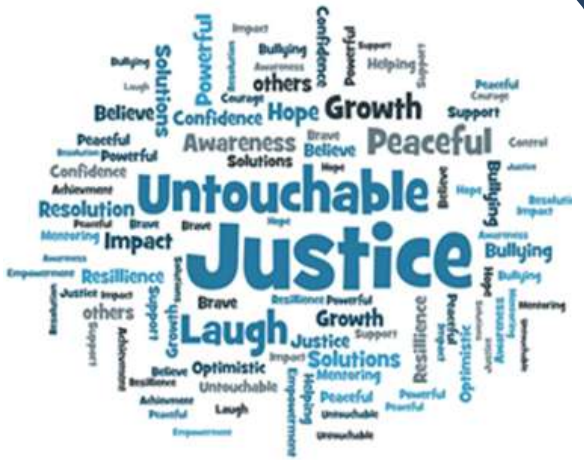
This year FGM has been a new area of work for the Board. Whilst the prevalence of FGM is not as high in Buckinghamshire as in many of our neighbouring authorities, the BSCB has led work to ensure there is a **proportionate and coordinated partnership approach** to tackling FGM. In September 2015 we jointly hosted an **FGM Challenge Session** with the Health and Wellbeing Board. This enabled us to gather information on current practice and identify areas for further work. The output from this session fed into the development of a draft partnership FGM **action plan** and a draft Buckinghamshire wide **strategy** for tackling FGM. Discussions between the Chairs of the Health and Wellbeing Board, Safer Stronger Bucks Partnership Board, Safeguarding Adults Board and the BSCB led to a decision that the Health and Wellbeing Board would act as the strategic lead for FGM.

Next Steps

This year we have started to put the foundations in place. Over the next 12 months we need to:

- Ensure the Buckinghamshire **strategy for tackling FGM** is published to provide a clear, coordinated vision for preventing and responding to FGM;
- Work in partnership to **increase awareness** of FGM with both professionals and the general public;
- Update our FGM **guidance and procedure** for practitioners to ensure we have a robust and clearly articulated procedure to help practitioners respond effectively and appropriately to cases of FGM.

Youth Voice Steering Group



During the Youth Voice Bullying event, the young people created this word cloud which reflected their thought on resilience and overcoming bullying.

The Board has continued its involvement with the Youth Voice Steering Group. This has included:

- Working with a group of young people to get their views on our Board priorities and to design a **children and young person's version of our Annual Report for 2014-15**.
- Running a **consultation** with young people about the information we provide for children and young people on our **website**. Those involved gave us some clear feedback that they would value information on safeguarding topics, but that they did not like our current format. The storyboard on p33 describes how their feedback led to the Board decision to commission a separate microsite for children and young people.
- Participating in a **Youth Voice event on Bullying**. This gave the Board the opportunity to hear directly from young people about the impact that bullying can have on their lives. The young people came up with some brilliant solutions for helping to tackle bullying and as a direct result of this the BSCB agreed to co-fund with Buckinghamshire County Council two trial Zap Bullying Workshops delivered by Kidscape, which will work holistically with the child and their parents to develop bespoke approaches for understanding and managing bullying.

Working with Youth Voice has also provided some good insight into how a number of our partners are working collaboratively with young people to influence the services they provide

"Bullying isn't gonna stop no matter how hard you try." **15 year old female, South Bucks**

"I have been bullied my whole life - at school, outside & on social media. Don't fight back. Ignore, don't react. To the bully I say - grow up & get a life. Leave people to get on with their lives. Don't take your problems out on other people." **15 year old female, Missenden area.**

Next Steps

Over the next 12 months we need to:

- Launch our new **children and young people's microsite** and continue to gather feedback so that we can make sure it is meeting need;
- Work with the Youth Voice Steering Group on a children and young people's version of this **annual report;**
- Hear the feedback from the **Zap Bullying workshops** and evaluate whether this approach provided good outcomes for young people.

Storyboard: BSCB Microsite

Why did we seek improvement?

During their 2014 inspection, Ofsted recognised that the BSCB website needed to be improved to make it **more accessible** to different audiences. Our website includes a section for children and young people and we wanted to work with them to understand what improvements we could make to this section of the site.

What did we do?

Consultation: We worked with the County Council's Youth Participation Team and the Youth Voice Steering Group to gather the views of children and young people on our current website. The consultation included:

- 2 focus groups (High Wycombe and Aylesbury);
- Social media requests for feedback;
- Youth workers engaged young people and gathered feedback at youth clubs.

Key findings: It was hard to engage young people in this consultation. This suggested the Board was not visible to young people and the current pages for young people were not written in a way that met their needs. Those that did engage worked really hard and told us what they wanted to change:

- Website too cluttered, illogical layout and not easy to navigate;
- Not enough headings, pictures or other ways to break up text;
- Website feels too corporate –would prefer a separate site for young people with its own branding;
- Language is too formal and not written for children and young people.

Action: The findings were fed back to the Board in September 2015 and they agreed to fund a completely new 'microsite' for young people. Since then we have worked with the Youth Voice Steering Group to design and agree the branding, name, logo and content for the site.

Evidence of impact and outcomes?

Young people have **influenced** the Board's activity:

- The feedback from the young people directly led to the Board's decision to fund a new microsite for children and young people.
- Our continued work with the young people means they have had control over deciding the name for the site (Safe Space) and have significantly influenced both the design and content. The web designer made a number of changes to the site design in direct response to the feedback from the young people. This included increasing the prominence of social media links and adding an easy format for young people to feedback their views on the website pages they visited. This function will not only be added to our microsite, but our web provider will also be able to roll this out to our main BSCB site and use it across other organisations they are working with.

The young people made a number of comments that were relevant across the whole of the BSCB website, not just the pages for young people. We have made a number of changes in direct response to their feedback including:

- Adding moving 'sliders' to the home page to promote key messages;
- Simplifying the layout of all pages;
- Changing the position of the search box on our home page.

Next steps?

Over the next 12 months we plan to:

- **Build and test** the new website through the Youth Voice Steering Group;
- Work with the Youth Voice Steering Group to **launch and promote** the site;
- **Monitor** usage and continue to make improvements in response to feedback;
- Ensure the site is well linked to other relevant local sites in Buckinghamshire to reduce any duplication of information.

E-Safety

This area of the Board's work is delivered through our **E-Safety Sub Group** which continues to have strong multi-agency engagement.

Key achievements

- Two E-Safety **conferences** delivered in partnership with Buckinghamshire County Council; one for professionals and one for children and young people. The storyboard on p35 provides further detail and evidence of outcomes.
- Between them, our sub group partners have delivered **136 sessions** on e-safety to **17,500 participants**. This includes delivering full school assemblies and training small groups of professionals on CEOP (Child Exploitation & Online Protection Centre) training days.
- Researching, refreshing and updating the **web pages** on e-safety on the BSCB website.
- Supporting the peer education **E-Safety Ambassadors** project and hearing directly from young people involved at our subgroup meetings.
- Supporting the CSE Sub Group by providing information on e-safety at the **CSE parents evenings** (p23 & 26).

"The day was informative and inspiring and I look forward to further events of this kind." **(Delegate at professionals conference)**

"What a great event it was – all of our students who attended were very engaged in the day and found the content both thought provoking and very informative." **(Feedback on conference for pupils)**

Next Steps

Over the next 12 months priorities include:

- We continue to get regular feedback that e-safety remains a big area of concern, in particular for schools. We will therefore run two further **conferences** (one for professionals and one for students) with a focus on e-safety and bullying.
- Schools are telling us that **sexting** is a big issue. We expect updated government and police guidance around this in the coming months which we will then promote to relevant partners.

Storyboard: Online safety – Raising the profile 2016

Why did we seek improvement?

As part of their inquiry into online safety (presented to the BSCB in March 2015), the Buckinghamshire County Council **Select Committee for Children's Social Care and Learning** made a recommendation for a **conference** to be held for professionals and young people to raise the profile of online safety. They, and the BSCB E-Safety Sub Group, recognised there were lots of projects happening around the county and felt it would be helpful to share good practice and learn from each other.

At the same a wide range of **concerns** were being expressed by schools and other professionals about sexting and other matters relating to e-safety including the link to CSE and grooming. Online safety is an ever developing area with a constant need to keep informed and updated about new threats and risks.

In addition, **Ofsted** now set clear criteria in their inspection framework about the requirements placed on schools about online safety.

What did we do?

Two conferences were delivered in February and March 2016. One conference focused on **schools** and other **professionals**, the other was for **young people**. The conferences covered topics such as online bullying, digital footprint, sexting, online grooming and radicalisation to match with the areas of concern being highlighted by professionals. A group of young people involved in the E-Safety Ambassadors programme presented at both conferences to raise awareness of this programme. External speakers from Ofsted and Intel Security attended as key note speakers to provide some expert input and young people were able to view a drama production from Bigfoot Arts Education.

A **write up** was done for each event and published on the BSCB website so that the learning could be shared more widely.

The event raised awareness of resources available for different audiences and of local services such as RUSafe? It helped us negotiate an offer with Parent Zone to provide a 20% discount on membership that will assist schools in meeting their duties around online safety. It also helped us collect more evidence of the needs and support requirements professionals have around e-safety.

Evidence of impact and outcomes?

- **36 pledges** made by schools and professionals to improve online safety awareness and support following the conferences. We are now following up on all of these pledges to see how many were delivered and to date there is good evidence of change. This includes signing up for Parent Zone, running a school Internet day, running sessions for parents, working with students around privacy settings and school staff undertaking further e-safety training. One school has trained 18 year 9 students as E-Safety Ambassadors. They will now be visiting local primary schools to speak to year 6 pupils about staying safe online.
- **12 different school** and colleges represented.
- Evaluations provide good evidence that the conferences were helpful including **increasing confidence** around how to deal appropriately with e-safety incidents and providing support for making future changes around e-safety.
- Consistent levels of requests from schools and youth organisations for online safety awareness raising sessions.

Next steps?

- Deliver further **two conferences** in 2017;
- Continue to provide specific and specialist information via our **website** and at **pop up events** to help professionals keep up with this fast paced agenda.

7 Our Performance: Neglect

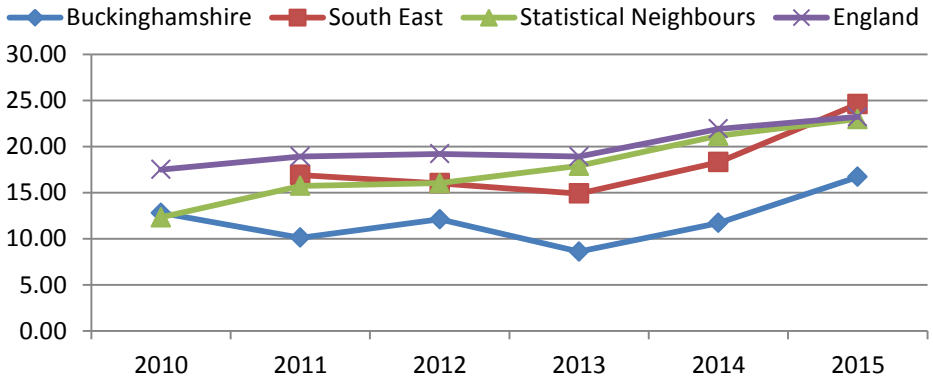
Our Aim

- **Early Help is available to support children and their families where there is evidence of neglect;**
- **Positive action is taken to ensure that children's development, emotional and wellbeing needs are met and they are able to meet their full potential.**

Research nationally identifies neglect as the most common reason for children to become subject to a child protection plan.[16] Compared to both statistical neighbours and national, Buckinghamshire has lower rates of children on a child protection plan for neglect (figure 24). However, in recent years there has been an increase in numbers locally, nationally and for statistical neighbours. Within Buckinghamshire, neglect remains **the largest category of abuse**. Although neglect has been a BSCB priority for the last 2 years, there has been no dedicated Sub Group to drive this work forward and the work plan has been under-developed.

In the last financial year, the BSCB agreed to endorse the **Graded Care Profile** for use in cases of neglect. During 2015/16, the NSPCC took ownership of this tool at a national level. They indicated that they would be launching an updated version of the tool and that this would be the only authorised version. The NSPCC refresh of the tool has involved extensive research and piloting. This is important in terms of ensuring the effectiveness of the tool is backed by a clear evidence base, but it has meant that the Board's work to roll it out has been delayed until the new Graded Care Profile 2 is launched. The Early Help Sub Group has kept in touch with the development of the tool and over the next 12 months will seek to become engaged with piloting at the earliest possible opportunity.

Figure 24: Children becoming the subject of a Child Protection Plan for neglect (rate per 10,000 children under 18)



[16] Department for Education. (2014) *Indicators of Neglect: Missed Opportunities.* Available from: https://www.gov.uk/government/publications/indicators-of-neglect-missed-opportunities

In the meantime a multi-agency **task and finish group** was set up in early 2016, reporting to the Early Help Sub Group, to work specifically around neglect. Work has started on drafting a **strategy for tackling neglect** and a multi-agency workshop is being planned for summer 2016 to feed into the further development of this strategy. In April, the Performance and Quality Assurance Sub Group commissioned an **audit around neglect**, which will feed into the development of our forward approach.

Next Steps

Our work on neglect has not had enough pace over the last 2 years. Over the next 12 months we need to:

- Publish a Buckinghamshire **strategy for tackling neglect** as currently there is no clear **vision or strategic approach** set out for partners.
- Better align our work on neglect with our **Early Help** priority. This reflects that a key element of our strategy will be that all agencies should be able to recognise and respond to the early signs of neglect. Having ownership through the Early Help Sub Group will also help drive progress on this work more quickly.
- Pilot the new NSPCC version of the **Graded Care Profile** and evaluate whether to roll this out across the wider partnership.
- We are not yet well enough engaged on this agenda with the broader set of local services that are in a good position to **spot the signs** of neglect – for example animal welfare organisations, refuse collectors and planning officers. This is an area for improvement.

Our short commercial, made with the Safeguarding Adults Board reminds people that we are all responsible for spotting signs of abuse and neglect.

We are supporting the Department for Education campaign to encourage the public to sport and report any concerns about children.

Learning from Audits: Children Subject to a Child Protection Plan for Neglect

Why did we do it?

The BSCB is embarking on an extensive work programme around neglect. To feed into this work, this externally commissioned **audit of 25 children's journeys** focused in particular on:

- Whether **early help** interventions were being put in place;
- Whether the **Graded Care Profile** was being used;
- How effectively the **voice of the child** was taken into account;
- The quality and effectiveness of **multi-agency working, information sharing and planning;**
- The appropriateness of **threshold decisions.**

What did we find?

Strengths

- Child protection plans were reviewed very regularly via conferences and core groups;
- There was generally a good perception of professionals working together via core groups;
- The threshold for child protection planning was generally sound;
- There was a good level of attendance by parents at conferences and core groups.

Areas for development

- The recording of children's views by all professionals needed to be clearer;
- Child protection plans were not adequately describing the detail of the work being undertaken;
- Clearer roles should be set out for partner professionals in the child protection plan;
- Partner professionals should be prepared to challenge drift in planning;
- There was only one example of the Graded Care Profile being used.

What improvements have taken place?

- **Training** is being run for conference chairs which covers those areas identified for development;
- Children's Social Care have undertaken further **audits** which shows some progress but suggest there is further work to be done.

Next steps?

- The conferencing manager will continue to **re-audit** cases on a 1:1 basis with conference chairs so that improvements can be evidenced;
- Given the learning that is also emerging from recent Serious Case Reviews around effective **challenge and escalation**, the Board is planning further work in this area.

8 Our Performance: Improving the Effectiveness of the BSCB

Our Aim

There is real collective ownership of the Buckinghamshire Safeguarding Children Board which is well regarded by partners and the community because of the positive difference it makes to outcomes for children and young people.

The Board set this priority following our inadequate Ofsted rating in summer 2014. By the time of our last annual report the Board had already made good progress in relation to a number of those areas identified for improvement. Over the last 12 months there has been a **sustained effort** from Board partners to continue this improvement journey. A partnership view of our improvement was provided when all Board members undertook a **self-assessment** of the BSCB against the Ofsted criteria for a good LSCB in March 2016. Some of the feedback has been used through this report in relation to specific priorities. Key messages relating to **governance and challenge** are summarised below.

Areas of improvement	Areas for further development
Stronger governance arrangements in place	We need to do more to evidence the impact and outcomes of our work for children and families
Joint Protocol has strengthened relationship between Boards with good evidence of joint working and challenge. This is starting to impact on priorities	Ensure all agencies are sharing ownership and taking the lead on different areas of work
Improvement and development plan articulates priorities and is regularly updated	We need to improve our understanding around children living outside of the local authority area
Improvements in data are starting to inform priorities	Need to ensure level of challenge is consistently high across all Sub Groups
Much more evidence of challenge at Board meetings and within Sub Groups	Budget contributions from partners are an ongoing challenge as all agencies are facing financial pressures
Newsletter helping to disseminate key messages	Need to undertake next Section 11 audit to gather up to date evidence on partner compliance

Feedback from this exercise was analysed in detail and has informed updates to our Board **Improvement and Development Plan**. All of those areas identified for further work have already been addressed or now have work underway to address them.

"Significant improvement has been made on promotion of a 'we are all in this together' culture – greater openness and transparency." **(Board member feedback)**

"I have been empowered and am confident to make appropriate challenges." **(Board member feedback)**

"The BSCB newsletter is helpful in disseminating information to frontline staff." **(Board member feedback)**

"There has been continuous improvement in board processes since changes were implemented in 2014…It feels that there is still work to do, but it is on the right path" **(Board member feedback)**

Joint Working

In early 2015 we agreed a **Joint Protocol** which set out arrangements for partnership working between the 4 strategic boards operating in Buckinghamshire (BSCB, Buckinghamshire Safeguarding Adults Board, Health and Wellbeing Board and Safer Stronger Bucks Partnership Board). Over the last 12 months these relationships have developed, and throughout this report there are some examples of the impact this is having. In January 2016 the Chairs of the 4 Boards met, and will continue to do so at least annually to ensure that partnership working remains strong and is having a positive impact on priorities.

Examples of impact

- There have been examples of **effective challenge** between Boards, for example to clarify governance arrangements;
- **Strategic leadership** for key agendas which are relevant across different boards has been agreed leading to increased clarity;
- Annual reports are presented across the different Boards to facilitate **joint working**, reduce duplication and to allow the Board's to influence each other's priorities;
- The Boards have worked together on challenge sessions to gain assurance and identify areas for improvement;
- The Board Business Managers / lead officers meet regularly to discuss forward work plans and to share emerging areas of **risk**;

Communication

We have made sustained efforts to improve Board communications over the last 12 months. We now have improved links with Communications Officers within our partner agencies and have widened the formats and methods we use for disseminating information. Key progress includes:


Buckinghamshire Safeguarding Children Board
Information Update

- The development of a **Board newsletter** in July 2015. This is published between Board meetings to provide information on topics the Board has been discussing along with other key safeguarding issues. It is widely distributed across partners with positive feedback received to date. Over the next 12 months we will seek to widen readership further and evaluate the reach and impact of the publication.
- Learning from audits, challenge sessions and other BSCB events is now shared via short **briefing papers** published on our website and circulated to partners. Feedback has been that this is making it easier to access and share information within their agency.
- We have made further significant improvements to our **website**, taking on board feedback from users. Over the next 12 months we will undertake a formal evaluation of these improvements.
- We have widened our **public facing communications**, and examples are provided throughout this report. This is an area where we aim to improve the consistency of our approach further over the next 12 months.

Supporting Schools

Support around safeguarding is provided to schools via the local authority's **Education Safeguarding Advisory Service** (ESAS). During the year there have been significant capacity concerns within this team, and this led to a challenge from the Board to the Local Authority. By the end of the financial year capacity within the team was increased and assurance provided that the level of support would be maintained.

Despite these challenges, ESAS remains a well-regarded service that has continued to undertake significant work to support schools. In particular, ESAS has launched a **revised training pathway** and refreshed the training available for Designated Safeguarding Leads (DSLs) to ensure it focuses on new and emerging priorities such as Prevent. During 2015/16 ESAS delivered refresher training to 184 DSLs in Buckinghamshire and trained 141 new DSLs. ESAS also works closely with the Bucks Learning Trust, which is commissioned by Buckinghamshire County Council to provide a range of services, including support for school governors. The Trust continues to ensure that appropriate safeguarding training is available for school governors.

School compliance with safeguarding responsibilities

ESAS monitors the compliance of schools with their safeguarding responsibilities via the **Annual Safeguarding Report to Governors**. An updated format for this report was agreed by the BSCB following concerns raised by schools that the previous format was too onerous. ESAS worked collaboratively with schools to develop an updated version, which took account of this feedback, whilst still ensuring the tool remained robust. The total number of returns for 2014/15 (results for 2015/16 are not yet available at the time of writing this report) was **81%**, which is the lowest rate of return for 5 years. This is likely to be down to a combination of factors including high rates of change within schools' leadership of safeguarding, the change-over in tool part way through the year, and the updates to Keeping Children Safe in Education 2015, which removed the previous reference to the responsibility of the Designated Safeguarding Lead to provide a formal annual report on safeguarding to governors. There is now capacity within the ESAS team to support increased returns for the next year.

Key Themes from School Safeguarding Returns

Good practice

- Each school has at least one Designated Safeguarding Lead and a safeguarding governor has been appointed;
- All schools have a minimum of at least one senior leader who has undertaken training to ensure safer recruitment principles are adhered to;
- All schools have a child protection policy in place, and a process for reviewing this.

Challenges

- Not all schools have robust record keeping systems, including to document training received by all those who work in the school. This means they cannot evidence how they meet the training needs of staff;
- Staff turnover continues to create challenges for schools, including in relation to ensuring robust safeguarding arrangements are in place;
- Some schools are using the model Child Protection Policy without tailoring this to their specific school needs and safeguarding issues;
- A number of schools are struggling to create ownership of their staff code of conduct which is central to staff working practice.

These challenges will be areas of focus for ESAS as they continue to work with schools. Other areas of focus for the coming 12 months have been developed based on feedback from schools. These include increased work around **healthy relationships** with primary schools, work with schools around **Female Genital Mutilation** and increasing understanding of **peer-on-peer abuse**, and tailored support for **special schools.**

A Safe Workforce

The BSCB has an **Employment Sub Group** which is run jointly with the Safeguarding Adults Board. Its remit is to ensure that people working with adults and children are safe to carry out that role.

Key achievements:

- Work has continued around the **transport sector** following the completion of an audit by Buckinghamshire County Council last year which raised some safeguarding issues. Progress is shown in the story board on p45.
- Following significant work last year to look at the response to the recommendations in the **Lampard Report** (relating to Jimmy Savile) within local hospital settings, the Sub Group has continued to gather assurance including around the response to the learning within a wider range of settings.

Next Steps

- The Sub Group has agreed an improved reporting framework for **LADO data** for the next financial year, which now needs to be implemented to ensure the Board has improved oversight of the management of allegations.
- The Sub Group has planned a **challenge event** to gather further assurance around how the learning from the Lampard report has been embedded across partners. This will ensure that any remaining challenges can be identified and that good practice can be shared.
- Some of the Board's key resources to support **safer employment** need to be updated so that professionals have access to clear and up to date information.

Allegations against People in a Position of Trust

Each Local Authority is required to have a nominated officer (in Buckinghamshire this is the LADO or **Local Authority Designated Officer**) to coordinate responses and action where an allegation is made that someone who works or volunteers with children may have:

- Behaved in a way that has harmed, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child in a way that indicates s/he may pose a risk of harm if they worked regularly and closely with children.

The LADO is a member of the Employment Sub Group and data on allegations is provided regularly for discussion. During 2015/16, there were **543 contacts to the LADO**. This level of contact is similar to the previous year (525 contacts). The largest number of contacts related to alleged sexual behaviour (26%, and 15% for online sexual behaviour).

The 543 contacts related to concerns about staff in a wide number of settings. The highest number of contacts were made in relation to the staff working in the following settings:

Setting	Contacts
Education	179
Early Years (child minders, pre-schools, nurseries)	102
Health	53
Residential Care	46
Foster Care	43
Transport (e.g taxi drivers, passenger assistants, bus drivers)	43
Sports Coach	16
Faith Setting	15

Of note compared to last year, is the slight increase in the number of referrals relating to individuals working in health settings. In the last annual report the low number of referrals relating to these settings was noted. The increase this year does not necessarily indicate an increase in incidents but may be a positive result of increased awareness around how to raise concerns and the importance of this.

Last year an increase in the number of allegations relating to transport staff was noted. This followed awareness raising activity within the sector and close working between the LADO and transport managers. The level of contacts relating to this sector has remained steady suggesting there is an ongoing impact from this work.

Next Steps

- This year has seen the introduction of a **new data system** for the LADO to improve the team's recording and reporting capabilities. However, further work is required over the next 12 months to ensure that this system beds in effectively and that the Employment Sub Group receives the right data to give a robust narrative around this area of work.
- In January 2016 the Board heard a report from the LADO which raised concerns around **capacity** within the team. The LADO provides a function that makes a vital contribution towards ensuring that children and young people are effectively safeguarded and work will be needed over the coming 12 months to ensure these challenges are effectively resolved.

Storyboard: Client Transport Safeguarding and Compliance

Why did we seek improvement?

Autumn 2014: Amey commissioned an independent safeguarding report into client transport services. It identified two main areas of concern:

- **Safer Selection:** Not all Transport Providers complying with safer selection requirements.
- **Training:** Mandatory training to be provided for all drivers and passenger assistants (PAs) working on contracts for vulnerable children and adults.

Scale of operation

- Approx. 12000 passengers transported daily;
- Approx. 75 transport providers;
- 2650 drivers or PAs currently hold a County Council identification (ID) badge and work on client transport services.

What did we do?

- Author of independent report retained to develop and deliver a **training package** for client transport team members.
- Multi-agency **Client Transport Safeguarding Group** (CTSG) established. Group met monthly to:
  - Develop and oversee the implementation of a programme to improve standards of safeguarding and embed good practice in the Client Transport services;
  - Deliver safeguarding training to drivers and PAs on Special Educational Needs & Disability (SEND) and Adult Social Care (ASC) contracts.
- All client transport services **reviewed and prioritised** to determine level of competence, good practice, and identify where training and improvements were required.
- Revised Disclosure & Barring System **(DBS) application** process introduced from 1st September 2015 meaning drivers and PAs applying for a County Council client transport badge must successfully complete the DBS process, be employed by an approved Buckinghamshire County Council transport provider who can confirm they have followed Buckinghamshire County Council safer recruitment processes and attend a Qualification Day where they must successfully complete:
  - The County Council's accredited written communication assessment;
  - The standard Client Transport safeguarding awareness training;
  - Provide character references to confirm they are suitable to hold a Buckinghamshire County Council ID badge.
- Transport providers are **monitored**; areas of concern with services are identified, prioritised and addressed.
- Client transport contracts were re-procured with emphasis on **quality** as well as price.

Evidence of impact and outcome?

- **95%** of all taxi drivers and PAs operating SEND and ASC contracts have received standard client transport **training**, including safeguarding and customer care since April 2015. The remaining drivers and PAs are identified through compliance checks or when ID badges are renewed. If identified they must complete the training within an acceptable time frame or have their ID badge suspended.
- 78% of all drivers and PAs operating client transport services have completed the standard client transport training.
- Since Sept 2015, 467 drivers and passenger assistants have completed the revised ID badge process.
- All positive DBS certificates are reviewed by the Safeguarding & Compliance Manager and the Human Resources Safeguarding Consultant.
- Contracts are now tendered 60% price and 40% quality. Depot monitoring ensures providers demonstrate and maintain the agreed quality standard.
- There is evidence that Transport Providers who deliver client transport contracts comply with **safer recruitment** requirements.
- Drivers and PAs who work on client transport contracts are able to communicate effectively in English and have a better awareness of **safeguarding standards** and requirements.
- There is better engagement with other agencies to share information about the suitability of drivers, PAs and transport providers.

Next steps?

- Re-establish the CTSG to act in a **scrutiny and advice** role for all client transport services;
- Continuous **monitoring** of drivers, PAs and transport providers, through compliance checks, transport provider Key performance indicators (KPIs) and depot audits;
- Continue to deliver **training;**
- Develop an annual **induction program** with SEND schools for drivers and PAs.

9 Compliance with Statutory Functions

Performance and Quality Assurance

This aspect of the Board's work is driven through the **Performance and Quality Assurance Sub Group**. This has been a key area of improvement for the Board over the last 12 months. During our Board self-assessment against the Ofsted criteria for a good LSCB, Board members recognised that there is improved data reporting to the Board, a clearer forward plan for auditing and early evidence of improved auditing practice. The challenge event format was viewed as helpful for exploring and sharing good practice and identifying areas for improvement. However, there was also a recognition that we need to do more to further develop the data dashboards, embed multi-agency auditing practice and ensure learning from audits is effectively disseminated. This sets a clear direction for continued improvement over the next 12 months.

> *"Development of new dataset and themed dashboards means there is now regular monitoring of multi-agency data but this is not yet embedded or always effective. However, structures are now in place to allow this to become effective as the Board and Sub Groups get used to the new format."*
> **(Feedback from Board self-evaluation exercise)**

Key achievements include:

- The development of **the data dashboard** system is allowing greater ownership of the data across the Board and Sub Groups. The impact of this is shown in more detail in the storyboard on p48 and some of the data from our dashboards has been drawn into this annual report.
- A clearer focus on the importance of **auditing** with a robust forward audit plan which reflects Board priorities and is embedding key areas such as the voice of the child and escalation into each audit. During the year multi-agency audits were undertaken on use of the Escalation Procedure, Children in Need, Supervision, Child Sexual Exploitation, The Swan Unit and Children Subject to a Child Protection Plan for Neglect. **Learning logs** are available on our website for these audits, and the headline findings from some are shared within this report.
- Our **risks and concerns log** is discussed at each Board meeting and allows the Board to have visibility of issues and challenges which have been raised through a number of different channels.
- The development of a revised **section 11 tool** (to be delivered in autumn 2016) which includes a greater focus on some of our local priorities and seeks increased evidence of impact.

Next Steps

Over the next 12 months we need to:

- Continue to **refine and embed our system of data dashboards**, including linking our dashboard more strongly to the data scrutiny systems through the other strategic boards (Safer, Stronger Bucks Partnership Board, Safeguarding Adults Board, Health and Wellbeing Board). This will ensure there is the right assurance around practice and risk at a strategic level without duplication of effort or gaps in practice.
- Continue to drive improvements in **multi-agency auditing practice**; in particular we must ensure we are better at undertaking audits effectively, that learning is shared quickly with the Board and disseminated more widely across partners. We also need to ensure we can take a more flexible approach to exploring emerging areas of concern.
- Undertake our **next Section 11** audit to gather further assurance from our partners around how they are meeting their safeguarding duties.
- Since the 2014 Ofsted inspection an independently chaired **Improvement Board** has overseen the improvement journey in Children's Social Care. As the role of this Board diminishes, the Board must be ready to take on its functions.

Learning from Audits: Children in Need (June 2015)

Why did we do it?

Both the **Ofsted inspection** in 2014 and emerging findings from the **Serious Case Review** for Baby K (Aug 2015) suggested the assessment and management of CIN cases needed to be improved. This in depth audit of 3 children's journeys provided an opportunity to review the quality of assessment and multi-agency working and involve practitioners directly in the learning.

What did we find?

- Good practice was identified across the 3 cases including high levels of support from some services. However, a number of concerns were noted, many relating to a lack of effective **multi-agency communication and engagement**, which in some cases resulted in **poor case management** and progression of the child's plan.
- Those practitioners involved in the audit found it a helpful learning opportunity.

What improvements have taken place?

- **Transfer points** have been reviewed between the Family Resilience Service, the Assessment Service and CIN to ensure that there is no delay in stepping forward and stepping up for the child.
- The **practice standards** for Social Workers have been reviewed to ensure that the GPs engagement is explicit across the whole journey for the child including the CIN. This has been reinforced by meetings between Children's Social Care and the Clinical Commissioning Groups and new auditing is being undertaken to provide evidence of improvement.
- The audit recommended deliberate activities should be designed to encourage connections between services. A monthly **Connecting for Children** meeting is now bringing together the strategic leads for key agencies. A child's journey is audited at each meeting to facilitate joint learning.

Next steps?

The findings from the subsequent SCR for Baby M alongside performance and audit reports from Children's Social Care have identified CIN as an **ongoing area of concern**. A range of improvement activity is planned and the Board will continue review the impact of this over the coming months.

Storyboard: The BSCB Dataset - Developing a Multi-Agency Perspective

Why did we seek improvement?

One of the findings of **Ofsted inspection** of the BSCB in 2014 was that the Board was not scrutinising multi-agency data as a means of assessing the effectiveness of local safeguarding arrangements.

What did we do?

Phase 1 dataset: During 2015 the Board's Performance & Quality Assurance Sub Group (P&QA) designed a new multi-agency dataset and agreed with partners the data they would provide for this. This was a huge step forward and provided P&QA with a large amount of data, but the format was unwieldy. It was difficult to scrutinise the data – which was organised by agency, identify trends or highlight areas of concern. It was also difficult for P&QA to report effectively to the BSCB, and Board members continued to express concern that data was not being used effectively to given them assurance around local safeguarding arrangements.

Phase 2 dataset: To resolve these issues, further work started on the dataset in autumn 2015. 5 themed datasets were created aligned to the BSCB priority areas. The dashboards present information in a format that is much more visual and user-friendly, making data easier to interrogate and understand.

Rather than all the data being scrutinised through P&QA, the new themed dashboards are owned across BSCB Sub Groups to try and ensure data is used effectively to inform planning and activity across all aspects of the Board's work.

For each themed dataset, a headline dashboard is created for every Board meeting. This contains top level data and notable trends. Red flag areas are highlighted where action is required or the Board may wish to undertake further scrutiny. This format means the Board has regular data in an easily accessible format, with assurance that the detail is being scrutinised in the Sub Groups.

Evidence of impact and outcomes?

Ownership of data across Sub Groups is opening up **new lines of enquiry** and **strengthening processes**. For example

- The CSE Sub Group felt there was not enough evidence in our data around CSE and learning disabilities. As a result they conducted an audit of M-SERAC minutes and are now conducting a wider self-assessment of our local response against the recommendations from the Barnardo's report 'Unprotected, Overprotected', which looks at CSE and learning disabilities.
- Requesting data on Outcomes Star usage across partners for the Early Help dataset highlighted the inadequacy of current reporting arrangements, which as a result are now being improved.

The new format is providing **better assurance** around the effectiveness of local safeguarding arrangements at both Sub Group and Board level. For example as the Early Help Panel process has developed the Early Sub Group has been able to provide ongoing assurance to the Board that early concerns around appropriateness of threshold decisions have been overcome.

The format is making it easier to identify areas of **risk** and is promoting **effective challenge** at both Board and Sub Group level. For example the dashboard has given the BSCB increased visibility of the Child Death Overview Panel (CDOP) backlog which led to this risk being escalated and increased action being taken to reduce it.

The dashboards have strengthened the **information flow** between Sub Groups and the Board, allowing Sub Groups to remind the Board of key messages or challenge partners where further action is needed.

The Board has given positive feedback on the new format and has commented on evidence of continued improvement.

Next steps?

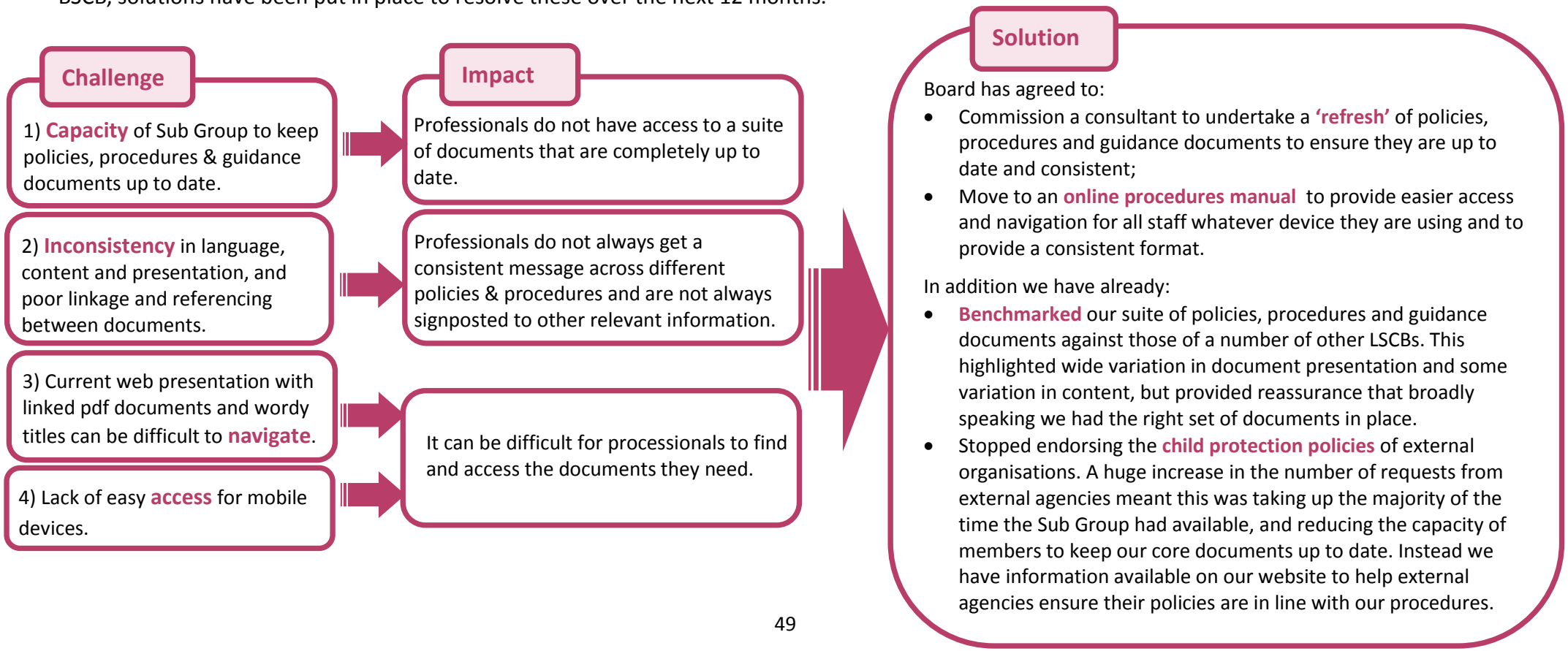
Over the next 12 months we plan to:

- Continue to **refine the dataset** and dashboard as the process is further embedded and ensure the system is more fully automated to reduce the time spent collecting data and producing reports;
- Explore **data links** between the BSCB, the Safeguarding Adults Board, the Safer Stronger Bucks Partnership Board and the Health and Wellbeing Board to ensure there is clarity around how and where data is scrutinised for those areas covered in the Joint Protocol;
- Consider what data could be made more widely available via our website.

Policies and Procedures

LSCBs have a statutory duty, set out in Working Together 2015, to develop policies and procedures for safeguarding and promoting the welfare of children in the local authority. The BSCB maintains a large number of multi-agency **policies, procedures and guidance documents**, all of which are published on the BSCB website. Work on keeping these up to date and on creating new documents as required, is led through the Board's **Policies and Procedures Sub Group.**

This year, the Sub Group has undertaken a **deep dive evaluation** of their role and how effective this is in ensuring that professionals can easily access up to date information to help them ensure children are effectively safeguarded. Whilst the Sub Group recognised the amount of work that was being undertaken, they identified a number of **challenges with current arrangements**. A high level summary of these is provided below. In discussion with the BSCB, solutions have been put in place to resolve these over the next 12 months.



Alongside this work, the group has updated a number of documents, including

- Agreeing a revised Escalation, Challenge and Conflict Resolution procedure which took on board learning from local SCRs and our Board audit of use across partner agencies.
- Undertaken an update to the BSCB Individual Case Management Procedures, which had been highlighted as out of date through our serious case review for Baby M.

Next Steps

Over the next 12 months we need to:

- Complete the commissioned **'refresh' of policies and procedures** and move to the **online manual** so that all professionals have quick and easy access to up to date policies, procedures and guidance;
- Publish our more extensive **child protection policy toolkit** to help agencies across Bucks write robust child protection policies;
- Do more work to understand how widely our policies and procedures are used and how **effective** they are for professionals, as our knowledge in this respect is currently under-developed.

Learning and Development

The BSCB aims to ensure that the children and young people's workforce has the right skills to ensure children receive the right help and support at the right time. The BSCB has a **Training Manager** to support the development and delivery of a high-quality multi-agency training programme. The Board also has a **Learning and Development Sub Group** which seeks to support a culture of continuous learning and development.

Multi-agency Training - Key achievements

- The BSCB continues to run a well-attended **multi-agency training programme**, including training across all BSCB priority areas. All provision is regularly updated to ensure it is in-line with local procedures, learning from serious case reviews, changing local priorities and national legislation. The programme is also adapted in response to delegate feedback and needs. During 2015/16 a total of **48 full training days** were attended by a total of **591 delegates**. This is broadly inline with 2014/15.

- In addition to the full training days, the Board also delivered **32 additional training events** including some bespoke single agency training where a specific need had been identified. This included delivering two of our Everyone's Responsibility basic safeguarding courses to Vale of Aylesbury Housing Trust and a session on CSE for sexual health staff within Buckinghamshire Healthcare NHS Trust.
- To support the implementation of the new Strengthening Families Model for Child Protection conferences, the BSCB organised **15 multi-agency briefing sessions** on the new model. Over 600 professionals attended a session.
- The Board held a **Learning and Development Challenge Event** in December 2015. As well as providing some assurance around the safeguarding training provided by individual agencies, this afforded our partners the opportunity to give us their ideas about how the Board's multi-agency training could be improved.
- The BSCB website now signposts professionals to a range of relevant **local training opportunities** that are provided outside of the BSCB, for example training around Prevent and Domestic Abuse that is provided through Buckinghamshire County Council.
- The Training Manager undertook a **quality assurance** observation of safeguarding training delivered by the voluntary sector in a local mosque. This provided assurance that the training was relevant and appropriate to the delegates in attendance.

Next Steps

- We have identified that some of our partners attend multi-agency training more than others. Feedback from our Learning and Development challenge event suggested that we could improve the breadth of attendance by offering a **greater variety of learning formats**. Over the next 12 months we will run more short courses and lunchtime briefing sessions to try and make our learning as accessible as possible.
- The Board maintains a pool of local trainers to support the delivery of our multi-agency programme. We face an ongoing challenge around having enough local trainers available within this pool. This has created significant pressures within the BSCB team with the Training Manager delivering a high proportion of training. Board partners understand the benefits of using local professionals to deliver training and are supportive of maintaining this approach. Over the next year we need to continue working with partners to **grow our training pool capacity.**
- The Board needs to have assurance that safeguarding training provided locally is of a high quality. Given the amount of training our Training Manager has needed to deliver during this year there has been less time available to undertake the **quality assurance** role. Over the next year, we need to find a way to increase our capacity for this function.

Evidence of Impact

All BSCB courses are evaluated on the day. A sample of delegates and their line managers are also selected to take part in a second evaluation 3 months after the course to assess impact on practice. This year, evaluations have continued to provide good evidence that training is valued by partners and that it is positively informing practice. Attendance at training and a summary of feedback from evaluation forms is shared with the BSCB as part of our new dashboard data reporting system.

Figure 25 Increase in knowledge and confidence between start and end of course (self-evaluation by delegate)

Course Title	no. courses	Average % increase
Everyone's Responsibility	5	16%
Working Together	10	20%
CSE	4	26%
Domestic Abuse	3	25%
Neglect	2	19%
Mentally Ill Parents & their Children	3	21%
Child Sexual Abuse	3	18%
Working with Challenging Families	2	21%
Effective Core Groups	1	24%

"XX has definitely gained confidence to deal with families after this training; she has kept calm in difficult situations and supported families through difficult choices." **(Manager 3 month feedback, Working with Challenging Families**

"I have been working for six months with a family in which the father has been verbally abusive to me. This course has given me the confidence to stand my ground and continue to confront the issues I have seen." **(Delegate 3 month feedback, Working with Challenging Families course)**

"I have become increasingly aware of the need for all agencies involved to work together for the safeguarding of children. My colleague and I have made some alterations to our Child Protection policy based on the training and disseminated the relevant information to the staff during INSET." **(Delegate 3 month feedback, Working Together course)**

"This course has allowed me to work more openly with families where mental health is an issue, to look at different ways of offering support and essentially more positive outcomes." **(Delegate 3 month feedback, Mentally Ill Parents course)**

"This course has enabled me to complete a good assessment and gathering information from other agencies." **(Delegate on the day feedback, Everyone's Responsibility Course)**

"I have used the knowledge and information to support two of my childcare settings who have concerns over children in their care. I feel more confident in giving detailed and accurate advice and both providers were grateful and have acted appropriately to best safeguard the children." **(Delegate 3 month feedback, Neglect and Emotional Abuse course)**

"We have been able to discuss specific cases within our team meetings and identify young people who we feel require further support" **(Manager 3 month feedback, Child Sexual Exploitation course)**

Child Death Overview Panel

The death of a child is always tragic, and leaves families with a sense of shock, devastation and loss. However, it is important that we review child deaths to see whether we can learn any lessons to improve the health, safety and wellbeing of other children, or to improve the support for bereaved families. As set out in Working Together 2015, the BSCB has a **Child Death Overview Panel** (CDOP) which fulfils this function.

CDOPs are required to prepare an annual report of information relevant to the LSCB and it is expected that this should inform our annual report. Findings from CDOP are presented in the full CDOP **Annual Report 2015-16**, but a summary of some of the key findings are presented below.

In our 2014/15 annual report we reported that our CDOP was managing a historic backlog of cases. The panel has worked hard over the last 12 months including setting additional meetings, but at the end of March 2016, CDOP was still working with a **backlog of 42 cases**. The Board has recognised this as a significant area of risk and strategies have been put in place to reduce this backlog as a priority. Whilst it is disappointing that we have not been able to reduce the backlog more quickly, it is clear that there are now much more robust systems in place to manage CDOP and an effective chair who is providing strong leadership and direction for the panel. Given this we are confident the backlog will be cleared completely within the next six months.

Despite the challenges relating to the backlog, there are a number of achievements to report from CDOP:


The Bucks Herald

Don't risk it

Police issue drugs warning following death of teen, as family pays tribute to someone who 'lit up the life of those who met him'

- The Board has agreed to fund a new **online database** for CDOP and we anticipate that this will go live during autumn 2016. Whilst some time investment has been needed to set this up, we are confident that this system will facilitate a more efficient CDOP process, including reducing some of the current administrative burdens associated with the panel, which are extremely time consuming;
- The appointment of a **part-time coordinator** for CDOP in October 2015 which is now providing more dedicated resource to the panel;
- Active involvement of the **Coroner's Office** on the CDOP panel;
- Improved links with the **Serious Case Review Sub Group** to ensure all child deaths are quickly considered for an SCR or partnership review when appropriate;
- Improved links with **Children's Social Care** to ensure appropriate involvement in the rapid response process;
- Improved links with the national and regional **network of CDOP's** which is allowing us to compare local themes and learning with other areas;
- An improvement in the proportion of reviews completed in **less than 6 months** (19% compared to 8% for 2014/15)

Issues identified and actions taken as a result of reviews by CDOP

One of the strengths of the CDOP process is to understand the reasons why children die and to put in place interventions to help improve child safety and welfare and to prevent future avoidable deaths. This section summarises some of the actions that have been taken following CDOP reviews.

- Dissemination of information about the safe use of **bath seats**;
- Dissemination of the **Water Safety Code** through Independent Schools Forum, Schools Bulletin and BSCB Newsletter to raise awareness of safety around water prior to summer holidays;
- Public awareness campaign around **substance misuse** by children and young people;
- Public awareness campaign around **road safety**;
- Promotion of the Lullaby Trust **safer sleep** campaign;
- Review and reinforcement of procedures about the **Rapid Response** process following some instances where deceased children were taken directly to the mortuary instead of A&E.

CDOP has made the following recommendations for agencies working in Buckinghamshire

- Ensure close monitoring and surveillance of infant mortality continues and remains a top priority for all organisations in Buckinghamshire including the LSCB;
- Buckinghamshire Healthcare Trust's Mortality Review Group to include child mortality review in their remit;
- Ensure there is a clear and agreed process in place for referring and sign-posting at-risk women to relevant services such as genetic screening and counselling, healthy lifestyle services and services that aim to prevent pre-term birth;
- Ensure Clinical Commissioning Groups and NHS England improve early access to antenatal and maternity services for pregnant women particularly those from areas of social deprivation including ethnic minorities;
- Ensure commissioners improve and enhance data collection on risk factors for child death in primary and secondary care settings through improved and robust contract and performance monitoring processes.

Next Steps

Ove the next 12 months we need to:

- Ensure CDOP is running with **no backlog** of cases;
- Improve our **review time** and reduce the proportion of reviews that take more than 1 year so that this is more in line with the national average;
- Implement the **online system** (E-CDOP) and assess the impact of this on the CDOP process so we can evaluate whether it is providing value for money;
- Start analysing child death data over a greater number of years to get a view of **trends** that may be emerging over a longer period of time.

Key findings from Child Deaths Reviewed in 2015/16

In 2015/16 CDOP was notified of **43 deaths of children aged 0-17** in Buckinghamshire and reviewed a total of 49 cases. Child mortality rates in Buckinghamshire are similar to the England average. However, there is a large disparity between the most and least deprived populations in Buckinghamshire. The diagram below provides key statistics for the 49 deaths reviewed during the last 12 months.

CDOP process	•19% were completed in less than 6 months which is an improvement from 8% in 2014/2015. •15 cases (31%) were completed within 12 months of the notification compared with 70% nationally. 34 cases (69%) took longer than a year to review compared with 30% nationally. This is an area where we need to perform better.
Demographics	•20 cases (41%) related to babies aged 0-27 days compared with 43% nationally. A further 11 cases (23%) were aged between 28 and 364 days compared with 21% nationally. Overall, 63% were in children aged 0-1 year old which is similar to the national average of 64%. •5 cases (10%) were in 1-5 year olds which is similar to the national average for this age group. 13 cases (27%) were in 5-17 year olds compared with 23% nationally. •29 cases (59%) were male and 18 cases (37%) were female, compared with the national average of 57% and 42% respectively. Two cases did not include information on gender. •19 deaths (38%) were in children of White (any White) ethnic background compared with 61% nationally. 8 deaths (16%) were in children of Asian (any Asian and mixed Asian background) compared with 15% nationally. 8% were in children of any black and mixed black background compared with 7% nationally. In 16 cases (32%) information on ethnicity was either unknown or not stated compared with 10% nationally. Due to the small number of deaths and the high number of caes where ethnicity was not recorded it is difficult to draw any conclusions from this. •No children were subject to any child protection plan or statutory order and no case was identified as an asylum seeker.
Factors involved in death	•Perinatal/neonatal deaths are the top category of death in Buckinghamshire (29% compared with 32% nationally), followed by chromosomal/congenital abnormalities (18% compared with 26% nationally). •In 17 cases (35%) the cause of death was determined as neonatal deaths compared with 41% nationally. In 10 cases (20%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally. •In 28 cases (57%) acute hospitals were the place of death followed by 13 cases (27%) in the normal residence of the child and 5 cases (10%) in public places. Nationally, 67% of the deaths reviewed occurred in an acute hospital, 22% in the normal residence of the child and 4% in public places. •Modifiable factors were identified in 8 (16%) cases compared with 17% in the South East, and 24% nationally (2015/16).

Serious Case Reviews

Working Together 2015 sets out that LSCBs are required to undertake a serious case review (SCR) in cases where
a) abuse or neglect of a child is known or suspected; and
b) either i) the child has died; or ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The BSCB has a **Serious Case Review Sub Group** which ensures that the Board can meet its statutory duties in relation to SCRs. The group is chaired by a Detective Chief Inspector from Thames Valley Police with responsibility for Child Abuse Investigation in the Buckinghamshire area. There is good representation from across a range of agencies and the meetings are consistently well attended.

Completed and Ongoing Reviews

In 2015/16 the Sub Group has overseen the progress of 3 SCRs:

- **Baby K** involved a one month old baby who tragically died (published August 2015)
- **Baby L** involved a three month old who tragically died (published October 2015)
- **Baby M** involves a four month old baby who suffered serious harm (unpublished due to ongoing criminal enquiries)

In May the SCR Sub Group made a recommendation to the Independent Chair of the BSCB that an SCR be conducted into the way **Child Sexual Exploitation** (CSE) was dealt with in Buckinghamshire during the period 1998 to the present. This followed the conclusion of a major Thames Valley Police investigation into CSE under Operation Articulate culminating in numerous convictions at the Old Bailey. Other cases of CSE during this period have also been or are being actively investigated by the police. The earliest date of an offence associated with these cases dates back to 1998, hence this being used as a starting point for the scope of the review. One individual case has already been the subject of a serious case review (Young Person J) and it was recommended that this was also considered in this wider re-examination of the CSE issue. The recommendation to conduct the SCR was approved and the process has been on-going throughout the year. The scope of the review is unorthodox, but it was felt that to conduct individual enquiries into the partnership response to individual children would become an impossibly huge task, and ultimately would not have been in the interests of children and young people in Buckinghamshire. The flexible approach to this issue has empowered the author to look beyond the Local Authority area to consider the national context around the issue of CSE. This will be useful in

benchmarking the local improvement journey that many agencies have been on following significant cases in other areas, such as Oxford and Rotherham. Whilst the review is in some ways quite historical, particularly in light of the 1998 starting point, the intention has been that the process is forward looking and cross references past experiences with present arrangements. It is hope that this will lead to an improvement for children and young people affected by CSE today. The full report is due for publication later in 2016.

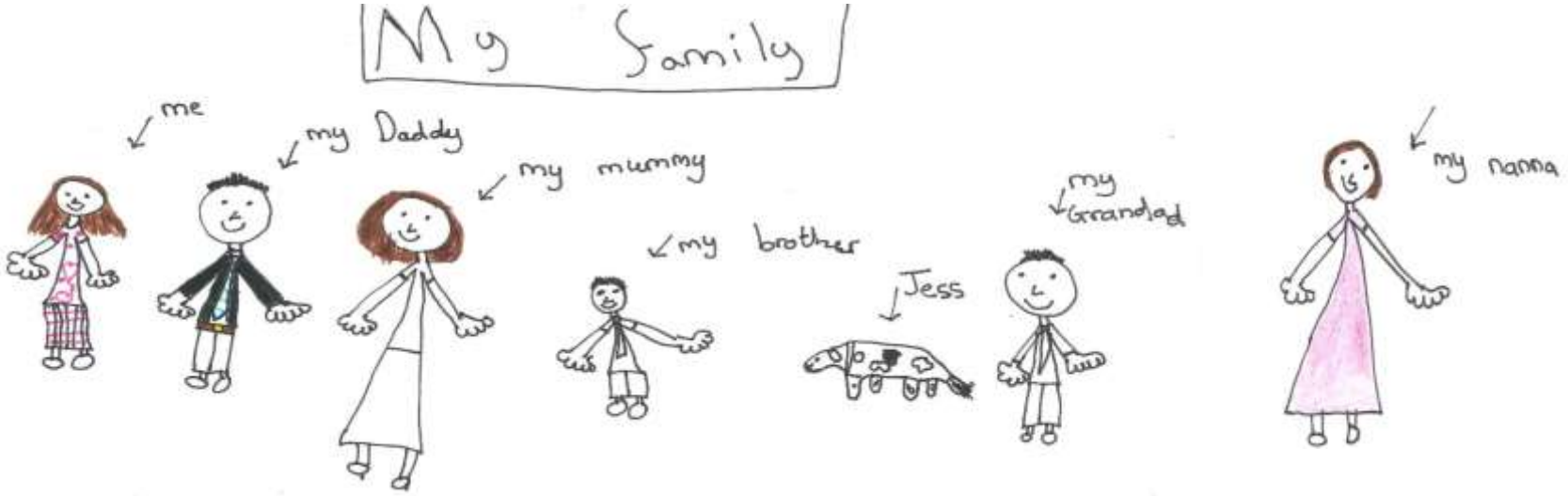
Key achievements

- The Sub Group has continued to review the way the **SCR process** is conducted in light of the flexibility afforded by Working Together 2015. The SCR for Baby L followed the Welsh Government Child Practice Review method which placed greater emphasis on the engagement of frontline practitioners, with less focus on creating detailed written internal reviews. The case of baby M involved a more 'traditional' method of SCR process, which required the author and panel processing a huge amount of written material. The SCR did also hold a successful practitioners' event, which was well attended and illuminated the review process. The contrasting approaches used will facilitate decision making about the favoured method to be used for future reviews.
- The SCR Sub Group has continued to keep all **recommendations** made in SCRs under review until they receive evidence that they have been fully implemented. This can be a challenging and sometimes lengthy process. This year we have tightened the regime around this, with the BSCB Business Manager and Sub Group Chair meeting regularly in between meetings to review the outstanding recommendations. This feeds into a newly established escalation process by which unresolved issues are flagged to main board members for the relevant agency and then ultimately to the independent chair. The amount of outstanding actions are also reviewed as a data performance indicator for the main board, so the general performance of the partnership is kept in view. These innovations have improved the process and the amount of outstanding actions is at a manageable and acceptable level. The link between the Child Death Overview Panel (CDOP) and the SCR Sub Group has been significantly strengthened this year. A representative from CDOP now attends the SCR Sub Group and reports on the details of unexplained child deaths since the last meeting. This helps give the partnership early indication of any concerning cases and also allows cases to be tracked through the Coroner's Court. This ensures that if neglect or abuse is established at the inquest stage the SCR Sub Group are able to reassess whether the criteria is met for an SCR in an organised and consistent fashion.
- The Sub Group has re-designed the **SCR referral form** which practitioners use to flag matters which might meet the criteria for an SCR. This now encourages professionals to refer matters which may fall short of the criteria but would benefit from some sort of review process.

Overall 2015/16 has been period where the SCR Sub Group has continued to **develop and innovate**. Generally it has become more effective in identifying areas of concern and monitoring agency improvement plans post review. This process of improvement should continue into 2017

Next Steps

- Running the SCR process in parallel with **criminal proceedings** continues to be a challenge. The Baby L case was assisted by virtue of the fact that the criminal process was resolved at an early stage, whereas in the case of Baby M there was an on-going complex investigation where some of the practitioners were potentially fully bound witnesses. This lead to the practitioners' event being delayed at the request of Thames Valley Police, which was disruptive to the process. The issues around this area are far from resolved, but there is a growing flexibility in relation to this issue and the case of Baby M has taught us that engaging with the Crown Prosecution Service at an early stage and working together to establish a framework which maximizes the exploration of the issues, whilst not undermining the need to secure justice, is something that can be achieved.
- Identifying cases of concern continues to be a challenge. We now require partners to register cases they have reviewed as a single agency over the last six months and this system is about to be tested. It is hoped that agencies will be efficient in sharing this information so the SCR Sub Group can effectively scope any serious safeguarding concerns that would be worthy of a more detailed review.
- Despite the flexibility afforded in Working Together 2015, SCRs continue to be expensive and **funding** may be an issue if we continue to commission SCRs at the same rate as previous years. This will need to be kept in view if any difficulties develop.
- The Board has not had the capacity to progress an intended piece of work to analyse the **impact and outcomes** of SCR recommendations across all of our local SCRs. Particularly as we are seeing some more recent trends emerge in our latest three SCRs, all of which relate to young babies, we are keen to progress this work in order to understand what difference our SCRs have made.
- As work on the CSE SCR continues, the BSCB will need to plan how to effectively **share the learning** from the review across the partnership.



Learning from Serious Case Reviews

Baby K

A one month old twin who died at home, the cause of death is unknown.

Mum had a difficult early life and had contact with a number of services primarily for mental health and drug and alcohol uses.

Learning

Good practice: Good support was identified from a number of agencies and this was appreciated by the mother. Some professionals were committed and persistent when the mother was missing appointments.

Areas for improvement

- There was **weak professional leadership** from Children's Social Care; the allocated social worker was not sufficiently experienced and there were insufficient supervision arrangements;
- **Pre-birth assessment** was inadequate and did not lead to a sufficiently robust plan to support the mother and safeguard her children;
- There was an **over-reliance** on Children's Social Care as the lead agency and an assumption that because they were involved, all the concerns apparent to agencies were being addressed;
- Other agencies held **information** which raised safeguarding concerns, but this was not always shared with Social Care.

What has changed?

- Following the Ofsted inspection in 2014 an Improvement Board was set up to monitor the improvements being made within Children's Social Care. A workstream was set up to address **workforce challenges** including capacity, caseloads, staffing levels and supervision. Regular reporting has shown that whilst there remain challenges around the level of agency staff, there have been improvements in the frequency and quality of management and staff supervision and there are now good systems in place to monitor this.
- **Minimum practice standards** have been produced for Children's Social Care, including for assessment, to ensure all staff know what is expected.
- Partners were reminded of the need to challenge and escalate any concerns they have about a child's journey. The BSCB's **Escalation Procedure** has been relaunched.

Baby M

Baby M was admitted to A&E after his father claimed to have fallen whilst holding him. He had a skull fracture, bruises and a torn frenulum. The father's account was accepted and Baby M was discharged. A few days later, Baby M was readmitted to hospital. He was discovered to have numerous bruises and rib fractures of different ages. Both parents had a long history of service involvement.

Learning

- There was **poor planning** in the **pre-birth** period and this led to missed opportunities;
- **Thresholds** were not well understood and as a result the case did not progress into the child protection arena;
- There was evidence of staff not being able to **challenge** senior colleagues over decisions made;
- The BSCB Individual Case Management Procedures were **out of date** and there were no clear links from the BSCB website to Children's Social Care procedures relating to Children in Need.

What has changed?

- Significant work has been undertaken to improve the understanding of **thresholds** across the partnership and there is now increasing evidence from internal and external audit that this has **improved** (see section 3);
- The Individual Case Management Procedures have been **updated** and there are now links to the Children's Social Care Procedures;
- Partners have been reminded of the need to challenge, and where necessary escalate, any concerns they have about a child's journey and the BSCB's **Escalation Procedure** has been relaunched.

Baby L

A 14 week old baby who died. Within this case there were a number of factors including maternal substance misuse, maternal ill health, missed health appointments, reluctance to allow professionals into the family's privately rented home, housing issues leading to mother spending a lot of time at the home of the maternal grandmother and a baby born out of the area.

Learning

Good Practice

- There was evidence of some good multi-agency working and flexibility in service delivery;
- Professionals made an effort to follow up on the family where appointments were missed;
- The father was engaged in discussions by some agencies, although this was not always recorded.

Areas for Improvement

- There was a **delay** in allocating a social worker meaning the pre-birth assessment was not completed before the baby was born;
- There could have been better **communication** between the GP, Health Visitor, Midwife and Social Worker to ensure information was shared in a timely manner;
- The drug and alcohol service was not in the loop and therefore there was a **lack of clarity** amongst professionals around the mother's substance misuse
- There was a lack of clarity around the operating procedure for the Out of Hours Social Work Team and information passed on by them to the allocated social worker in the day team was not seen immediately because the social worker was part time;
- **Interagency collaboration and communication** was based on individual commitment rather than organisational processes. Greater scrutiny around the inter-agency working of Child in Need cases was recommended.

What has changed?

- For progress around Children's Social Care workforce, see Baby K summary;
- A review of **liaison meetings** between GPs, Heath Visitors and Midwives has been conducted with broadly consistent findings. Overall 92% of responses indicated there were regular liaison meetings in GP surgeries with 57% of responses stating these were at least monthly. The audit provided evidence of good information sharing but also identified some of the barriers to effective liaison meetings. A number of recommendations were made to help ensure that effective liaison meetings continue to be promoted and to seek to overcome some of these barriers;
- The **Drug and Alcohol service** has made improvements to its systems to ensure that communication is improved;
- The **Out of Hours** Social Work Team has been completely reviewed and the operating procedures updated. Communication to the day team now goes to a central mailbox.

What do we still need to do?

Collectively there are a number of themes emerging from these three reviews that will need further work over the next 12 months:

- The need for ownership, **challenge** and where necessary **escalation** across all partners;
- The management of CIN cases – in particular to ensure **consistent social work practice** and **good engagement** across the partnership;
- The absence of robust **pre-birth assessments.**

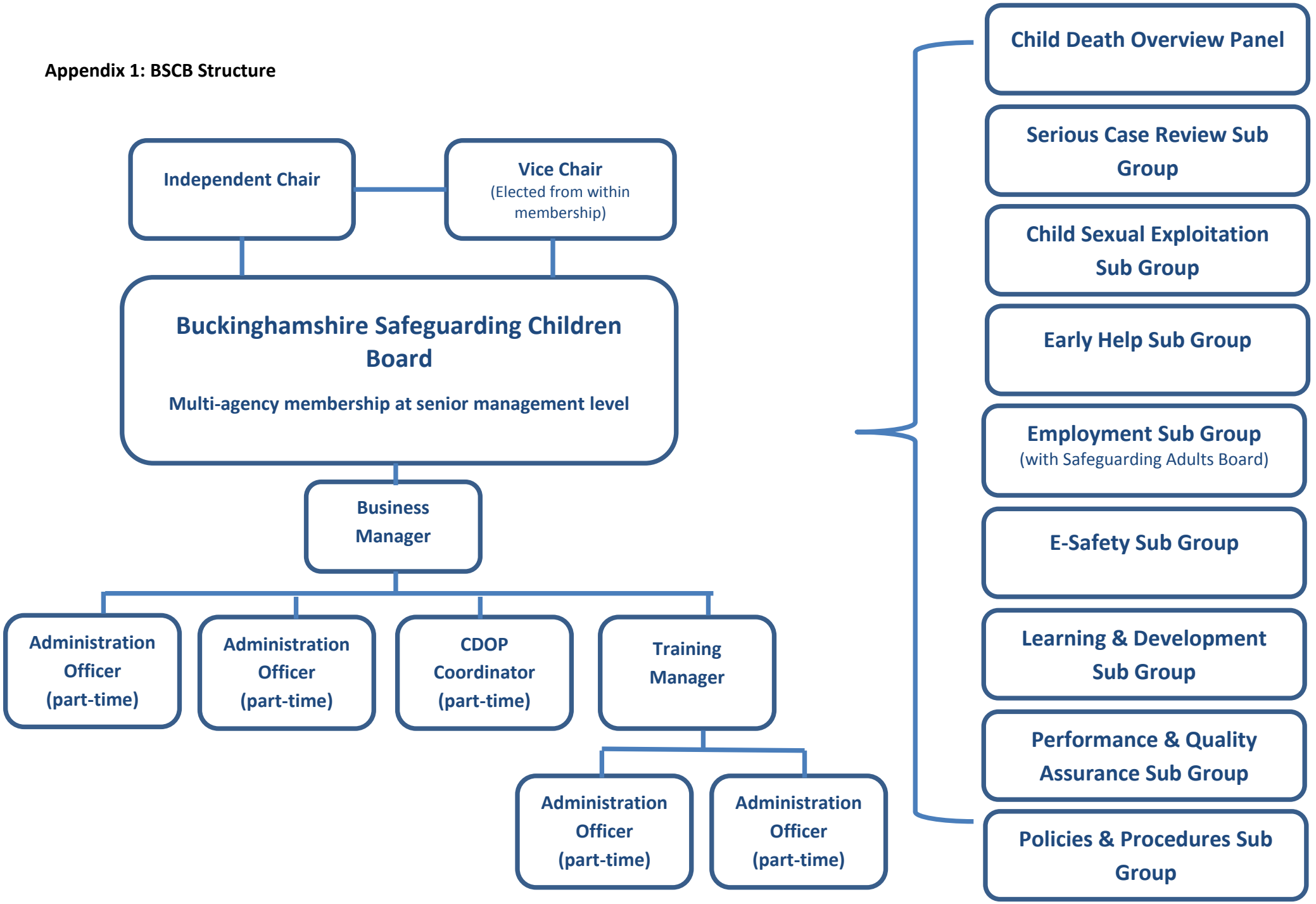
10 Conclusions

In this report we have sought to set out the Board's journey over the past 12 months. The report presents areas of **good practice** and **improvement**, and the amount of change this year has been significant. **The Board does not underestimate the amount of work that partners have put into this, at both a strategic and an operational level.** We recognise the **commitment** that has been shown by so many, both individually and collectively to improve outcomes for our children. However, the report also highlights some remaining areas of **challenge**, both for the Board and for our partners. Over the next 12 months we must continue to work together in partnership to address these remaining areas of concern, and to tackle any new and emerging challenges that arise. Almost two years on from the inadequate rating from Ofsted for both the Board and Children's Social Care, we need to **maintain the momentum of change**. The pace of change has not always been fast enough, and we are still not at a point where slowing our pace is an option. It is clear that across the partnership, agencies are facing their own pressures. However, we are confident that with continued strong leadership and commitment from across local agencies, **we can continue this journey together**. This commitment was affirmed in April 2016, when partners collectively agreed a new vision and values for children and young people in Buckinghamshire, to be used not just by the Board, but by all agencies working to protect children and young people in Buckinghamshire.

Together…Keeping Children Safe

'Children and young people are safe, happy and healthy, feel valued and value others, are treated fairly, have lives filled with learning, thrive and are able to enjoy life and spend quality time with family and friends.'

Appendix 1: BSCB Structure



Appendix 2: Board Membership as at March 2016 and attendance log

First Name	Surname	Organisation
Ros	**Alstead**	**Oxford Health NHS Foundation Trust**
Tania	**Atcheson**	**Buckinghamshire Clinical Commissioning Groups**
Trevor	**Boyd**	**Buckinghamshire County Council (Communities, Health and Adult Social Care)**
Pauline	**Camilleri**	**Youth Offending Service**
Stephanie	**Clifford**	**Independent School Representative (Maltman's Green School)**
Heidi	**Crampton**	**CAFCASS (Children & Family Court Advice & Support Service)**
Steve	Czajewski	**Thames Valley Community Rehabilitation Company**
Carol	**Douch**	**Buckinghamshire County Council (Children's Social Care)**
Frances	**Gosling-Thomas**	**Independent Chair**
Lin	**Hazell**	**Buckinghamshire County Council Cabinet Member for Children's Services**
Martin	**Holt**	**Chiltern & South Bucks District Council***
Sheila	**Jenkins**	**NHS England**
Elaine	**Jewell**	**Wycombe District Council***
David	**Johnston**	**Buckinghamshire County Council (Children's Social Care & Learning)**
Sarah	**Leighton**	**Primary School Representative (Hughenden Primary School)**
Matthew	**Band**	**Voluntary Sector Representative (Action 4 Youth)**
Ed	**McLean**	**Thames Valley Police**
Stephanie	**Moffat**	**Aylesbury Vale District Council***
Carolyn	**Morrice**	**Buckinghamshire Healthcare BHS Trust**
Richard	**North**	**Thames Valley Police**
Jane	**O'Grady**	**Buckinghamshire County Council (Public Health)**
Lesley	**Ray**	**Designated Doctor**
Dal	**Sahota**	**Chiltern Clinical Commissioning Group**
Pauline	**Scully**	**Oxford Health NHS Foundation Trust**
Juliet	**Sutton**	**Aylesbury Vale Clinical Commissioning Group**
Charlie	**Walls**	**National Probation Service**
Rhian	**Williams**	**Secondary Schools Representative (Sir William Borlase Grammar School)**

*** Although there is a Board member for each District Council, only 1 attends per meeting.**

% attendance at Board meetings by agency (last 5 meetings as of March 2016)			
Agency		**Agency**	
Adult Social Care (BCC)	80%	National Probation Service	60%
Children & Families (BCC)	100%	NHS England	80%
Buckinghamshire Healthcare Trust	100%	Oxford Health NHS Foundation Trust	100%
Bucks Legal Team	60%	Primary Schools	100%
Cabinet Member	80%	Public Health	80%
CAFCASS	0%	Secondary Schools	20%
Clinical Commissioning Group	100%	Thames Valley Police	100%
District Councils	100%	Community Rehabilitation Company	40%
Independent Schools	40%	Voluntary Sector	100%
Lay Member	60%	Youth Offending Service	80%

Appendix 3: BSCB Budget

Agency	2014-15			2015-16			
	Contributions (BASE BUDGET)	Additional in-year contributions	Total for 2014-15	Contributions (BASE BUDGET)	Additional in-year contributions	Change from 14/15 base budget contribution	Change from 14/15 overall contribution (including one off payments)
BCC	94,820	40,000	**134,820**	172,260		83%⇧	28% ⇧
Thames Valley Police	15,000		**15,000**	15,000	16,000	0% ⇔	106% ⇧
Aylesbury Vale CCG	12,069	6000	**18,069**	70,180		70% ⇧	2% ⇩
Chiltern CCG	19,692	9000	**28,692**				
Bucks Healthcare Trust		25000	**25,000**				
Probation	3,470		**3,470**	3,470		0% ⇔	0% ⇔
Wycombe District Council	7,566		**7,566**	10,633		43%⇧	43%⇧
Aylesbury Vale District Council	7,566		**7,566**	10,633		43%⇧	43%⇧
South Bucks District Council	3,784		**3,784**	5,317		67%⇧	67%⇧
Chiltern District Council	3,784		**3,784**	5,317		67%⇧	67%⇧
Cafcass	550		**550**	550		0% ⇔	0% ⇔
Oxford Health (CAMHS)	n/a			**8,000**		NEW ⇧	NEW ⇧
TOTAL BASE BUDGET	**168,301**		**248,301**	**317,360**		52% ⇧	14% ⇧

Together…Keeping Children Safe