




Buckinghamshire
BSCB
Safeguarding Children Board

ANNUAL REPORT

2016-17

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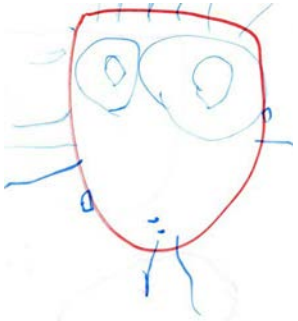


Forward

Welcome to the BSCB Annual Report

I am proud to write the Chair's introduction to this year's annual report as I really believe that local children's services and partnership working in Buckinghamshire have turned yet another important corner in the last year and the Board itself has reached a more mature phase. Both are now well placed to take on some broader challenges with other partnerships and to support further innovation in front line services over the year to come. The closer involvement of Head Teachers and Schools, and some new lay members, in the work of the Board has also helped deliver significant improvement and connectivity that benefit children and young people across the County.

During 2015/16 the Board signed off the delivery of its improvement and development plan, following recommendations from the 2014 inspection of children's services. In addition a lot of further work was completed to strengthen governance and synergy across the Board and its sub-groups, strengthen and broaden the Board's Learning and Improvement Framework and to increase multi-agency learning opportunities in addition to the BSCB core programme. This included sessions to share and embed the learning from a series of Serious Case Reviews (SCR), including our SCR into Child Sexual Exploitation in Buckinghamshire between 1998 and 2016, and SCRs on babies who died as a result of non-accidental injury. These actions and learning from these reviews are being closely monitored and reported to the Board. I would particularly like to commend the work of the Child Death Overview Panel (CDOP) and to thank them for their drive and commitment to review and complete a significant back log of cases and to implement a new electronic system which will support more timely reviews in future years.

I would also like to commend the work of the Performance and Quality Assurance Sub Group, in particular their work with other sub groups to develop what is now a very robust set of performance data reports to help the Board to monitor and challenge progress in key areas of concern and take further action where this is required. Some examples from this data reporting are contained throughout this report.

I am also pleased to report on how young people have been further involved with the work of the Board for example through the ongoing development of our new website for young people, participating in the delivery of our two anti-bullying and e-safety conferences and through representation on our E-safety Sub Group. The Board was also pleased to be part of a Youth Voice event on E-safety. The views of young people expressed at this event will inform our future work in this area.
In last year's report we were able to set out all the changes and activity that the Board and its partners had driven or supported. However, we weren't able to fully evidence this in terms of the difference it was making for children. I am delighted that in this year's report we are able to more fully evidence the impact of work over the recent year. Examples include evidence of improvement within a number of services including the Independent Reviewing Officer (IRO) and Local Authority Designated Officer (LADO) and improvements in the timeliness of responses to contacts and referrals to Children's Social Care.

I would like to say a huge thank you to all the partners who have given so much commitment to helping the BSCB make a real difference for children, also to front line staff across the partnership who are the ones who have actually delivered these improvements. We all value the extra mile which so many staff go to help children and young people in Buckinghamshire.

Fran Gosling-Thomas
BSCB Independent Chair

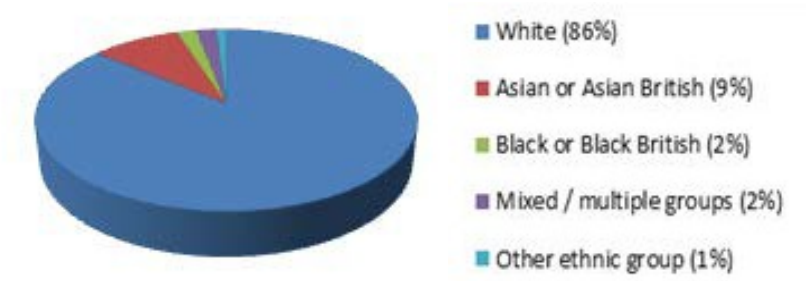
1. Our County and Our Children

Buckinghamshire is a county of contrast, with a predominantly rural north and a more urban south. Mid-year population estimates for 2016 project a Buckinghamshire population of almost 535,000. Each year around 6,000 babies are born. The current child population is[1]:

0-4 years	33,132
5-9 years	36,035
10-14 years	33,175
15-19 years	31,113

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[2]). Of these 5.3% are of non-British white origin. The largest non-white ethnic group is Asian / Asian British, 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.

Figure 1. Buckinghamshire Population by Ethnicity (2011 census)



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 17.5% of children and young people speak English as an additional language (England average: 20.6%) and in secondary schools the figure is 16.3% (England average: 16.2%).[3]

In Buckinghamshire, 5.3% of households (10,550 households) were classed as lone parent households with dependent children, compared to 7.1% in England.[4] 9% of babies (540 babies) were born to lone parents in 2015 in Buckinghamshire, with lone parent families more prevalent in these deprived areas of the county.[5]

Buckinghamshire has much better educational attainment than the national average, a highly skilled workforce, and lower levels of poverty and unemployment. Buckinghamshire is ranked as the second least deprived county in England.[6] In 2014, about 10,500 (10.8%) children under 16 years of age lived in low income families, compared with 14.7% in the South East and 20.1% in England.[7] The proportion of children entitled to free school meals is 6.4% in primary schools (the England average is 14.1%) and 4.5% in secondary schools (the England average is 12.9%).[8] Overall, a number of

[1] Mid-year Population Estimates 2016. Available from: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool
[2] 2011 Census
[3] 2017 data from Local Authority Interactive Tool. Available from:www.gov.uk/government/publications/local-authority-interactive-tool-lait
[4] 2011 Census
[5] Director of Public Health Annual Report 2016. Available from: www.healthandwellbeingbucks.org/jsna-dphar
[6] 2015 Indices of Multiple Deprivation. Available from: www.buckscc.gov.uk/community/research/deprivation/
[7] Director of Public Health Annual Report 2016. Available from: www.healthandwellbeingbucks.org/jsna-dphar
[8] 2017 data from the Local Authority Interactive Tool.

favourable socio-economic circumstances contribute to the better health and wellbeing of the Buckinghamshire population compared to nationally.

However, Buckinghamshire also has a number of pockets of significant deprivation, with some areas in Aylesbury Vale falling in the second most deprived decile.[9] The geography and location of the county also lead to some specific challenges. For example, across the Buckinghamshire Thames Valley Local Enterprise Partnership area, 8.2% of households are in the most deprived 10% of areas nationally in terms of barriers to housing and services. This reflects low income relative to high housing costs and the distance to services in more rural areas of the county.

Deprivation can have a significant and lasting impact on children and therefore it is important that agencies providing and commissioning services in Buckinghamshire understand local need and can target services accordingly.

- children living in the most 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 most 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]

[9] 2015 Indices of Multiple Deprivation. Available from: www.buckscc.gov.uk/community/research/deprivation/
[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. Our Board

The Children Act 2004 currently 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 safeguard 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 eight 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 2016/17 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[12]:

- 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.

Business Planning and Priorities

Every year the BSCB holds a business planning session 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 2016/17, the BSCB agreed on the 5 priority areas on the next page.

This year has seen a continued focus on driving improvement following the 2014 Ofsted inspection when both the Board and local authority services for children in need of help and protection, children looked after and care leavers were judged to be inadequate. However, whilst 2015/16 was used to review the foundations of the Board and ensure the right building blocks were in place, 2016/17 has been an opportunity to move back to business as usual. It has also been an opportunity to look forward and start to think about the future shape of the BSCB following the Wood Review of Local Safeguarding Boards and the subsequent changes to the statutory framework for LSCBs which are now underway. The new framework will remove the requirement for LSCBs in their current format and give local areas greater freedom to agree their own local arrangements. However, given the significant improvements the Board has put in place over the last two years and the sustained effort from partners to put the Board on a more secure footing, Board members have agreed not to implement any radical changes to the current Board structure for the time being.

[12] 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

Priority 1

Early Help, Thresholds & Neglect

Priority 2

Child Exploitation

Priority 3

Child's Voice & Journey

Priority 4

Workforce

Priority 5

Impact & Effectiveness of the Board

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. During 2016-17 we recruited 3 new Lay Members to the BSCB, after our previous two long-standing Lay Members stood down during 2015/16. We are delighted to welcome the new perspectives and voices that our 3 new members bring to the Board, and the strong commitments and contributions to the Board that our new Lay Members have already demonstrated.

3. Early Help, Thresholds and Neglect

Our Aim: Children and their families have timely access to appropriate early help and support.

Working Together 2015 sets out a specific role for LSCBs to assess the effectiveness of the help being provided to children and families, including early help. 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.

For 2016/17, the BSCB incorporated neglect into the early help priority as we recognised the importance of an approach based on partners identifying neglect and putting the right support in place at the earliest possible opportunity. Research nationally identifies neglect as the most common reason for children to become subject to a child protection plan.[13] 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.**

Figure 2. Children becoming the subject of a Child Protection Plan for neglect (rate per 10,000 children under 18)

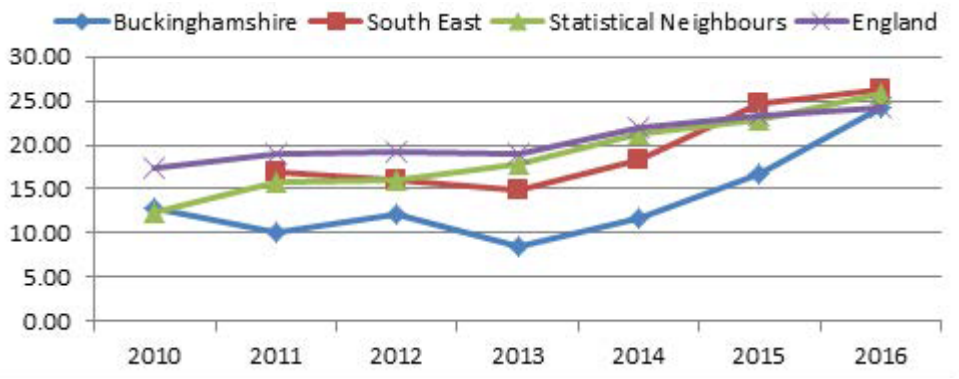
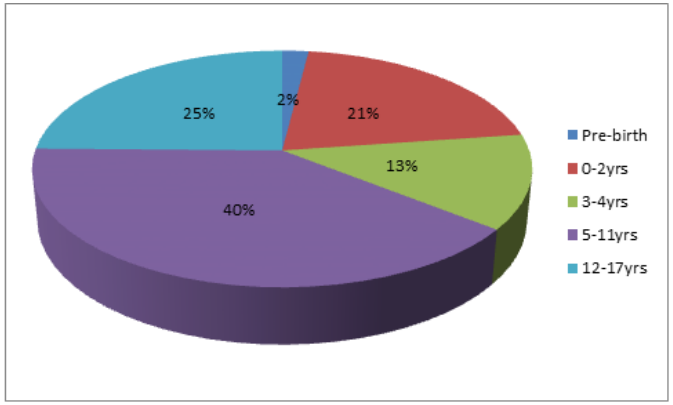


Figure 3. Buckinghamshire children on a child protection plan for neglect by age (snapshot May 2017)



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

Improving Knowledge and Understanding of Thresholds

What did we do?

Over the last two years the BSCB has put in place a strategy to improve knowledge and understanding of thresholds. This has included:

- thresholds document updated in partnership and over 4,000 laminated copies distributed for display across partners
- two wallet cards and a referral flow diagram produced to reinforce knowledge about what action professionals should take when there is concern about a child
- tailored awareness raising training provided across a number of partners including Thames Valley Police, Early Years Providers, District Council staff, libraries, clerks to Governors, and tools provided to help agencies deliver their own training to staff
- the embedding of key messages around Early Help and Thresholds into BSCB training and the inclusion of Early Help awareness and Family Outcomes Star courses into the main BSCB training programme
- significant work between Children's Social Care and partner agencies to look at the quality and appropriateness of referrals.

Why did we do it?

The BSCB Thresholds document outlines 4 levels of need to identify when a child may need additional support to reach their full potential. When Ofsted undertook their inspection in Summer 2014, they commented on poor knowledge of thresholds across the partnership. It is important that thresholds for intervention are well understood by professionals working with children so that the right support can be put in place at the right time to effectively meet the child's needs.

Next steps?

Whilst there is now good evidence that knowledge of thresholds has improved and is now embedded, the Board and its partners will continue to promote knowledge and understanding as part of our 'business as usual' activity. For example:

- reviewing the appropriateness of Thresholds decisions is a standard part of BSCB multi-agency audit activity
- the BSCB training programme will continue to promote effective use of thresholds
- we are producing an online training tool around Early Help and thresholds which will be available via our website
- Children's Social Care continues to work with partners to review the quality of referrals and to offer support where any concerns are identified.

Evidence of impact and outcomes?

In Spring 2015, the BSCB ran an online thresholds survey which provided further evidence that knowledge needed to be improved. Between September and December 2016 we ran a second survey to help us understand how well the Thresholds document is used and understood across partners. 460 professionals responded and the results demonstrated a large increase in knowledge and usage of the document compared to the 2015 survey.

- 90% of respondents were aware of the Thresholds document compared to 60% in April 2015
- 93% said they know where to access the Thresholds document
- 87% said the thresholds document is prominently displayed in their office
- 79% said they use the thresholds document either regularly or sometimes compared to 61% in 2015 (not all respondents were in a role where we would expect them to use the document on a regular basis)
- only 6% of respondents said they never used the Thresholds document.

There has been good external validation that partnership knowledge has been improving. For example, a peer review of the local authority noted there was good evidence of the Thresholds document being prominently displayed in partnership settings, and following one of their monitoring visits Ofsted noted *that "The partnership has been working effectively to strengthen a common understanding of thresholds".*

There have also been improvements to the conversion rate between contact and referrals, in particular a decrease in the number of contacts with No Further Action.

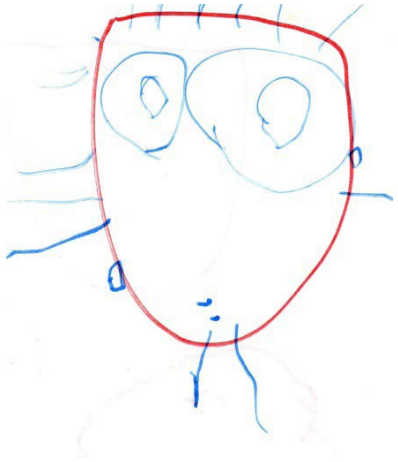
At a **strategic level**, the key areas of progress during 2016/17 have been:

- Clearer **governance arrangements** were designed in partnership and put in place for early help. These changes led to the creation of two new multi-agency groups (an Early Help Strategy Group and an Early Help Operational Group) to drive early help at both a strategic and operational level. As a result of this, the BSCB disbanded its previous Early Help Sub Group, with reporting to the BSCB now provided through the new groups.
- Continued development and use of the early help **data dashboard** to give the BSCB oversight of the effectiveness of local arrangements.
- Continued **communication** and awareness raising around thresholds (see story board on p9).
- Incorporation of early help **training** into the main BSCB programme, through the provision of Early Help Awareness Raising training and roll out of Family Outcomes Star Training.
- A multi-agency workshop to start developing a clearer multi-agency response to neglect which fed into the development of our draft neglect strategy.
- Work with the NSPCC as part of the phased piloting and roll out of the new Graded Care Profile tool for neglect. By April 2016 targeted training and testing had been completed ahead of roll out as part of the main BSCB training programme.

At an **operational level**, work has focused on the continued embedding of our **Early Help Panel**. The aim of the Panel is to improve positive outcomes for children and families with complex issues, who require a coordinated, multi-agency response. This is achieved by creating tailored plans that strengthen protective factors in the family and mitigate against risk factors. Early Help Best Practice Guidance has also been produced and published on the BSCB website to help support and further embed good practice across all professionals working with children and families.

Looking beyond the Early Help Panel, high level indicators for early help show that we perform well in comparison to our statistical neighbours in relation to a number of areas and this helps achieve good outcomes for children:

- There is a high level of take up of targeted, **free nursery provision** for 2 year olds.
- **Rates of unauthorised and persistent school absence** are lower than statistical neighbours and the national average at both primary and secondary level.
- Buckinghamshire continues to have lower rates of 10-17 year olds entering the **criminal justice system** for the first time compared to statistical neighbours and the national average; and a lower rate of young people who receive a conviction in court who are sentenced to custody.[14]



[14] Source: Local Authority Interactive Tool data to 2016. Available at: www.gov.uk/government/publications/local-authority-interactive-tool-lait

Evidence of effectiveness: The Early Help Panel

The Panel Process is now well embedded

- In the first year of operation (to June 2016) 459 families and 1,113 children were discussed at the Early Help Panel.
- The appropriateness of referrals heard at the Panel was a concern during the early months of operation, but had increased to 90% by the time of the 12 month evaluation report and increased to almost 100% in the months following this report. This means the Panel is able to concentrate on the right referrals.

Strong partnership working continues to contribute to this success

- Strong partnership working has been a major contributing factor to the success of the Early Help Panel, and the Panel has also helped drive improvements in partnership working.
- During the first year of operation, there were 30 different referral source agencies to the Panel, with schools being the largest single group at 43%.
- Lead Family Workers were provided by 18 different agencies, with the Family Resilience Service continuing to take the bulk of referrals at just over 60%.

There is emerging evidence of positive outcomes for families

- Although it will also be important to review outcomes for families on a longer term basis, for those families who had concluded their engagement with the Panel by June 2016, positive outcomes were achieved for 67% of families. A further 33% were successfully stepped up to statutory Social Care services which were required to provide the family with the level of support they needed.
- In Spring 2016, the Early Help Operational group oversaw the preparation of a booklet of Family Stories. This illustrates the positive difference that has been made to the lives of a number of individual families through the provision of early help support. The full booklet is available on the BSCB website, and one of the case studies is reproduced on the next page.
- There has been positive feedback on the success of intervention from over 400 children and families.
- A longitudinal study is being carried out by Oxford University on outcomes for children, and early indications from this are positive.

Case Study: The Jenkins Family

The family

- Mum is Trina Jenkins who lives with her son Roger (10).
- The Jenkins family were referred by school and discussed at the Early Help Panel, as the relationship between Mum and Roger was an area for concern. Mum stated they had never bonded and frequently argued.
- Roger had told school staff that he wanted to kill himself and had very low self-esteem.
- Mum also had mental health issues and was smoking cannabis. She was not able to meet Roger's needs, the home was unkempt and she was not cooking meals.
- Roger has a diagnosis of ADHD and takes daily medication.
- The school reported that Roger was exhibiting inappropriate behaviours towards other students. He was socially isolated and not completing his homework.
- Roger regularly visited his father and new partner. It is known that the partner has had children removed from her care.
- Mum was claiming benefits, did not budget well and had accrued significant debt. She had a history of drug use and was fostered early in her childhood. She had also recently received two police cautions.

How did we help?

- We supported Mum with debt management and introduced her to a supportive charity.
- Parenting support was provided to help with boundaries, routines and rewards and the star chart was introduced.
- We arranged practical support as Mum doesn't drive and delivered free food parcels.
- We found activity camps for Roger to attend over the summer holidays and provided transport.
- We completed one-to-one support for Roger including trips to the cinema, a dog's home, parks and caves. Mentoring support was also completed for Mum.
- We linked with the appropriate primary and secondary schools to aid Roger's transition.
- We liaised with a family worker at a local Church to look at Social Networks going forward for Roger.
- We held a school meeting with the Deputy Head Teacher and Mum, where we discussed Mum's concerns about Roger and formulated a plan to aid communication.
- We had a conversation with Dad about supporting Roger with homework during weekend visits, and to adapt his routine so Roger can attend the after school homework club.
- We negotiated with Dad to provide additional financial support.

What has changed for the family?

- There is a stronger relationship between Mum and Roger, who engaged in outings and spent quality time together over the summer holidays. For the first time Mum bought presents on Roger's birthday.
- Roger is fully prepared for secondary school, with all his uniform purchased and labelled. School are reimbursing Mum for uniform costs from Pupil Premium.
- School are funding free school lunches for Roger.
- Mum is now prioritising Roger's needs, preparing packed lunches (when needed) and proper meals, as well as completing homework tasks together.
- Mum is proactively dealing with the financial situation and following advice from the charity.
- Mum has reduced her use of cannabis.
- Mum has visited her GP about her personal wellbeing and drugs habit and is taking regular anti-depressant medication.
- Dad is actively involved in Roger's needs around school.

"My son now sleeps in his own bed and his behaviour has become a lot less aggressive and my daily routine has come together."

Next steps?

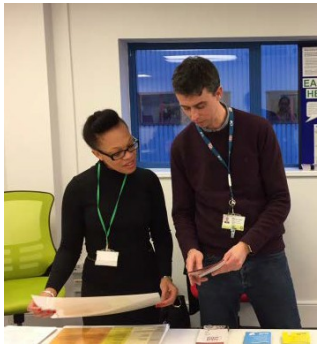
- Mum to continue to receive support from Bucks Floating Support, Citizens Advice, Rape Crisis, Thames Valley IDSVA and her local church.
- Book Mum a place on the Teen Triple P parenting course.
- Continue to advise Mum to seek help from her GP in relation to her Mental Health.

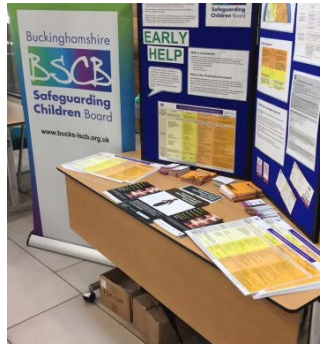
Next Steps

- Over the next 12 months it will be important to ensure new governance arrangements for Early Help are fully embedded, and that they continue to provide the BSCB with oversight of the effectiveness of early help. The Early Help Strategy will need to be updated to reflect these new arrangements and our developing approach, and the existing early help dataset will need to be aligned with the new outcomes framework for early help.
- Analysis of Early Help Panel and Children's Social Care referrals is raising some bigger systemic questions that will be important to consider as our approach to early help continues to evolve. For example

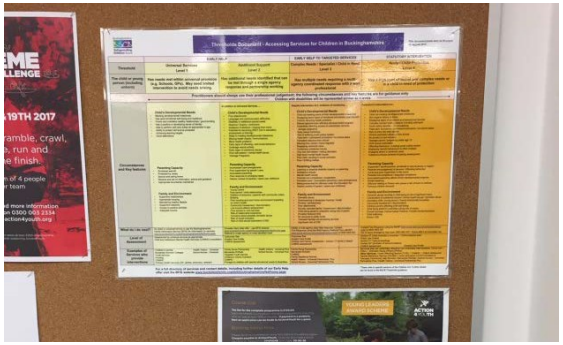
  - Currently a large proportion of families referred to the Early Help Panel are already known to Children's Social Care. Whilst this proportion may decrease as the system continues to embed over time, this will be important to keep in view to ensure we are providing help at the earliest possible opportunity.
  - Given that the highest proportion of Early Help Panel referrals are coming from schools there may be a need to explore whether concerns are being picked up early enough in a child's life.

- The key challenge in relation to early help is the increasing pressure that is being put on Children's Services at the same time as less money in the public purse. However, this is also an opportunity for partners to think about how we can work differently together to ensure that collectively we provide joined up services that reach those that need them the most, and which try to stop small problems becoming bigger and more difficult to manage. Against this context, the Local Authority is currently reviewing its own Early Help services and this will be an area of increasing focus for 2016/17.
- The partnership has still not set out a clear strategy for tackling neglect and this needs to be progressed as a matter of urgency.
- Whilst early progress has been made in starting to train staff to use the Graded Care Profile for use in cases of neglect, training will need to be rolled out much more widely over the next 12 months and some work done to look at evidence around the impact of using the tool.





Board representatives continued to attend events to raise awareness of Early Help and Thresholds. Above left: two Board representatives are attending an event for the voluntary sector arranged by Action 4 Youth. Above right: the BSCB stand at our Pre-Birth conference.



This year we continued to see the impact of our Thresholds awareness raising. We found the Thresholds document on notice boards all over Buckinghamshire.

4. Child Exploitation

Our Aim: Children and young people in Buckinghamshire are effectively protected from exploitation

Last year the BSCB had a specific priority around Child Sexual Exploitation (CSE). This year, the priority was broadened to include the wider child exploitation agenda, for example radicalisation, human trafficking and modern slavery. This acknowledges the similarities between CSE and other forms of exploitation, both in terms of the vulnerabilities and warning signs amongst children who are exploited, and the 'grooming' behaviour from those perpetrating this type of abuse.

At a **strategic level** key developments include:

- Completion and publication of a Serious Case Review exploring the response to CSE in Buckinghamshire from 1998 until 2016. This found **good practice** and **strong partnership working** in place to tackle sexual exploitation, as well as identifying some areas where working could be strengthened further. The story board on p17 provides information on the main findings and next steps in relation to this review.
- Joint working with the national charity PACE (Parents against Child Sexual Exploitation) to start a **dialogue with parent**s of local children who have been sexually exploited. The feedback from this dialogue is now informing the further development of BSCB work around CSE and one of the parents is now a full member of our Child Exploitation Sub Group.
- Continued use of the **RUWise2it?** campaign to raise awareness of CSE amongst children, parents and carers.
- Following our successful delivery of the drama production **Chelsea's Choice** during 2015/16, we were successful in gaining funding from the Police and Crime Commissioner to deliver this production for the third time starting in September 2017.
- Continued use of the parents evening/ community event format to **raise awarenes**s of CSE with parents and carers. These ran until July 2016, with almost 300 parents reached.
- Engagement with the **local media** to raise awareness of CSE, with a focus on spotting the signs, reporting concerns and where to go for help. This included work to coincide with CSE Awareness Raising Day, to promote parents evenings and significant work with the local media ahead of the publication of our CSE Serious Case Review.
- A developing dialogue with the Safeguarding Adults Board (BSAB) and Safer Stronger Bucks Partnership Board (SSBPB) to explore our response to children who are exploited as they become

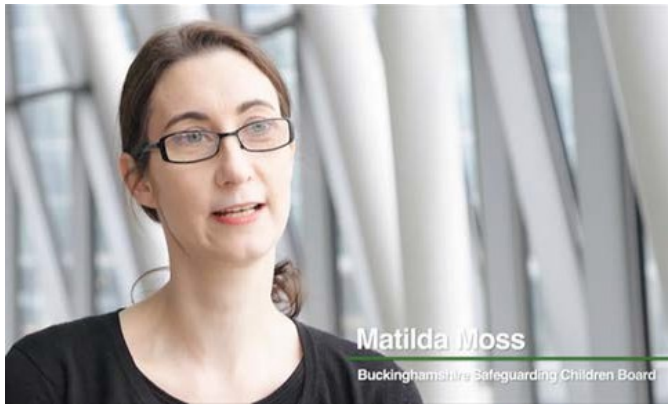
Above left: poster advertising community awareness raising events on CSE.

Above right: many of our Board partners continued to show their commitment to tackling CSE by displaying our CSE promise in public areas (this example from Chiltern District Council).

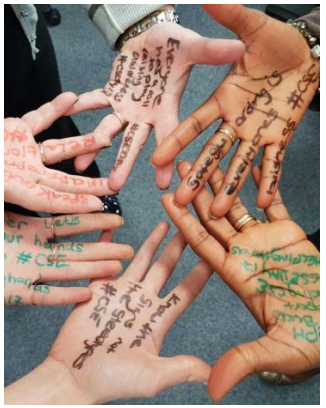
adults, and our response to adults who disclose that they were exploited in their childhood. The story board on p16 provides some of the key learning from a BSCB audit to look specifically at **exploitation and transitions** which has influenced these dialogues.

- The Child Sexual Exploitation Sub Group undertook some work to explore the link between **CSE and learning disability**. This included auditing the minutes from M-SERAC meetings and benchmarking our local approach against the recommendations from the Barnardo's report *'Unprotected, Overprotected: meeting the needs of young people with learning disabilities who experience, or are at risk of sexual exploitation'*. The findings from this will inform our work moving forward.
- The completion of some work on peer on peer abuse with the MsUnderstood Partnership through the University of Bedfordshire. Following a programme of work during 2015/16, we continued to share local learning on peer on peer abuse, including through a multi-agency session led by Carlene Firmin MBE. The Board was also invited to share their learning with other local authorities at the launch of the University's Contextual Safeguarding Network and contributed a short video to their online resources.
- Discussions through the Designated Safeguarding Lead forums for schools to share good practice and understand challenges for schools in relation to CSE and Prevent.

Above left: peer on peer abuse learning event. Above right: discussing CSE and Prevent with school Designated Safeguarding Leads.



The Board Business Manager recorded a video for the University of Bedfordshire's online Contextual Safeguarding network.



Images from our CSE Awareness Raising Day campaign in March.

Learning from Audits: Child Exploitation and Transition

What did we do and why?

The CSE Sub Group raised questions around whether there is:

- Sufficient support in place for children who have been exploited once they turn 18. At this point they cease to be eligible for support through Children's Social Care and a number of other services that are provided for children
- A sufficient local response in place for victims of exploitation who have learning disabilities.

Our Performance & Quality Assurance Sub Group therefore led a multi-agency audit of the journeys of 5 individuals; 3 children approaching the age of 18 and 2 adults who had recently turned 18. The audit explored whether any transition planning was taking place and whether appropriate services were available after the age of 18.

Key learning?

Good practice: Looking back over the journeys of these 5 individual highlighted a number of areas where our response has improved in more recent years. This included the development of stronger disruption activity and more robust responses to alleged perpetrators of exploitation compared to the past. This is consistent with findings from the CSE Serious Case Review (see p14).

Areas for development:

- There was **no transition planning** for any of the 5 individuals as they approached 18. At the same time, there is a drop off in services at 18, with much higher thresholds for adult services.
- Children with a diagnosed **learning disability** are able to be supported for longer through Children's Services (until 21 years), but this can just postpone the drop off in services. Where a learning disability is undiagnosed this may impact on the continued availability of services
- The audit raised questions about the **availability of services:**
  - The lack of a specific response in Buckinghamshire to adult exploitation. Currently Adult Mental Health Services may end up as the only available route for continued support, but this is not always appropriate.
  - The level of support for young people identifying as Lesbian, Gay, Bi-Sexual, Transgender (LGBT).

Evidence of impact and outcomes?

By the end of the financial year, the following action had been taken in response to the audit:

- Learning from this audit and the CSE Serious Case Review have informed on-going discussions around how to **improve our response** for children who are exploited as they turn 18 and beyond. The BSCB will continue to support this dialogue with a view to having an effective response in place within the next 12 months.
- The learning from this audit influenced the decision of the CSE Sub Group to broaden its remit and look at broader issues of **child exploitation**. This reflected the fact that across the 5 journeys different forms of exploitation existed alongside CSE.
- The BSCB asked all Board partners to review their own **arrangements for transitions** in the light of the learning from this audit.

Next steps?

- Consider whether there needs to be a multi-agency forum to discussion **transitional arrangements** in relation to exploitation.
- Further explore the support provided to **LGBT** young people.
- Continue to support discussions around how services continue to be provided **post 18.**

Storyboard: CSE Serious Case Review

What did we do?

The BSCB commissioned a Serious Case Review (SCR) to look at the partnership wide response to CSE from 1998 to 2016. Unlike most SCRs, it did not concentrate on 1 child. The Board recognised there were a number of victims across this timeframe and wanted to be able to take account of the full spectrum of cases and look at the effectiveness of the partnership response over time. Whilst not focusing on one child, the review engaged with a number of victims and some families, and their views and stories are woven throughout the report.

The aims of the review were to:

- look at how CSE was **managed** in the past in Buckinghamshire
- find out what **level of service** is currently available to children and adults facing CSE
- look at whether **outcomes** for children and young people have improved
- identify what is going well and any areas of **learning**
- identify what needs to **change** to improve our response.

Key learning: good practice

More recently, and in particular over the last 3 years there has been **significant improvement**. For example:

- agencies now work better together to provide a **coordinated response**, for example through the specialist Swan Unit and through improved partnership working overall
- there is a strong CSE service provided by **R U Safe?**
- there is **improved leadership** at a strategic level through the BSCB
- increased **training and learning opportunities** are available for professionals through the BSCB and training provided by individual agencies
- a range of **awareness raising** activities are carried out for children, parents and carers.

Key learning: areas for improvement

14 recommendations were made, highlighting areas which could be strengthened both locally and nationally. These focused on:

- **Support for children:** The need to maintain a frontline CSE Service and for the BSCB to continue awareness raising work with children to help them recognise the signs and know where to seek help.
- **Support for parents and families:** The report recognised the impact on parents and families and recommended that a family worker should be employed to make sure the parents and siblings of victims can access appropriate support.
- **Support for adults:** Partners should work together to ensure exploited children continue to get the right support once they turn 18 and that the right support is in place for adults who come forward and disclose exploitation many years after it happened.
- **Taxi licencing:** The report recognised the important role taxi drivers can play in spotting and reporting concerns, but that it can be difficult for licencing authorities to get enough information to help them respond where there are concerns about the behaviour of drivers. The report recommended the government could improve this by having a single database of all licenced drivers who have been subject to any sanctions. Our District Councils also need to work more closely with Thames Valley Police to share information on taxi drivers.
- **Communication and information sharing:** A clear approach needs to be put in place for sharing different types of information relating to CSE – for example information relating to a location or group rather than an individual child.
- **Community Engagement:** We need to have a stronger strategy in place to engage with communities around CSE. We also need to evaluate and strengthen the developing work in the night-time economy – e.g. with hotels, pubs and taxi drivers.

Next steps?

The publication of this SCR came right at the end of the financial year. Therefore a key task for the BSCB will be to drive and monitor the implementation of the recommendations through 2017/18 and to build on the good practice identified.

At an **operational level** a coordinated partnership response is supported through the following arrangements:

- **Barnardo's R U Safe** continues to provide a 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, awareness raising and preventative programmes. A number of other services are also available to support children, and increasingly these services are taking a shared responsibility for the partnership response, particularly for those cases where there is a lower level of risk. For example, our youth service is able to provide targeted work around healthy relationships or some of the other areas of risk associated with CSE.
- The multi-agency **Swan Unit**, which was set up in 2015, provides a specialist input to the assessment of new referrals where there is CSE or a risk of CSE, managing strategy meetings (MACE) and supporting other professionals who are working with young people experiencing or at risk of CSE. All new referrals of children to Children's Social Care which involve CSE are now initially managed through the Swan Unit.
- 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?

- Figure 4 shows that the number of referrals to R U Safe? has remained fairly consistent over the year. A total of 166 children were referred to R U Safe? because they were at risk of or experiencing CSE. This compares to 178 referrals in 2015/16. However, as the year progressed the focus of the service shifted more heavily towards children missing. This accounts for the drop in the number of children on the active caseload, which reached a low point of 72 during quarter 4. It is expected that the greater focus on missing will continue into the next financial year. This partly reflects that the partnership response to CSE is now well embedded with the Swan Unit and other services able to effectively manage a number of cases that would previously have been channelled through R U Safe? The BSCB will continue to monitor the impact of this shift to ensure that children to receive the service they need. Data for the Swan Unit is only available from October 2016. Between October 2016 and March 2017, the Swan Unit started working with 32 children who had been referred to Children's Social Care as a result of concerns around CSE.
- Age: The majority of R U Safe? clients for 2016/17 were aged 14 or 15 (44% compared to 45% for 2015/16) and 83% of all CSE clients were aged between 13 and 17 (compared to almost 90% for 2015/16). The M-SERAC profile is broadly in line with this.
- Gender: More females are reported at risk of or victims of CSE. During 2016/17, 87% of children using the R U Safe? service were female (compared to 90% in 2015/16). The M-SERAC profile is broadly in line with this.
- Ethnicity: 76% of R U Safe? CSE clients during 2016/17 were white British (compared to 79% in 2015/16). 7% were Asian or Asian British (compared to 6% in 2015/16) and 5% were Black or Black British (the same as 2015/16). 2011 Census data recorded that 78% of the Buckinghamshire population aged between 10 and 19 was white British meaning figures are largely reflective of the local demographic.
- 29% of R U Safe? clients (missing and CSE) held Child in Need status, 20% were on a Child Protection Plan and 24.5% were Looked After Children.

Evidence of Outcomes

- **R U Safe**: Across quarters 1-4 an average of 71% of clients maintained engagement with planned care (against a target of 70%). At point of exit, 100% of sexual exploitation clients fed back that they had benefited from the service, 78% had reduced association with risky peers / adults, 87% demonstrated knowledge of sexual health strategies, 81% had satisfactory school or college attendance.
- **Swan Unit**: Auditing within the Swan Unit continues to show good evidence of positive outcomes being achieved for children.

"My RUSafe worker understood everything about me and helped so much."

"I now know many dangers/ risks I wasn't aware of before."

"I have changed the way I look at life and what I want to do in life."

"I chose not to listen to my worker and think I was cleverer but I wasn't, but she's still changed me and helped me."

Figure 4: Barnardo's R U Safe? Number of children referred, number of children on active caseload and number allocated to an R U Safe? worker

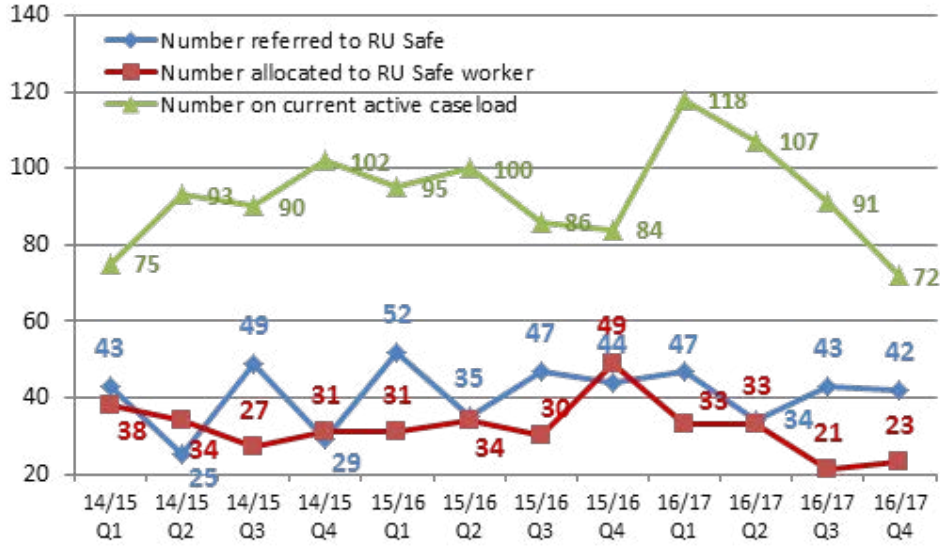
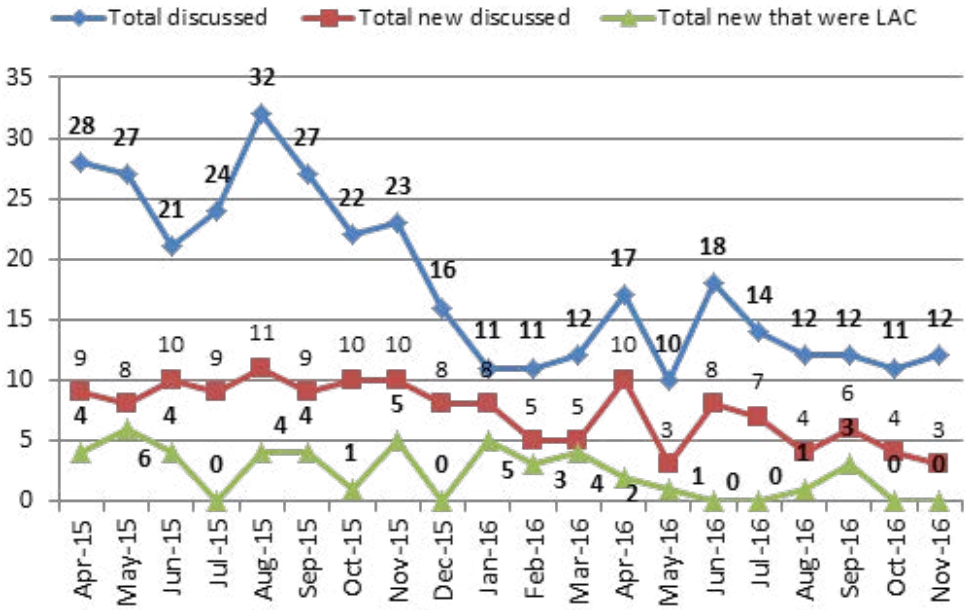


Figure 5: Number and type of new cases discussed at M-SERAC



Next Steps

Whilst the CSE Serious Case Review in particular has provided assurance that there is a good partnership response to CSE, there are a number of key areas of focus for the year ahead:

- ensure we deliver the recommendations from the **CSE Serious Case Review**
- deliver the next round of **Chelsea's Choice** and continue to evaluate this as a mechanism for **raising awareness** with children
- widen our approach to raising awareness with parents and carers so that we can reach a larger number of people
- strengthen our approach to wider forms of exploitation, including;
  - reviewing and broadening out our current CSE dashboard so the Board has assurance around the wider exploitation agenda
  - broadening our CSE Strategy and Practice Guidance to embrace the wider agenda
  - running two Exploitation Conferences in April and May to look at exploitation acrosss adults and children – jointly with the Buckinghamshire Safeguarding Adults Board (BSAB), the Health and Wellbeing Board (HWB) and the Safer Stronger Bucks Partnership Board (SSBPB).

Children Missing

At an operational level, M-SERAC continues to act 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. Feedback is that the M-SERAC process is working well with good multi-agency engagement. Children missing is now reported to be taking up a larger proportion of these meetings which is reflective of an embedded partnership approach to CSE and reinforces that missing needs to be an area of focus going forward.

Figure 6: Number of children age 11-18 reported missing and returned (source R U Safe?)

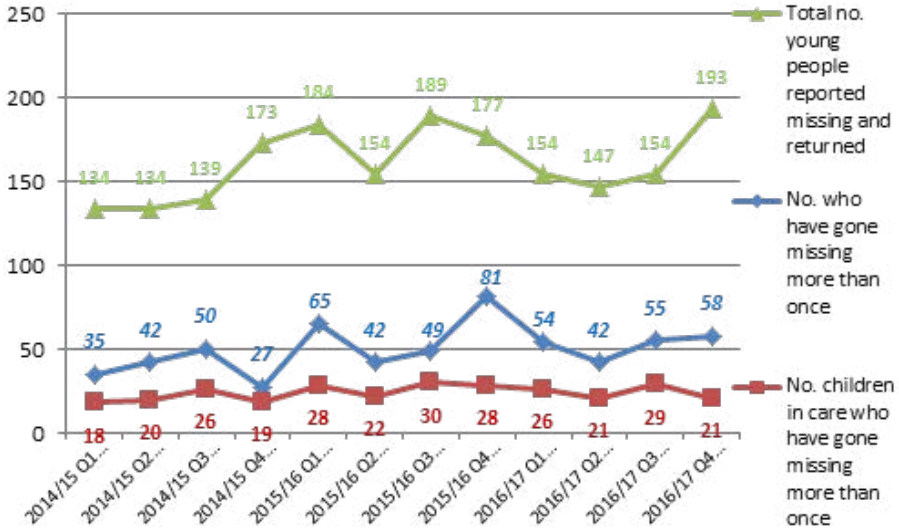
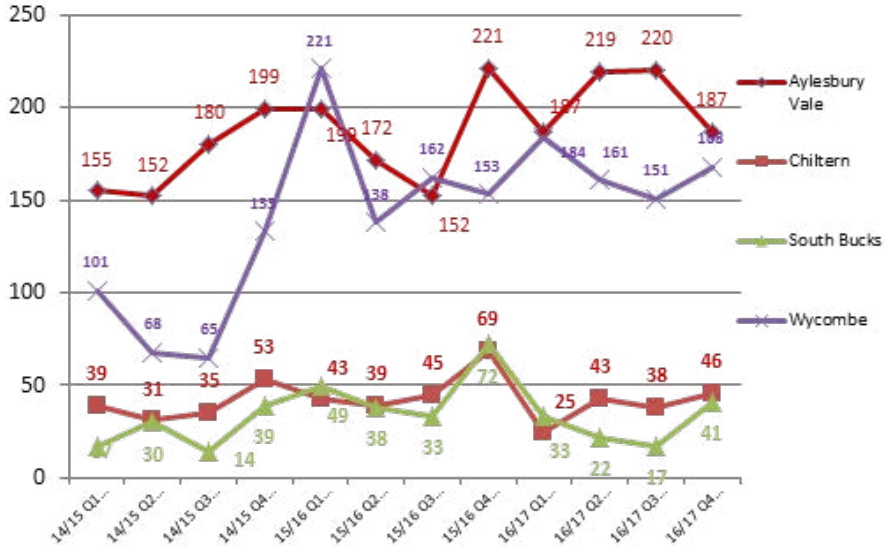


Figure 7: Missing episodes for children age 0-18 in Buckinghamshire (by District Council area) (source Thames Valley Police)



Barnardo's R U Safe? provides a missing service, including completing return home interviews for children returned from missing episodes. Over 2016/17 as a whole, an average of **69%** of the clients had a **reduced number of missing episodes** after working with the service, **100% had reduced association with risky peers or adults and 100% had satisfactory school or college attendance**.

Over the last year:

- Aylesbury Vale and Wycombe continue to have a significantly higher number of missing episodes for children compared to the other districts (figure 7)
- **81%** of all missing episodes reported to Thames Valley Police were for children aged between **14 and 17**
- for the cases where ethnicity was recorded, **75%** of missing episodes were children from a **white background**. However, ethnicity was not recorded or stated in 27% of cases, making it difficult to draw conclusions around this data
- for children aged 0-18, **boys** have slightly more missing episodes than girls (52% and 48% respectively).

Next steps

Over the next 12 months the Board needs to:

- continue to have oversight of the developing **operational response** to children missing
- continue to seek assurance around the quality and timeliness of **return home interviews** conducted for children missing
- update our **practice guidance** on children missing.

Press conference to launch our CSE Serious Case Review

5. The Voice and Journey of the Child

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.

The first part of this section explores the journey of the child through Children's Social Care by drawing on some key data. It seeks to highlight some of the key improvements both within Children's Services and across multi-agency working, as well as highlight areas of challenge that partners will need to work together to address. The second part of this section looks at how the voice of the child has directly influenced the work of the Board.

The Journey of the Child through Children's Social Care

The Front Door: Contacts and Referrals

The **First Response** team provides the **'front door'** or entry point to Children's Social Care and Early Help. The number of referrals can be influenced by different things at both local and national level. Nationally, there is evidence that demand on Children's Services is increasing as a result of multiple and complex factors including system changes across different organisations, changes to funding and to the local child population. Other factors have also been identified by Local Authorities as contributing to increasing demand, including rising levels of poverty and homelessness, increased pressures relating to domestic abuse, poor mental health and substance misuse.[15]

In Buckinghamshire, there was a spike in **referrals** to Children's Social Care in 2014 that was not reflected across statistical neighbours or nationally. To a large extent this was due to a temporary change in process where all contacts were progressed to referrals.[16] It also reflects a time when there were a number of challenges within the local system that were reflected in the outcome of the 2014 Ofsted inspection of local authority services for children in need of help and protection, children looked after and care leavers. Figure 8 shows that following this spike, there was a period when our referral rates were falling back in line with those of our statistical neighbours. However, since 2015 there has been an overall increase, which has been more significant than that across our statistical neighbours. One reason for this is likely to be the high **rate of re-referrals** (figure 11) in Buckinghamshire compared to statistical neighbours and national. At the end of quarter 4 2016/17, our re-referral rate was 32% compared to a South East regional average of 24%. Research and analysis led by the Local Authority has started to unpick the complex reasons for this. However, in-depth, coordinated work across the partnership will be needed to further explore and address some of the systemic questions that are likely to be behind our high rate. This is something the BSCB will need to drive forward over the coming 12 months to ensure that we are providing the right help and support for children the first time around.

[15] Molloy, D., Barton, S., Brims, L. (2017) Improving the Effectiveness of Child Protection Systems: Local Government Association. Available at: www.eif.org.uk/wp-content/uploads/2017/06/improving-effectiveness-child-protection-system_June2017.pdf

[16] 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 8: Rate of Referral to Children's Social Care (per 10,000 children under 18)

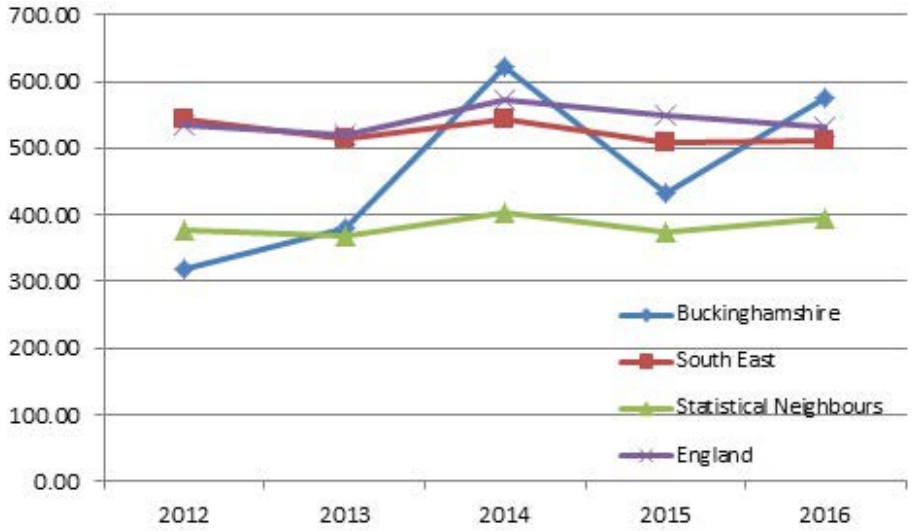


Figure 9: Buckinghamshire Rate of Referral to Children's Social Care (per 10,000 children under 18)

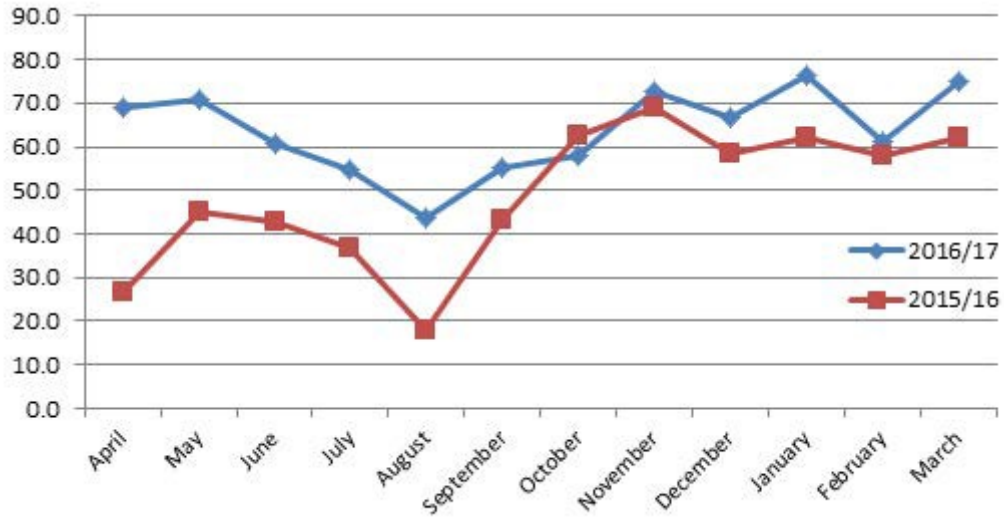


Figure 10: Outcome of Contacts to Children's Social Care

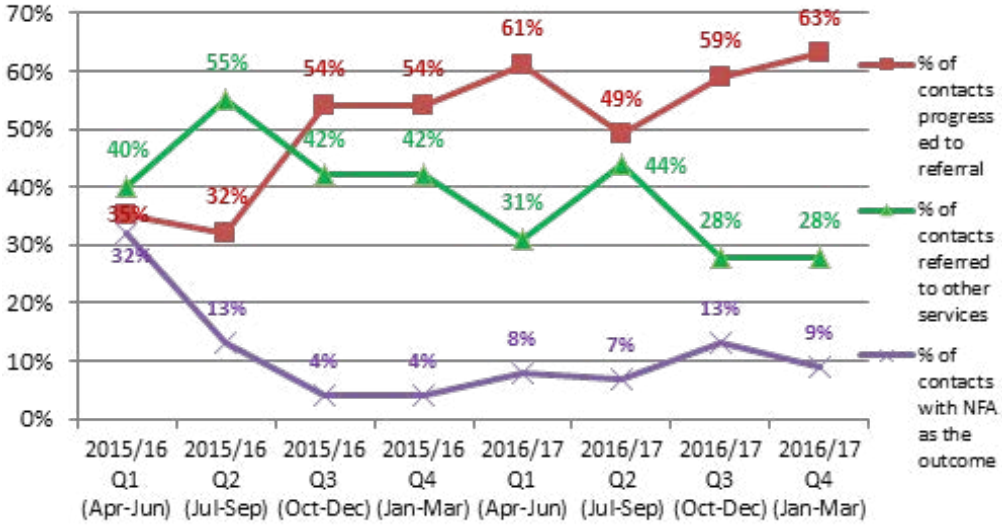
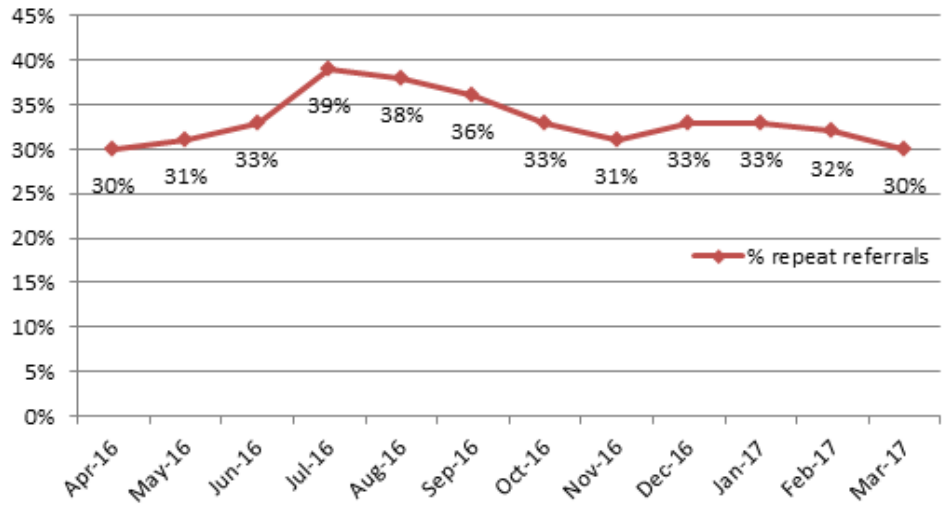


Figure 6: Rate of Repeat Referrals to Children's Social Care



The monthly breakdown of referrals for 2016/17 (figure 9) shows that referral rates have fluctuated during the year. The fluctuation of referrals is seasonal, for example with a dip in referrals over the school summer holidays when schools are making less referrals, and known peaks in December. Compared to last year, the number of referrals has increased but with traditional seasonal fluctuations continuing.

As last year, the highest number of contacts and referrals came from the Police (30% or 4812 contacts and 28% or 2539 referrals). Schools once again accounted for the second highest number of contacts and referrals (19% or 2998 contacts and 15% or 1400 referrals). Contracts and referrals from across the health economy were the third highest (17% or 2728 contacts and 13% or 1202 referrals).

Between June 2016 and March 2017, figure 12 highlights 10 primary reasons that accounted for almost 70% of all referrals to Children's Social Care (the data is not available in the same format for April and May 2016). The highest percentage of referrals were about domestic abuse (15.9%), physical abuse (12.2%) and neglect (8.5%).

The Multi-Agency Safeguarding Hub (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. Over the last 12 months there has been good and consistent multi-agency representation in the MASH which has assisted with the consistent application of thresholds and timely responses to child protection investigations. However, there have also been capacity issues within the MASH which have led to delays in decision making and additional pressures on staff. Fluctuations in the number of MASH enquiries (figure 13) suggest there is a lack of clarity around what should go through the MASH process. Work across the partnership will be needed over the coming months to ensure we have a resilient MASH in order to assist quick and effective decision making.

Figure 12: Reason for Referral to Children's Social Care (April 2016 – March 2017)

Reason	No of referrals	% of referrals
Domestic abuse	1199	15.93%
Physical abuse	923	12.27%
Neglect	641	8.52%
Behavioural problems	619	8.23%
Sexual abuse	472	6.27%
Socially unacceptable behaviour	347	4.61%
Mental health (another person)	302	4.01%
Drug misuse (parent/carer)	242	3.22%
Child sexual exploitation	205	2.72%
Emotional abuse	183	2.43%

Figure 13: Percentage of Referrals with MASH Enquiries

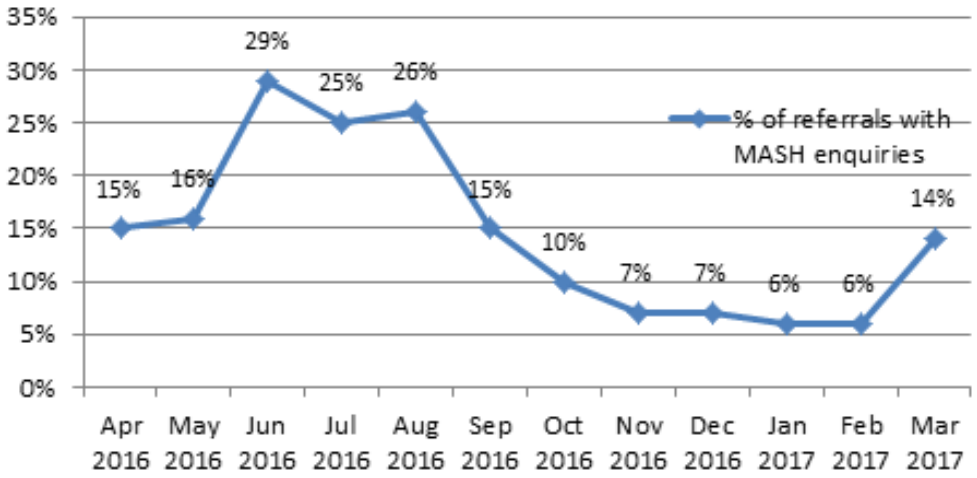


Figure 14: Percentage of Assessments Completed within 45 Working Days

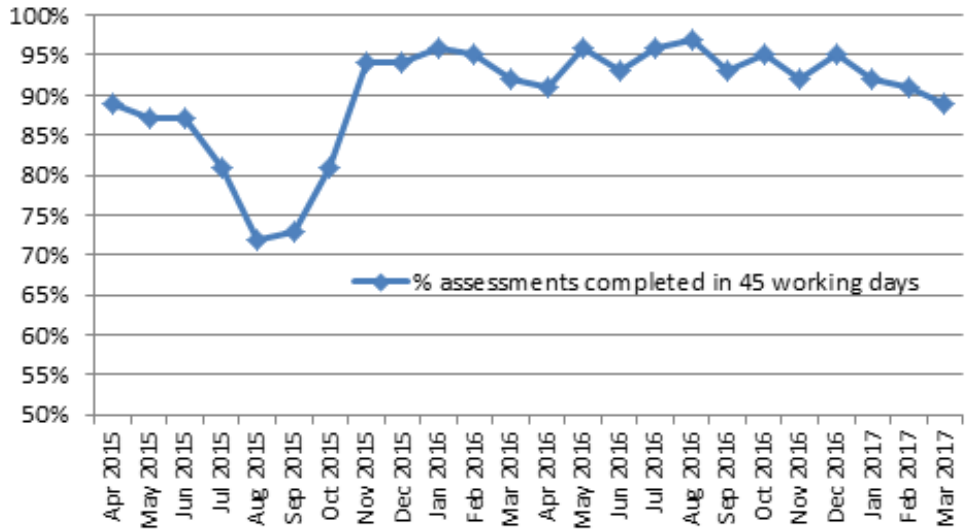
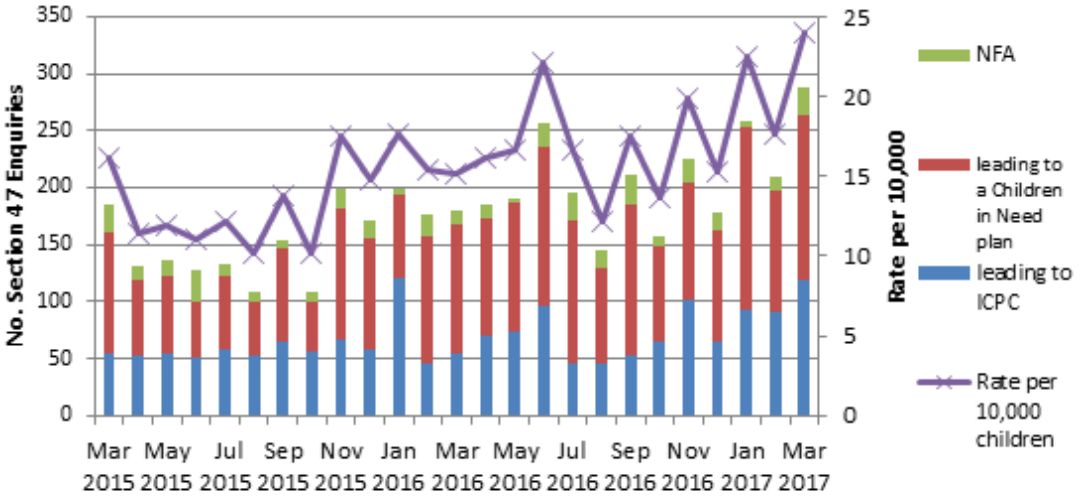


Figure 15: Number and Outcome of Section 47 Enquiries



Once a child has been referred to Children's Social Care, an assessment is undertaken to decide the most appropriate course of action. There have been some fluctuations in the number of assessments completed within the statutory 45 day timescale (figure 14). Despite this fluctuation Buckinghamshire's performance compares well with statistical neighbours (average was 86% in 2016) and the South East regional average (which was 83% in 2016). The variable performance in the early part of 2017 can be attributed to the introduction of new staffing structures across the child in need and child protection / court teams.

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 fluctuated over the course of the year (figure 15), but the overall trend is upwards reflecting the increased pressures that are noted across the system. The conversion rate from Section 47 enquiry to Initial Child Protection Conference remains an area for further review and has seen little change over the last year. It would be usual to expect a conversion rate of around 60-65% whereas in Buckinghamshire the performance as at March 2017 was 41%. Analysis and insight work in being undertaken in 2017 to gain an understanding of why the picture is different.

Children in Need (CIN)

Compared to both statistical neighbours and national, Buckinghamshire has had lower rates of children in need (figure 16) although this has increased markedly from 2014 and it is anticipated will become more in line with statistical neighbours as the new service model introduced early in 2017 becomes embedded.

Figure 16: Children in Need 2009-2015 (rate per 10,000 children under 18)

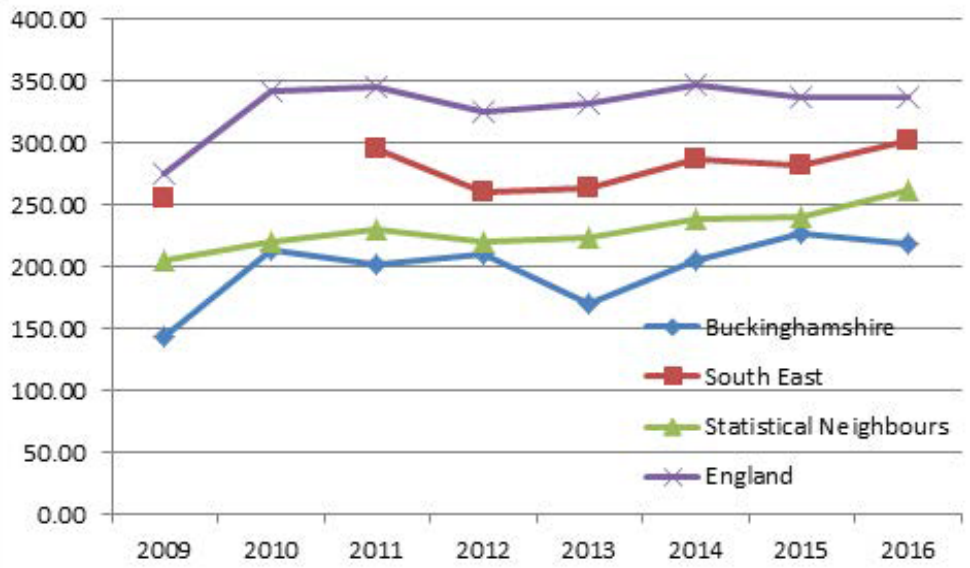
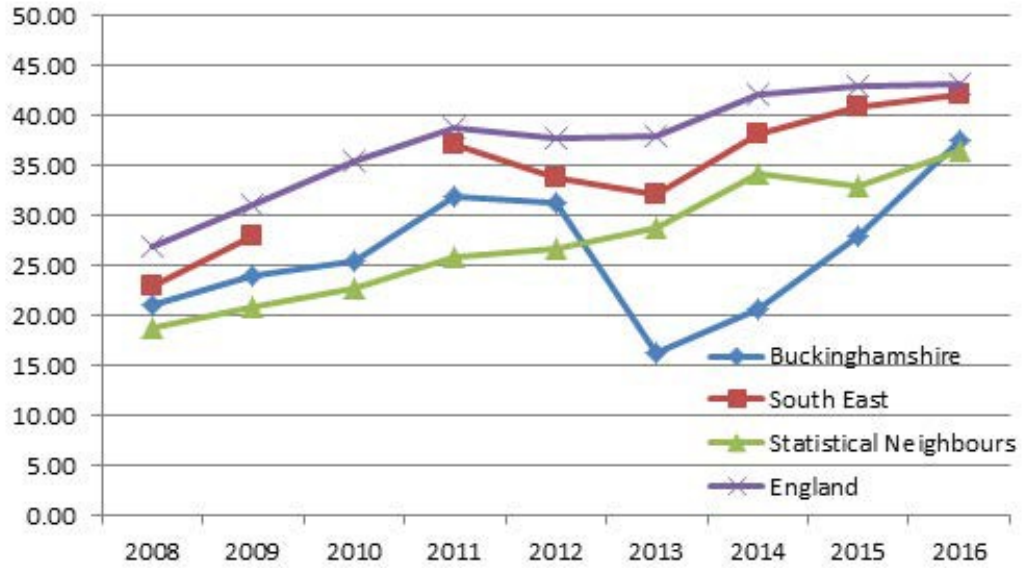


Figure 17: Children with a Child Protection Plan (per 10,000 children under 18)



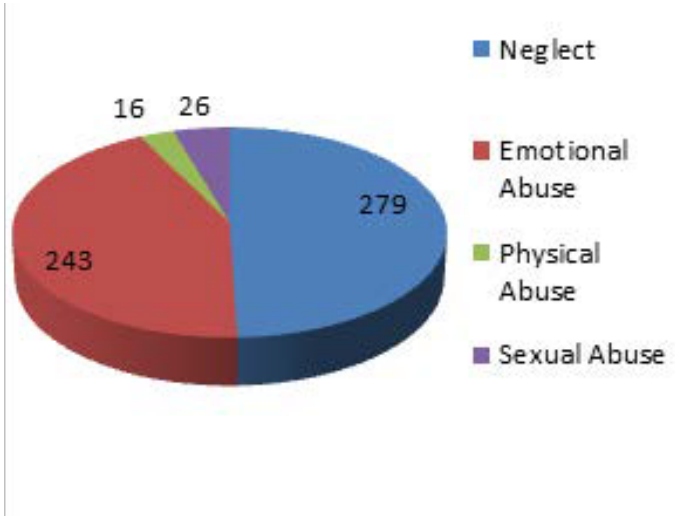
Children with a Child Protection Plan

The rate of children with a **child protection plan** in Buckinghamshire has now aligned with statistical neighbours (figure 17). This is a positive reflection of the work around thresholds and scrutiny across the child's journey. Neglect was the most frequent category of child protection plan, followed by emotional abuse (figure 18).

Challenges

- There has been an increase in the number of Child Protection Plans, and numbers are continuing to rise. At the end of March 2017, 564 children were subject to a Child Protection Plan, an increase of 42% in 2 years. This has led to an increase of 32% in the number of Child Protection Conferences. The BSCB recognises this is increasing demand across partners.
- The duration that children are on a Child Protection Plan needs further monitoring. 25% of Plans concluded between 6 and 12 months, which is the expected time for the majority of Plans. However, 24% concluded between 3 and 6 months, which is too high.
- Not enough reports are being shared with parents within the required timescales ahead of conferences. The BSCB has asked all partners to review and improve performance and will continue to monitor this area.
- Partners have identified that further work is required around Core Groups to ensure that they help progress the Child's Plan and achieve positive outcomes without drift or delay.

Figure 18: Category of Child Protection Plans 2016/17



Improving Practice

- There has been a steady reduction in the number of children subject to a Child Protection plan for a second or repeat time. We would anticipate that this number would be maintained as Buckinghamshire is now performing well in this area compared to statistical and regional neighbours.
- Children's Services implemented the Strengthening Families Framework to Child Protection Conferences in April 2016. This Board supported this by organising 16 multi-agency briefings which were attended by over 600 colleagues from across the partnership. Early evidence is that the new model is improving overall performance and outcomes. This will need further review over time.
- The quality of Child Protection Plans has been strengthened. Considerable work with the Conference Chairs has led to more family-friendly language, SMART outcomes, clear measures of reduced risk and time-limited contingency plans.
- In August 2016 Ofsted saw evidence that attendance by partners at child protection conferences has significantly improved. The Conferencing Service conducted a review of this in November and found 89% professionals invited to conference attended or sent someone of their behalf.

The Child Protection Conferencing Service Annual Report 2016/17 provides further data and a more detailed analysis of performance.

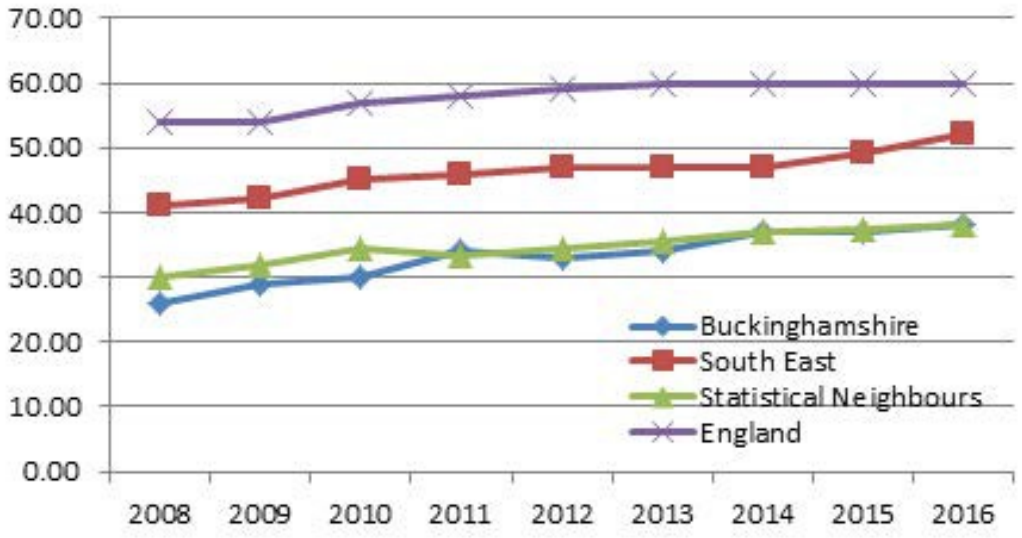
Children Looked After

Our rates of **children looked after** (figure 19) 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.

There were 458 children looked after by Buckinghamshire County Council on 31st March 2017. The number of looked after children has increased consistently since 2008 and the current total is the highest recorded in the last 20 years.

- 38% were placed no more than 20 miles from home, which is considerably fewer than our statistical neighbours (62%). Work continues to improve this figure, but there is still some distance to travel when comparing to the national average of 74%. This has a significant impact on children, for example in terms of contact with friends and family and maintaining their school placement
- 192 lived with an agency foster carer and 78 with a Local Authority foster carer
- 7 were in independent living; 26 were in supported living
- 26 lived with parents and 57 with family or friends.
- at March 2017 there were 22 unaccompanied asylum seeking children.

Figure 19: Children Looked After (rate per 10,000 children under 18)



In the last 12 months there have been 38 adoptions – the same number as for 2015/16. 6 new foster carers were identified (a reduction from the 20 identified in 2015/16 and 30 in 2014/15). In addition, 14 stopped being foster carers within the same timeframe.

In terms of health outcomes for children in care, over the year:

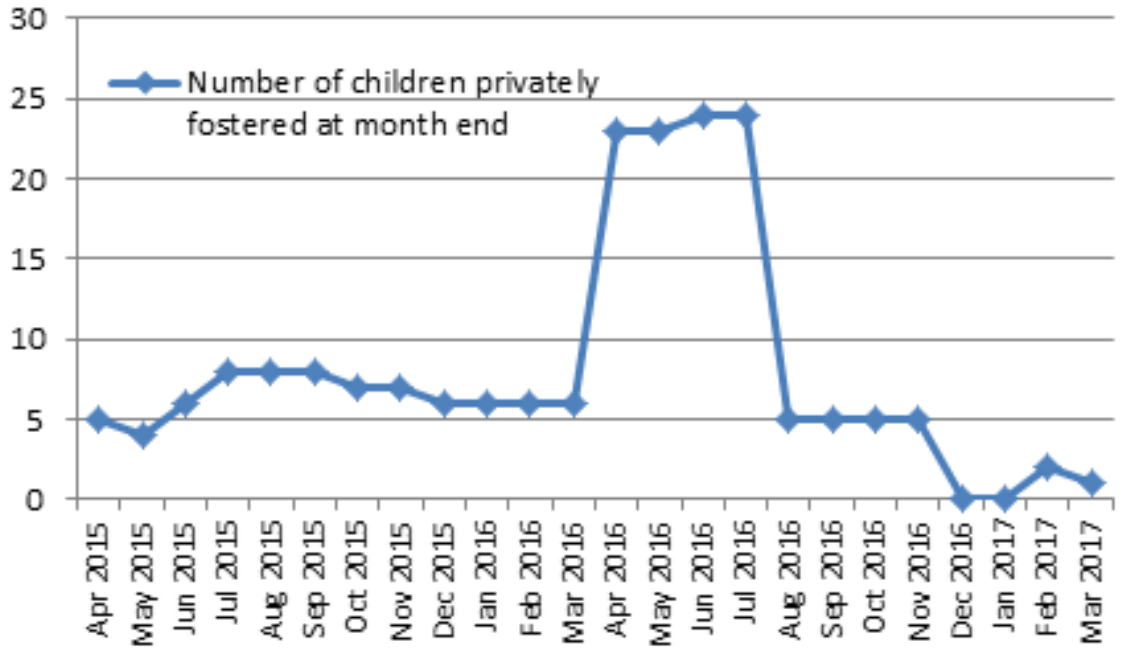
- 95% had up to date immunisation compared to 88% in the previous year
- 95% had a dental check in the previous 12 months compared to 92% in the previous year
- 92.6% had a health assessment completed compared to 95% in the previous year.

Key challenges continue to be a **lack of suitable placement**s 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. Difficult local market conditions mean there are ongoing challenges around creating local places and this continues to be a significant area of focus for the Local Authority.

The role of the **Independent Reviewing Officer** (IRO) is to bring rigour and challenge to care planning, escalate contentious issues, drive plans for permanence and monitor and challenge the performance of the local authority as a corporate parent. Above all the IRO must make sure the child's current wishes and feelings are given full consideration. During the year the Board has been presented with evidence of steady improvement in this service and demonstrable impact on the quality of services provided to our children in care. The IRO service now has a compliment of permanent, experienced staff which has meant there has been minimal change in the allocated worker for individual children over the last 12 months. The consistency of worker has been positive for children, as they know who will be turning up for their review meetings and the IROs can demonstrate that they know their children very well.

The Independent Reviewing Officer Annual Report 2016/17 provides further data and a more detailed analysis of performance.

Figure 20: Number of Children Privately Fostered at Month End



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.

The Local Authority continues to undertake work to increase awareness of private fostering, but this is not having a significant impact on the number of private fostering notifications (figure 20). Over the last 12 months, the BSCB has supported this activity by seeking to raise awareness with professionals working across the partnership, including through updated information on the BSCB website and articles in our newsletter. Over the next 12 months there is an opportunity to look at how we support our partner agencies to raise levels of awareness and knowledge amongst their own staff.

Listening to the Voice of the Child

Whilst reviewing data around the child's journey helps the Board to understand how effectively the system is working to support the needs of children, we use a number of other mechanisms to more directly hear the voice and story of individual children.

Youth Voice Steering Group

This year the Board has continued to engage with the Youth Voice Steering Group – a group of children and young people from a variety of backgrounds who come together to share their views on things that are important to them. This year our work with Youth Voice has included:

- Regular attendance at **Youth Voice meetings** to hear the views of young people. This included a dialogue around the BSCB priorities and a decision from the young people that they did not feel it was necessary to have a separate young person's version of the BSCB Annual Report. The young people told us that they would much rather engage with the Board through individual activities (such as Youth Voice) as this was more relevant to their priorities.
- Participation in a **Youth Voice event on e-safety**. This was an excellent opportunity for the Board to hear the views of young people directly. It was clear from the discussion that this remains a priority area for young people. In particular the Board was given lots of ideas about how best to present e-safety advice to young people and are using these to inform our work.
- Following on from last year's Youth Voice event on bullying, the Board supported the delivery of two **Zap bullying workshops** run by Kidscape. Feedback demonstrated these had a positive impact for the children and their family members.

During the Youth Voice event, young people shared their concerns about e-safety.

E-Safety Sub Group

Our E-Safety Sub Group has had a high level of direct engagement with young people this year including:

- Recruiting a young person to be a member of the E-Safety Sub Group
- Sub Group members have delivered young ambassador training to enable young people to deliver peer to peer e-safety education programmes
- Members of our E-Safety Sub Group were part of a panel at the Youth Voice E-Safety event to answer questions and challenges from young people
- The Sub Group worked with Buckinghamshire County Council to deliver two conferences on anti-bullying and e-safety:

1. The first conference in February 2017 was for professionals working with children and young people and was attended by approximately 80 delegates. One of the highlights of the conference was a powerful presentation on gender equality from 4 students who attend Aylesbury High School. The girls, who are supporting the United Nations 'He for She' campaign told professionals that it's possible to help young girls and boys in Buckinghamshire to avoid being affected by stereotypes and gender inequality by delivering education to all ages that proves to them that they can do anything, and be whoever they want to be. They said they would like to see specific educational activity designed to address gender equality and are helping to introduce a series of workshops that will engage with the topic by talking to boys and girls in primary schools from the age of 8. Professionals also heard from a range of other speakers and a full write up of the conference is available on the BSCB website. All those who attended were asked to write a pledge to say how they would use the learning from the conference to influence their work with children and young people. We will follow these up with delegates to understand the difference we are making for children and young people in Buckinghamshire.
2. The second conference in March 2017 was attended by groups of students from 14 secondary schools and colleges. The students heard from a range of speakers and then worked in their school groups to action plan how they would use the conference learning back in their own setting. Some of the plans students made were to run assemblies, put things into PSHE lessons, run class discussion, use poster campaigns, bring in guest speakers, run student questionnaires and use peer mentors. We were really impressed with the engagement of the students with the topic and the focus they put into planning. We will be doing some follow up work with all of the schools to find out how they have put their plans into practice.

Sharing information on e-safety at a voluntary sector event.

Some work from pupils at St. Mary's CE School in Aylesbury for Safer Internet Day 2017. The school undertook various activities with parents and pupils and we were pleased to be able to share some of the work via our Board newsletter.

Wider Board Activity

Much of the Board's activity is designed to understand the experiences of children, but activities such as auditing and reviewing data can often seem very far removed from the daily lived experiences of our children. This year we have sought to more directly bring the voices of children into our activity. This has included:

- Audit reports now include a section describing the story of each child whose journey was audited. This more clearly brings the voice of child into the report.
- This year we delivered some learning sessions focusing on pre-birth safeguarding and non-accidental injury. This followed a number of SCRs in recent years relating to babies and a multi-agency audit which identified opportunities to strengthen practice. These sessions used an innovative, interactive format which sought to bring the child directly into the room. This included playing a soundtrack of a baby's heartbeat and building the child's journey step by step as the session continued. Evaluation forms indicated that those who attended valued the opportunity to focus on the child's perspective.
- As part of our CSE SCR we undertook a range of engagement activity with victims and survivors of CSE. This included both children and adults who had been abused in their past. Further details can be found on p17.

"It was good to hear from the baby's point of view."
(Delegate feedback SCR learning session)

"Very informative; made me think 'outside the box'; beneficial to see situation from child's point of view."
(Delegate feedback SCR learning session)

"Well presented and a good reminder of how to look at something from a child's view."
(Delegate feedback SCR learning session)

"It was a good idea to have the speech bubbles with the child's voice, emphasising how important it is to listen to the voice of all children."
(Delegate feedback SCR learning session)

Professionals starting to map the journey of the child at our SCR learning session.

6. Workforce

Our Aim: The children and young people's workforce has the right skills and competencies to keep children safe and ensure they receive the right help and support

This priority brings together the following areas of work:

- Workforce capacity
- Workforce skills, knowledge and confidence
- A safe workforce.

Workforce capacity

For partners to work effectively to keep children safe, there need to be sufficient staff in place across key roles and services. Whilst the number of staff in post does not correlate directly to how safe children are, staff vacancies, a high staff turnover or high caseloads can put pressure on the workforce and on multi-agency working, and have the potential to lead to inconsistent or poor practice.

The BSCB recognises the ongoing pressures and challenges across partner organisations in relation to workforce capacity. These include challenges around recruiting to key positions such as social workers, retaining professionals within the local workforce, as well as funding pressures. These issues are not specific to Buckinghamshire, but factors such as our geographic proximity to London and the high cost of local housing can exacerbate some of the challenges relating to the recruitment and retention of staff.

For these reasons, during 2016/17 the BSCB started to undertake regular monitoring of capacity issues across the children and young people's workforce. The table on the following page highlights the progress that has been made and the outcomes achieved in relation to some of the areas where the Board has offered scrutiny and challenge over the last 12 months.

Workforce Skills, Knowledge and Confidence

This area is led through our **Learning and Development Sub Group** which seeks to support a culture of continuous learning and development. The Board also has a full time **Training Manager** to support the development and delivery of a high-quality multi-agency training programme.

Key achievements

- The BSCB continues to run a well-attended multi-agency training programme, which includes training focused around BSCB priority areas. Courses are regularly

Delegates at our Pre-Birth Safeguarding Conference

Area of Scrutiny	Outcome	Next Steps
In their 2014 inspection, Ofsted noted concerns around high caseloads within Children's Social Care as well as workforce instability as a result of a high number of agency social workers and many interim managers.	Whilst the number of agency social workers remains fairly high, it is now in line with many other authorities, and ongoing work around recruitment and retention has improved in the stability of the workforce. This has been helped be recruitment the recruitment of permanent managers.	Whilst there has been an improvement in stability, quality assurance activity continues to show some inconsistency in social work practice. This can lead to a variation in the level of service received by children and is an area for furtherimprovement.
Regular scrutiny and escalation have raised questions relating to the front door and Multi-Agency Safeguarding Hub (MASH): • Multi-agency capacity concerns which have led to backlogs and delays in decision making for the child. These have been exacerbated by an overall increase in referrals through the front door which is putting pressure across the whole system. • No domestic abuse notifications to schools.	• The Board has had assurance that immediate capacity issues have been resolved and that work is underway within individual agencies to ensure increased future resilience. • Thames Valley Police are exploring a force wide IT system to support domestic abuse notifications to schools across the region. In the meantime, and as a result of discussions through the BSCB, notifications have been reinstated within Buckinghamshire.	• We will need to look in partnership at MASH resilience to ensure that multi-agency working in the MASH is having a positive impact on decision making and outcomes for thechild. • The BSCB will continue to monitor the implementation of the domestic abuse notification system to schools, including seeking feedback from BSCB school members.
A lack of resource within the Local Authority Designated Officer (LADO) service was highlighted by the 2014 Ofsted inspection, and as part of a monitoring visit in August 2016 Ofsted reported that *"capacity to manage allegations against professionals working with children remains insufficient to respond effectively to all referrals"*. The Employment Sub Group also continued to flag ongoing concerns around LADO capacity to the Board as part of regular dashboard reporting.	• The LADO service has engaged with the Employment Sub Group to provide regular updates on progress. • The Board has supported the dissemination of key messages to partners, including the need to report outcomes back to the LADO to help close cases. • The LADO Annual Report provided good evidence that process improvements and the reduction in the backlog of open cases (a reduction of 83% during 2016/17) has had a positive impact on capacity. The service now feels that current staffing levels are sufficient to provide optimum services to meet need and ensure statutory requirements are met.	• The BSCB will continue to monitor service capacity over the coming months as new staff settle into post. • The BSCB will continue to work closely with the LADO service to increase knowledge and confidence around the LADO process, including through training and awareness raising.

updated to ensure they are in line with local procedures, learning from serious case reviews, changing local priorities and national legislation. The programme is adapted in response to delegate feedback and needs. During 2016/17 a total of 66 full training days were attended by a total of 934 delegates. This is an increase on of 32% from 2015/16, mainly due to the introduction of Graded Care Profile and Family Outcome Star training sessions.

- In addition to the core programme, the Board delivered four additional training events which are not included in the figures above. This included some bespoke **single agency training** where a specific need was identified. In this case, two 'Everyone's Responsibility' courses were delivered for a housing association. We also delivered our '**Training for Trainers** in Child Protection' courses which allow delegates to deliver training within their own agency. Following some concerns from partners about waiting times for the Training for Trainers course, it has been agreed that the Education Safeguarding Advisory Service (ESAS) will once again start delivering this provision for schools. This will increase capacity for other partners to attend the BSCB training.
- A number of observations of independent trainers, single agency and multi-agency trainers have been carried out as part of the Board's **quality assurance framework**. The chair and vice-chair of the Learning and Development Sub Group observed two single agency sessions following some concerns raised by a practitioner. In addition, the Training Manager has observed two single agency trainers, two multi-agency trainers and one independent trainer providing constructive feedback to them. The training manager has also been observed as part of the quality assurance process by a peer within another LSCB.
- The BSCB have been part of a pilot with the NSPCC to introduce a new version of the Graded Care Profile assessment tool (see p10 for further detail). Professionals wishing to use the tool are required to complete training and pass a short assessment. Part of our regular dialogue with the NSPCC during the pilot phase has included sharing with them some of our assessment results. The NSPCC were encouraged that our results showed effective quality control over use of the tool.
- In response to feedback from partners that it would help make learning more accessible, the BSCB has this year focused on delivering **shorter learning opportunities** to complement the main training programme. Sessions have included Deprivation of Liberty, Early Help Awareness Raising, Harmful Sexual Behaviour and learning from SCRs, with further sessions planned over the coming months. Feedback from delegates has been extremely positive, with emerging evidence that this is helping to broaden even further the range of professional who are engaging with BSCB learning activity.
- In response to a recommendation from

Speakers at one of our three safeguarding conferences

the Serious Case Review for Baby M, the Board ran four half day workshops looking at barriers and enablers to **effective challenge and escalation** (see story board on p38 for further detail).

- During September 2016, the BSCB ran **three half day conferences** which were attended by 235 professionals from across a wide range of organisations. Each half day session provided an opportunity for delegates to attend two workshops of their choice, with sessions available on a variety of different topics. This was a new format for the BSCB, and one which was designed to take on board feedback we had received, including that half day conferences can be more accessible for many professionals than full day sessions. Overall, feedback was positive and it was clear people valued the opportunity to come together in a multiagency setting and hear about a variety of topics.
- The BSCB and Bucks New University delivered a multi-agency half-day learning session on **pre-birth safeguarding** in Spring 2017. The conference was attended by almost 100 delegates and included learning from local SCRs and national research, information on local services and the opportunity to hear a user of the ReConnect service provided by Oxford Health NHS Foundation Trust recount her own powerful and emotional story.

Next Steps

- This year we have been able to grow the number of local trainers within our **multi-agency training pool** to support the delivery of the local training programme. However, other trainers have needed to leave the pool and there are ongoing challenges around finding a sufficient number of local trainers to deliver our programme. We are therefore looking at options for commissioning some aspects of our programme to reduce pressures on the Training Manager to deliver a large proportion of training.
- Over the coming months we will be moving to an **online booking system** for BSCB training. We hope this will improve the efficiency of administrative processes and make it easier for professionals to book places on courses. It will also provide us with enhanced reporting capabilities. We are working with the Safeguarding Adults Board to explore opportunities for a coordinated booking system across both Boards.
- Following the success of our shorter awareness raising session we will be exploring a range of further opportunities for **disseminating learning** including online tools such as webinars.
- Following the latest round of **section 11 auditing**, the Training Manager and the Learning and Development Sub Group will be following up any areas of concern relating to learning and development within individual agencies.

Escalation, Challenge and Conflict Resolution

What did we do?

- We revised and re-launched the BSCB Escalation Procedure with clearer steps on the actions professionals should take if they want to challenge the actions or decisions of another professional. We also worked with the Safeguarding Adults Board to ensure some consistency between our procedure and their newly developed Escalation Procedure.
- Following a multi-agency audit on the use of the escalation procedure in 2015/16, appropriate challenge and escalation was embedded as a standard line of enquiry in relevant BSCB audits.
- Specific questions about the Escalation Procedure were incorporated into our updated Section 11 audit tool for 2016/17 to explore how partners are helping to create a culture where challenge and escalation are encouraged and supported.
- We ran 4 half-day multi-agency workshops to explore the barriers and enablers to effective challenge and escalation. The key learning from these events has been shared with partners via a learning log, which partners have been encouraged to disseminate and use as part of single agency training and discussion.
- We have updated the BSCB Escalation Training Course so that it is in line with the half day workshop session. This increases the focus on delegates undertaking active problem solving.
- We have used the BSCB newsletter and audit learning logs to share learning relating to challenge and escalation.

Why did we do it?

In 2014, the Ofsted inspection of the BSCB found variable knowledge and compliance with the BSCB Escalation Procedure. The inspection report identified the promotion of effective escalation and challenge within and between agencies as a priority area of work for the BSCB.

Since 2014, two local Serious Case Reviews (SCRs) have also highlighted concerns about the effective use of challenge and escalation.

- Published in 2014, the SCR for **Child F** identified a lack of awareness of, or a reluctance to use the escalation procedure. This meant that the poor responses of Children's Social Care in this case were not challenged.
- The SCR for **Baby M** (signed off May 2016) identified a number of occasions when escalation could have been appropriately used to challenge the decisions that were being made.

Next steps?

- Continue to run half day training format and evaluate this to ensure it meets delegate needs.
- Develop a toolkit to be used alongside the Escalation Procedure highlighting some of the barriers and enablers to effective challenge that were identified through the workshops and giving some practical examples to assists effective challenge.
- Continue to offer opportunities for professionals to network at BSCB events to promote an understanding of different roles and responsibilities.
- Continue to monitor challenge and escalation as part of routine auditing activity.

Evidence of impact and outcomes?

- Increased feedback from partners that professionals are now more confident in escalating concerns and that the Escalation Procedure is being used effectively in multi-agency settings such as the MASH.
- Increased feedback that challenge is taking place as part of routine working practice, with the right conversations taking place to resolve differences in opinion at an early opportunity.
- Feedback from partners through the Escalation workshops and the Section 11 audit process has identified that a number of agencies are proactively supporting effective challenge and escalation. For example through running internal workshops and training; using team meetings to regularly discuss cases where escalation has taken place; inviting other services to attend team meetings to talk about their role this recognises that one of the key factors in effective challenge is building relationships with other practitioners and understanding different roles and responsibilities.)

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 Learning & Development Sub Group and the BSCB as part of our dashboard data reporting system.

Figure 21: Increase in knowledge and confidence between start and end of the course (self-evaluation by delegate)

Course title	No of courses	Average % increase
Everyone's Responsibility	5	20%
Working Together	9	19%
CSE	4	22%
Domestic Abuse	1	26%
Escalation, Challenge & Conflict Resolution	1	11%
Working with Challenging Families	2	20%
Introduction to Protective Behaviours	2	37%
Effective Core Groups	1	28%

"[XX] now has the outlook that it is okay to challenge family's and core group members which in turn proves that outlook and outcomes from young people are much more positive."
(Manager 3 month feedback, Working with Challenging Families course)

"Very useful, it was a good opportunity to touch base with a variety of services and understand the current situation. Facilitator was very knowledgeable and approachable."
(Delegate feedback, Effective Core Groups)

"Brilliant course, absolutely essential for all relevant professionals to undertake. Difficult content /emotionally evocative but sensitively handled. Brilliant trainers engaging and knowledgeable."
(Delegate feedback, Working Together)

"[XX] has been able to use this knowledge to the benefit of families she has worked with. She has been able to discuss concerns with parents who then were able to put safety boundaries in place around their children"
(Manager 3 month feedback, Child Sexual Exploitation course)

"The whole course was useful and enabled me to reflect on my abilities. More confidence in being able to challenge other professionals."
(Delegate feedback, Working Together)

"[XX] has shared his knowledge with our front line team who are now more confident and better equipped to uphold our safeguarding procedures."
(Manager 3 month feedback, Working Together course)

A Safe Workforce

The BSCB has an **Employment Sub Group** which seeks to ensure that people working with adults and children are safe to carry out that role. Whilst for the last two years, this has been run jointly with the Buckinghamshire Safeguarding Adults Board (BSAB), at the end of 2015/16 BSAB unfortunately decided that, due to other priorities, they were no longer able to support the work of the Sub Group. Whilst this is disappointing, the BSCB will continue to support the Sub Group and seek opportunities to work in partnership with BSAB or adult services where this is of benefit.

Key achievements:

- In July 2016 the Sub Group hosted a multi-agency challenge event to look at how effectively the learning from the Lampard Enquiry (into matters relating to Jimmy Savile) had been embedded across partners. The session highlighted a number of areas of good practice, including evidence of agencies developing robust practice in response to context and organisational need. See the story board on p41 for further details.
- The Sub Group developed a short self-assessment toolkit to help agencies consider how well they were meeting the recommendations from the Lampard Enquiry, and partners were encouraged to use this to review and improve practice.
- The BSCB section 11 audit tool was updated to include some specific questions relating to learning from the Lampard Enquiry, and responses from partners have provided some good assurance around safer recruitment and employment practice. Regular scrutiny through the Sub Group of arrangements across different organisations also continues to provide assurance as well as highlight good practice. For example the Early Years story board on p40 shows how the Buckinghamshire County Council Early Years team are supporting effective practice across the sector.
- The BSCB Safer Recruitment Toolkit was reviewed and updated in partnership to simplify the document and make it applicable across a wider number of organisations. Early feedback on the toolkit has been extremely positive.
- A Child Protection Policy Toolkit was developed to support agencies to produce or update their own Child Protection policies. This was tested with a small number of partners during the development phase with extremely positive feedback.
- Improved reporting and scrutiny of **LADO data** through the Sub Group has allowed risks within this service to be monitored and assurance around progress to be shared with the Board.

Next Steps

- In response to requests from partners, the BSCB will have an increased focus on supporting organisations in the effective management of allegations. This will include a series of workshops looking at allegations management and transfer of risk as well as updating our procedures for managing allegations.

Story Board: Early Years Commissioning Team Sector Support

What did we do?

- Ensure that the Early Years and Childcare Sector of 1,513 providers have the information, advice and training to enable them to meet their legal requirements under their Ofsted registration and other legislation.
- Publish on an annual basis safeguarding guidance for the sector which reflects BSCB guidance, Ofsted requirements and good practice.
- Ensure that the Early Years website provides direct links to the BSCB website and alternative sources of safeguarding information and examples of good practice.

Why did we do it?

- The Childcare Act 2006 places a statutory duty on Buckinghamshire County Council (BCC) to provide information, advice and training to all Early Years and Childcare providers and those seeking to join the childcare market.
- BCC aims to ensure that as many children as possible attend early years and childcare provision that is judged good or better by Ofsted; current target is 90% of all providers.
- BCC aims to reduce the risk that a child/ children are put at risk of harm as a result of poor recruitment and staff management.
- BCC aims to reduce the risk that a child/ children are put at risk of harm as a result of poor health and safety practices.

Next steps?

- To continue to maintain quality of provision at current levels.
- To improve provider understanding of the threshold for allegation referrals to the LADO.
- To ensure providers have the knowledge and understanding of Female Genital Mutilation (FGM) to ensure they comply with the requirement to report all suspected cases to First Response.
- To continue to evaluate current information, advice and training to ensure it remains fit for purpose, reflects changes in legislation and guidance, builds on good practice, has the expected impact and delivers planned outcomes.
- To implement and embed the updated Early Help Strategy and BCC Education & Skills Strategy ensuring that safeguarding is the golden thread focusing on our most vulnerable children and ensuring they are kept safe, enjoy life and achieve their full potential.

Evidence of impact and outcomes?

- Providers are fully informed about developments in the sector.
- As at March 2017, 96.5% of setting based provision and 93% of childminders are judged by Ofsted to be good or better in Buckinghamshire.
- During 2016-2017 Designated Senior Manager and the Deputy Designated Senior Manager were supported on 60 potential allegations against the childcare workforce, of which 33% required further action by the LADO.
- 793 Early Years Staff working in Buckinghamshire provision have undertaken Safeguarding Training through the Early Years Training Programme managed by Buckinghamshire Learning Trust in 2016-2017.
- From evaluations after safeguarding training and events, providers have improved confidence to manage safeguarding concerns effectively.
- From an evaluation of Officer Compliance Visit Reports, the majority of setting based provision have undertaken Prevent and/or Wrap training and have added this to their induction programme for new staff.

Story Board: Learning from Lampard

What did we do?

- The Employment Sub Group held a challenge event in July 2016 to gather further assurance around how learning from the Lampard Report following the Savile Inquiry, had been embedded across the wider children's workforce in Buckinghamshire.
- The session was aimed in particular at partners working with volunteers and visitors in the workplace.
- We asked partners to come with examples of things they had done to improve practices relating to volunteers and visitors including:
  - training & supervision arrangements and methods for maintaining a robust register for volunteers/visitors
  - visitor policies and arrangements for DBS and identity checks, as well as arrangements for VIPs/celebrities
  - policies & procedures for reporting concerns, handling complaints & whistle blowing.

Why did we do it?

- We used the challenge format because it encourages learning, questioning and sharing of good ideas and best practice amongst partners. This encourages collaboration and integrated working. It also helps and encourages partners to self-evaluate and reflect on practices that are working well or where there is room for improvement.
- We wanted to facilitate thinking and debate around the findings from the Savile Inquiry & Lampard Report.
- We also wanted to ensure that any remaining challenges could be identified and that good practice could be shared.

Evidence of impact and outcomes?

- There was a good attendance and a high level of engagement at the event.
- There were some excellent examples of robust practice. For example:
  - Buckinghamshire Healthcare NHS Trust has a 'speak out safely' campaign that encourages staff to raise any concerns about the health or wellbeing of a patient.
  - Thames Valley Police described their strong arrangements to control access to buildings.
  - Wycombe District Council has more closely aligned their policies for volunteers to those for staff.
  - Buckinghamshire County Council Early Years provided good evidence that they are using lessons from serious case reviews to inform expected standards.
  - Action 4 Children demonstrated the software they use to recruit and manage their volunteers. They provided evidence of strong supervision and face to face training requirements for volunteers.
  - Chesham Bois CE School talked about modifications they had made to the school building to create a more secure entry point to the school.
- A full write up of the event was published on the BSCB website and fed back through the BSCB. A self-evaluation tool was created so that those partners who were not at the event were able to assess their own performance in relation to the recommendations from the Lampard report.
- The information gathered during the event was fed into the forward work plan for the Employment Sub Group and a number of items were identified as being relevant for revisions to the Safer Recruitment Toolkit.

Next steps?

- Lunchtime training events are being planned for reporting concerns and safer recruitment from autumn 2017.
- The Employment Sub Group will continue to act as a forum for discussing and sharing good practice and concerns in relation to recruitment and employment practice.
- The Employment Sub Group will revisit the findings from the challenge event to assess evidence of continued improvement.

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 Manager is a member of the Employment Sub Group and data on allegations is provided regularly for discussion. During 2016/17, there were **325 contacts to the LADO**. The number of allegations made against people in a position of trust has stabilised over 2016/17 after it rose dramatically in 2015/16 (543 allegations). Whilst there are always some fluctuations, the more recent stabilisation reflects improved processes and boundaries within the LADO Service.

The largest number of contacts related to alleged physical abuse (34%) followed by neglect (20%). This year the service has had increasing contact around 'transfer of risk' cases. These are cases where there are concerns about the care someone in a position of trust affords their own children (for example their own children are subject to a Child Protection Plan).

Education continues to be the highest referrer to the LADO due to the number of employees they have that are in a position of trust. It is positive to see Health as the second highest, as there were historic concerns that health providers were not always referring relevant concerns. However, health partners have fed back to the LADO that this category needs to be broken down further as it covers a number of different providers.

This year has seen a number of Freedom of Information Act requests focusing on sports coaches due to cases in the national headlines. Whilst local data does not suggest this is a specific area of concern in Buckinghamshire, the BSCB is supportive of planned work by the LADO service to raise knowledge and confidence around managing allegations with sports clubs.

The Local Authority Designated Officer Service Annual Report 2016/17 can be accessed on the BSCB website.

Setting	Contacts
Education	114
Health	47
Early years/childcare	46
Transport (e.g. taxi drivers, passenger assistants, bus drivers)	33
Other	33
Foster care	23
Voluntary sector	8
Sports coach	8
Faith setting	8
Children's social care	5
Children's centre	1

7. Impact & Effectiveness of the Board

Our Aim: There is a real collective ownership of 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. Beyond the completion of those areas identified by Ofsted for completion, retaining a priority around the impact and effectiveness of the Board has helped to keep focus on the continued improvement journey of the Board. This priority area also covers a number of areas of statutory activity.

Performance and Quality Assurance

This aspect of the Board's work is driven through the **Performance and Quality Assurance Sub Group**.

Key achievements for 2016/17:

- Continued development of a dashboard, which is now embedded as a mechanism for ensuring the Board is aware of key data and performance trends. The **dashboard** continues to help the Board identify areas or risk, monitor and gain assurance around areas of improved practice and open up new lines of enquiry.
- The BSCB led **multi-agency case file audits** on the following themes: Pre-birth safeguarding (see story board on p45), Child Exploitation and Transitions to Adult Services (see p16) and domestic abuse. Learning logs from all of our audits are available on the BSCB website. In addition, the Performance and Quality Assurance Sub Group head feedback from a range of **single and multi-agency** audits conducted across the partnership.
- The key audit for the BSCB this year was the **Section 11 audit**. This audit is sent out to all partners every two years in order to assess their compliance with safeguarding duties set out under section 11 of the Children Act.

Delivery of revised section 11 audit

For this round of auditing a number of changes were made to the audit tool and process:

- **Revised questions**: The audit questionnaire was revised to make specific reference to some areas of local priority including Early Help, Thresholds, Child Sexual Exploitation, Prevent, Female Genital Mutilation and equality, diversity & cultural awareness. This aim was to allow us to gain further assurance and evidence of practice in relation to these areas.
- **Online tool**: The BSCB agreed to move to an online audit tool, which we have developed in partnership with our website provider Phew Internet, and which has now been adopted by a number of other LSCBs. This tool offers positive benefits, including providing quick and easy access to responses, the ability to track agency progress and a range of reporting functionalities.
- **Peer challenge**: We moved to a system of peer challenge to allow all Board members to participate in the challenge process and to better share areas of good practice and learning. This process was conducted through our main Board meeting and a number of sub group meetings. Overall this process has worked well. Feedback from those who participated indicated that it gave them a good insight into the functions of other agencies, helped them improve their understanding of the roles of other agencies and was an enjoyable process. There was a good level of debate and discussion at the peer challenge sessions, and it was helpful for people to be able to compare what they had written with responses from other agencies who had similar functions.

The table on p44 provides some of the key headlines from this audit including some areas of good practice. The Board will continue to work with those agencies where the need for additional information or improvement was highlighted.

Theme	Good Practice	Areas for Improvement
Senior managers take leadership responsibility for safeguarding children and safeguarding is embedded in the organisation.	Overall, agencies provided good assurance and demonstrated they had structures and processes in place to embed safeguarding. Examples: • Joint working across District Councils in terms of Board attendance and participation in BSCB Sub Groups. • Public Health has made good links with the Board and Sub Groups, particularly around CSE.	• A few agencies did not provide sufficient detail and were asked to submit further information.
Safe recruitment of staff and volunteers.	• Strong processes around recruitment and selection were highlighted within Thames Valley Police. • Clear processes for staff and volunteers were highlighted within Oxford Health including to review allegations and complaints.	• A number of partners were signed up to organisational policies and procedures around safer recruitment but there was less evidence about how these were put into practice or how effective they were.
Effective Practice with Children and Families.	• Within Oxford Health there is good evidence of knowledge of thresholds and the appropriateness of referrals due to an internal review. • Within Thames Valley Police initiatives such as the Safer Schools Partnership and the Cadet Scheme show good engagement with children and young people. • Good multi-agency work through the Swan Unit.	• A number of agencies recognised the need to do more to engage children around the way services are designed and provided. • The need for improved attendance from some agencies at multi-agency meetings was highlighted. In some instances non-attendance was ascribed to an agency not always being invited to meetings.
Contracting with Third Parties.	• Safeguarding is routinely included in commissioning processes. In particular, commissioned services within Buckinghamshire County Council's Children's Services use the Section 11 questions with providers as part of the contract monitoring process. • Public Health provided evidence of strong service user engagement with the procurement process.	• Some partners identified that they could use the Section 11 process to review in more detail the safeguarding practice of commissioned services. The BSCB and Buckinghamshire Safeguarding Adults Board (BSAB) have produced a joint template to assist with this process.
Training, Learning & Development.	• Aylesbury Vale District Council overcame challenges to deliver WRAP training to refuse collectors. • The CCG response considered learning and development in its widest possible sense rather than just concentrating on training and demonstrated that training is responsive to local need. • The Buckinghamshire Healthcare NHS Trust response outlined how 1:1s and team meetings are used as part of a learning framework.	• Keeping records of staff training is a challenge for some organisations and across some agencies there was insufficient assurance that the right processes are in place to identify which staff require safeguarding training and to ensure this is provided. • There were challenges around whether all staff in commissioning roles have sufficient knowledge and skills to embed safeguarding into commissioning processes and address safeguarding as part of routine contract monitoring.
Learning from Reviews.	• A number of agencies described a variety of ways in which they were sharing learning from reviews including team meetings, training events, newsletters etc.	• There was lots of information about how learning is shared, but less about how confident agencies are that learning is being applied.

Story Board: Pre-Birth Safeguarding Audit (November 2016)

What did we do and why?

A pre-birth audit was selected for completion as part of the BSCB's annual audit programme due to findings from the Serious Case Reviews (SCRs) for Baby K, Baby L and Baby M. All 3 SCRs identified opportunities for improving pre-birth assessment and safeguarding practice.

A random sample of 4 children was identified from all the cases where a pre-birth assessment had been started within the 6 months prior to the audit. A multi-agency group of professionals reviewed these journeys in order to assess the effectiveness and impact of pre-birth safeguarding.

Key learning?

To a large extent the findings were consistent with the learning from the 3 SCRs:

- whatever their age, the core focus of the assessment was on the mother and not on the risks to the unborn baby
- fathers, whether actively involved or not, were considered and assessed less than mothers
- recordings were often insufficiently detailed and did not efficiently reflect the work undertaken
- there was variability in terms of when information was shared between agencies
- in two of the cases audited, there was no evidence of validation regarding information shared by parents; with professionals either simply accepting what had been said or hoping that it was the truth.

Evidence of impact and outcomes?

As a result of the learning from this audit and the combined learning from the 3 SCRs, the BSCB has:

- delivered a series of 2 hour learning session focusing on pre-birth safeguarding, with a focus on listening to the voice of the child
- delivered a half day learning event on pre-birth safeguarding to almost 100 delegates
- completely re-written the multi-agency Pre-Birth procedures, taking into account the learning from the SCRs and auditing activity.

Next steps?

The SCRs and auditing activity identified that further improvements need to be made in this area. Over the coming months, the BSCB will need to:

- launch the revised Pre-Birth procedures and seek evidence of impact
- seek assurance around improved pre-birth practice, including though feedback from Board partners and additional auditing activity
- continue to emphasise some of the key messages from this audit through BSCB training.

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. Our multi-agency policies, **procedures and guidance documents** are published on the BSCB website and 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**.

Last year our annual report highlighted that we had undertaken a review of some of the challenges associated with maintaining an up to date and easily accessible suite of policies and procedures. This year, we have made good progress towards overcoming these challenges.

Challenge

Capacity of Sub Group to keep policies, procedures & guidance documents up to date.

Inconsistency in language, content and presentation, and poor linkage and referencing between documents.

Current web presentation with linked pdf documents and wordy titles can be difficult to **navigate**.

Lack of easy **access** for mobile devices.

Action taken

The BSCB commissioned a consultant who worked with the Policies & Procedures sub group to:

- implement a consistent style across all of our procedures
- update all documents ahead of a move to a new online manual.

These updates across over 40 documents have required significant input from the Sub Group and wider partners. By the end of the financial year, updates were almost complete with a number of procedures completely re-written and significantly improved in terms of the quality of content.

The BSCB agreed to move over to an online procedures manual in order to improve access and navigation between documents and ensure easy access via mobile devices. This has also required a significant amount of work, both from the BSCB and our website provider. By the end of the financial year a format for the online manual had been agreed ready for the updated procedures to be entered.

Next steps

- Following completion of the updates to existing procedures, we anticipate the new manual will be ready to launch in September 2017.
- Evaluation of the new manual will also need to take place.

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, BSAB, Health and Wellbeing Board [HWB] and SSBPB). Over the last 12 months these relationships have continued to develop.

Examples of joint working:

- It has been agreed that the HWB should act as the strategic lead for **Female Genital Mutilation** (FGM), with support from across the other Boards. To this end, the BSCB led on the development of a Buckinghamshire wide strategy for tackling FGM which has now been signed off across all the Boards. We also led on creating new practice guidance on FGM; the new guidance includes pathways for both children and adults. This is the first time we have produced a joint piece of guidance, and it is a format we would like to replicate in the future. The BSCB and HWB also worked together on a publicity campaign ahead of the summer holidays. This included a joint press release from the chairs of all Boards, articles in the BSCB newsletter and the provision of free resources to partners to raise awareness of FGM.
- The recommendations from our CSE SCR started to raise questions about the support available for **adult victims of exploitation**. As a result the SSBPB have led on some work with the Office of the Police and Crime Commissioner to pilot an **anti-slavery network** for the Thames Valley and to set up an Adult Exploitation Working Group. This will be a key area of joint working to progress over the coming 12 months.
- Joint working, in particular with the SSBPB, has started to highlight concerns around the partnership response to **Domestic Abuse** (DA). This led to work with the SSBPB on two DA **challenge events** before Christmas. These allowed statutory and voluntary sector partners to think about our local response in relation to the Joint Targeted Area Inspection (JTAI) Framework for children living with the impact of DA. As the reports from other local authority JTAI inspections were published, we also jointly benchmarked our local approach with the good practice and areas for improvement identified in the reports. In February 2017 the BSCB led on a multi-agency DA audit. The audit brought a range of professionals together to review the journeys of 6 families who had experienced DA, all of whom had been engaged with a number of services for many years. All of these pieces of work highlighted questions about the sufficiency of our whole systems response to DA. This will need to be a key area of partnership working over the coming months.

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 2016-17, but a summary of some of the key findings are presented below.

Key achievements

- The inherited backlog of cases has been cleared and our review time for child deaths has improved considerably. Our review time is now better than the national average.
- Close links between CDOP and the Buckinghamshire Healthcare NHS Trust' Mortality Review Group have been established. The CDOP chair attends the hospital mortality review group and data on child mortality is being shared with the group as appropriate.
- eCDOP, an online database for CDOP, has been implemented and is already helping to streamline administration processes and the sharing of information.
- A close link with the Acute Trust's Clinical Governance Team has been established.
- Strong links with National and Regional Network of CDOP's have been maintained and members of the panel participated in the national stakeholder events held to review and standardise the processes and collection of data for child mortality reviews.

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.

- An internal review by the Trust identified poor documentation and recording as an issue and as a result appropriate measures were taken to improve recording and documentation.
- In one case there was some uncertainty about the positioning of the tube in the oesophagus. As a result relevant training was given to staff.
- In one case the accuracy of a telephone conversation between a patient and maternity staff was an issue and as a result of this all calls to the labour ward are now being recorded.
- Following a couple of deaths due to Bronchiolitis, improvements have been made to the Bronchiolitis pathway and PEWS chart (Paediatric Early Warning Scores). The new bronchiolitis pathway now includes an additional section on the use of high flow oxygen therapy, when and when not to use. This means that there is now clear guidance on the management of severe bronchiolitis. The new chart and pathway have been successfully used over this last winter. Alongside this a new High Dependency pathway has also been developed involving increased monitoring.
- Changes have been introduced to existing procedures with regard to undiagnosed breech presentation. Learning from one case has led to a decision that, in future, additional scans will be offered to those with a previous undiagnosed breech presentation.
- Following a number of neonatal deaths our local hospital trust invited the Royal College of Obstetricians and Gynaecologists to carry out an independent review and the findings of this have been openly shared with CDOP enabling the panel to monitor these themes in the future.

CDOP has made the following recommendations for agencies in Buckinghamshire

- Ensure close monitoring and surveillance of infant mortality continues and remains a top priority for all organisations in Buckinghamshire.
- Ensure commissioners and providers improve and enhance data collection and reporting on important risk factors such as ethnicity, consanguinity, obesity, smoking and alcohol and substance misuse in children and maternity records in all health and social care settings.
- Ensure there is a clear and agreed process in place for referring and sign-posting at-risk women particularly those from areas of social deprivation including ethnic minorities to relevant services such as genetic screening and counselling, the Skilled for Health classes for BME population, healthy lifestyle services and services that aim to prevent pre-term birth such as the local prematurity clinics.
- Ensure effective actions are taken by relevant partner agencies to reduce sudden unexpected death in infancy (SUDI), including promoting safer sleeping practice for babies, reduce parental smoking, encouraging and supporting breastfeeding and through clear communication of risk factors.
- Ensure close links between LSCB and Children and Young Peoples 'Emotional Well-Being Group' and the Suicide Prevention Group in order to ensure the full implementation of the Buckinghamshire Suicide Prevention Partnership Action Plan for children and young people.
- For the LSCB to promote actions to reduce child death.

Next Steps

- Further improve the review time and aim to reduce the proportion of reviews that take more than 1 year by 50%.
- Fully implement eCDOP in order to improve data recording and reporting process, and review and update all procedures in light of the implementation of eCDOP.
- Ensure that the recommendations of the Buckinghamshire neonatal mortality review by the Royal College of Obstetrics and Gynaecology are fully implemented, monitored and audited by Buckinghamshire Healthcare NHS Trust.
- Analyse child death data over a number of years to get an accurate picture of deaths in children in Buckinghamshire.

Key Findings from Child Deaths Reviewed in 2016/17

In 2016/17 CDOP was notified of **29 deaths of children aged 0-17** in Buckinghamshire and reviewed a total of 58 cases. The larger number of cases reviewed reflects a historic backlog of cases which has now been cleared. 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 on p50 provides key statistics for the deaths reviewed during the last 12 months.

CDOP Process	• Of the 58 cases reviewed in the year ending 31 March 2017, 29% (17 cases) were completed in less than 6 months which is an improvement from 19% in 2015-16 and 8% in 2014-15. • 74% (43 cases) were completed within 12 months of the notification compared with 30% in previous year. This is above the national average of 70% in 2015-16 (national for 2016/17 not available at the time of writing). • 26% (15 cases) took longer than a year to review compared with 69% in previous year. This is well below the national average of 30% in 2015-16.
Demo-graphics	• Of the 58 cases reviewed, 35 cases (60%) were 0-27 days old at the time of death compared with 43% nationally (2015-16). A further 12 cases (21%) were aged between 28 and 364 days which is similar to the national average for that age group (2015-16). • Overall, 81% (47 cases) were in children aged 0-1 year old which is higher than the national average of 64% (2015-16). • 5% of cases were in 1-5 year olds which is lower than the national average of 10% for these age groups (2015-16). 8 cases (14%) were in 5-17 year olds compared with 23% nationally. • 28 cases (48%) were male and 30 cases (52%) were female, compared with the national average of 57% and 42% respectively (2015-16). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011. • In 10 cases (17%) information on ethnicity was either unknown or not stated compared with 10% nationally (2015-16). This is an improvement from 32% of cases with unknown/not stated ethnicity in previous year. • 20 deaths (33%) were in children of White (Any White) ethnic background. 22 deaths (38%) were in children of any Asian/mixed Asian background. A small proportion of deaths were in children of any black and mixed black background. Data reported on ethnicity is unreliable due to inaccurate and incomplete data recording and the number of deaths is small overall which makes statistical analysis problematic. It is therefore not possible to benchmark these figures against the national average. • One child was 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 were the top category of death in Buckinghamshire (27 cases, 47%) compared with 32% nationally (2015-16), followed by chromosomal/congenital abnormalities (16 cases, 28%) compared with 26% nationally (2015-16). • In 34 cases (59%) the cause of deaths was determined as neonatal deaths compared with 41% nationally (2015-16). In 7 cases (12%) the cause of death was determined as 'known life-limiting conditions' compared with 27% nationally (2015-16). • In 42 cases (72%) Acute Hospitals were the place of death followed by 10 cases (17%) in the normal residence of the child. Nationally, 67% of the deaths reviewed occurred in an acute hospital and 22% in the normal residence of the child. • Modifiable factors were identified in 9 (16%) cases compared with 17% in the South East, and 24% nationally (2015-16). Nationally the number and percentage of reviews which were assessed as having modifiable factors has increased from 20% in 2012 to 24% in 2016. In Buckinghamshire the figure for this year is similar to last year's figure.

Learning from 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. The Sub Group monitors all SCR recommendations to ensure they are completed and escalates any ongoing concerns about outstanding actions to this BSCB.

This year the Sub Group has continued to take a more flexible approach to SCR methodologies, seeking to adopt a methodology which will best suit each individual case. Last year we reported some challenges in relating to running an SCR alongside criminal proceedings. However, the partnership discussions to overcome these challenges have proved beneficial and this year we have been able to work very effectively alongside criminal processes.

Completed and Ongoing Reviews

In 2016/17 the BSCB published two SCRs:

- Baby M involves a four month old baby who suffered serious harm.
- Child Sexual Exploitation in Buckinghamshire from 1998 – 2016 (for further information see the Child Exploitation section of this report).

By the end of the financial year we were also in the process of completing the SCR for Baby Q. This involved a young baby that suffered non accidental injury.

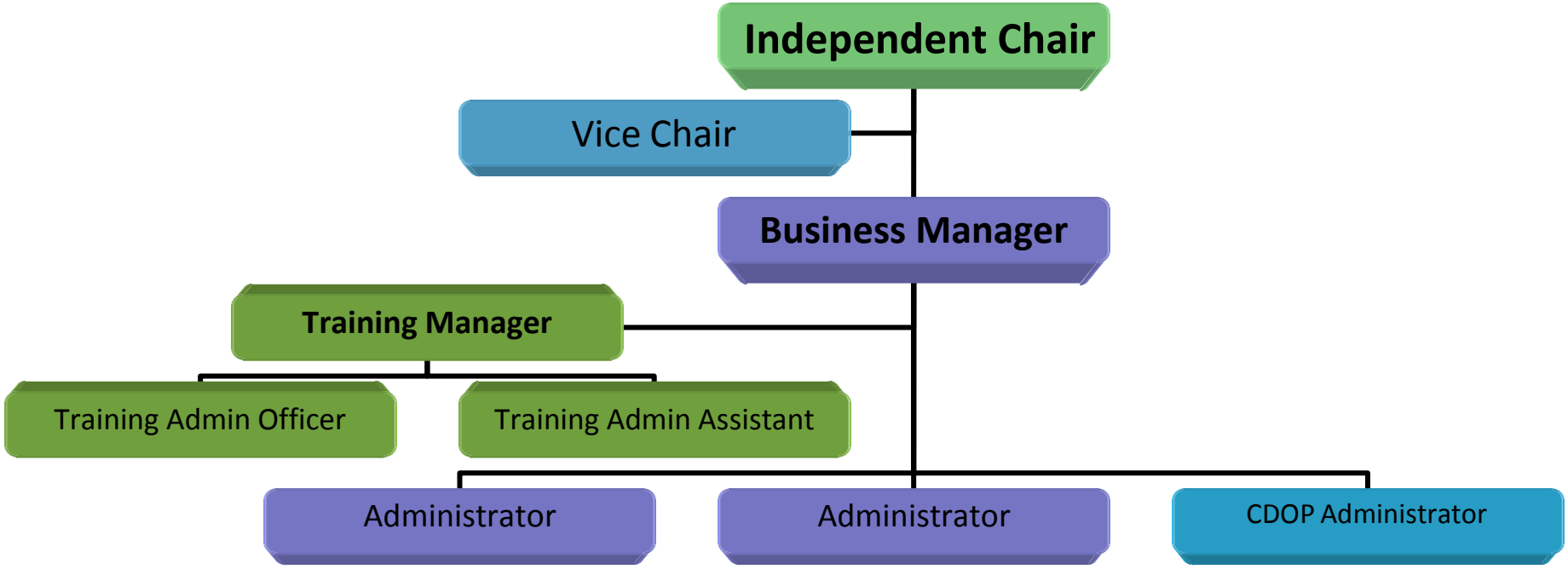
Learning from SCRs continues to be embedded within BSCB core training. We have also used the BSCB newsletter to share learning with our partners. There has been a stronger emphasis this year on sharing the key messages from SCRs as part of wider learning opportunities. For example earlier sections of this report refer to specific learning events and a conference that have been carried our around pre-birth safeguarding following a number of SCRs involving non accidental injury to babies. We hope to continue this approach over the next 12 months.

Next Steps

- The key theme of recent SCRs in Buckinghamshire continues to be non-accidental injury in babies. Some of the other sections of this report describe the activity that has already taken place in response to this. However, this will need to remain an area of focus for BSCB partners over the coming 12 months.
- The BSCB will need to respond to any changes to the SCR framework as a result of the recent Wood Review of LSCBs.

Appendix 1

BSCB Structure Chart



The Buckinghamshire Safeguarding Children Board (BSCB) was set up in January 2006 in accordance with Working Together to Safeguard Children, to safeguard and promote the welfare of children in Buckinghamshire. Under the requirements of the Children Act 2004, the BSCB is the key statutory mechanism for agreeing how the relevant organisations in Buckinghamshire will co-operate to safeguard and promote the welfare of children in its area. Under this statutory requirement, the BSCB is also required to ensure the effectiveness of what these organisations do.

Phone: 01296 383485 **Email: bscb-chair@buckscc.gov.uk** **Website: www.bucks-lscb.org.uk**

BSCB Sub Groups

The BSCB has eight sub groups which each have their own work plan and function which, between them, consider a wide range of safeguarding issues relevant to children in Buckinghamshire.

Buckinghamshire BSCB Safeguarding Children Board

Appendix 2: Board Membership as at March 2017 and attendance log

First Name	Surname	Organisation
Ros	Alstead	Oxford Health NHS Foundation Trust
Tania	Atcheson	Buckinghamshire Clinical Commissioning Groups
Phil	Beaumont (interim)	CAFCASS (Children & Family Court Advice & Support Service)
Jenifer	Cameron	Voluntary Sector Representative (Action 4 Youth)
Pauline	Camilleri	Youth Offending Service
Stephanie	Clifford	Independent School Representative (Maltman's Green School)
Steve	Czajewski	Thames Valley Community Rehabilitation Company
Carol	Douch	Buckinghamshire County Council (Children's Social Care)
Gillian	Gallagher	National Probation Service
Kelly	Glister	Thames Valley Police
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 Services)
Sarah	Leighton	Primary School Representative (Hughenden Primary School)
Ed	McLean	Thames Valley Police
Fiona	Morey	Aylesbury College
Carolyn	Morrice	Buckinghamshire Healthcare BHS Trust
Jane	O'Grady	Buckinghamshire County Council (Public Health)
Julie	Puddephatt	Buckinghamshire County Council (Communities, Health and Adult Social Care)
Lesley	Ray	Designated Doctor
Will	Rysdale	Aylesbury Vale District Council*
Juliet	Sutton	Aylesbury Vale Clinical Commissioning Group
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 2017)			
Agency		**Agency**	
Adult Social Care (BCC)	80%	**National Probation Service**	60%
Aylesbury College	60%	**NHS England**	60%
Children & Families (BCC)	100%	**Oxford Health NHS Foundation Trust**	100%
Buckinghamshire Healthcare Trust	100%	**Primary Schools**	60%
Cabinet Member	60%	**Public Health**	100%
CAFCASS	0%	**Secondary Schools**	60%
Clinical Commissioning Group	100%	**Thames Valley Police**	100%
District Councils	60%	**Community Rehabilitation Company**	60%
Independent Schools	80%	**Voluntary Sector**	80%
Lay Member	60%	**Youth Offending Service**	100%

Appendix 3: BSCB Budget

Agency	2015-16				2016-17		
	Contributions (BASE BUDGET)	Additional in year contributions	Total for 2015-16		Contributions (BASE BUDGET)	Change from 15/16 base budget contribution	% Change from 15/16 base budget contribution
BCC	134,902	35,950	170,852		105,683	29,219	22% ⇩
Thames Valley Police	15,000	16,000	31,000		24,290	9,290	62% ⇧
Aylesbury Vale CCG	70,180		70,180		70,180	0	0% ⇔
Chiltern CCG							
Bucks Healthcare Trust							
Probation (CRC)	1,735		1,735		1,735	0	0% ⇔
National Probation Service	1,735		1,735		1,227	508	29% ⇩
Wycombe District Council	10,633		10,633		10,633	0	0% ⇔
Aylesbury Vale District Council	10,633		10,633		10,633	0	0% ⇔
South Bucks District Council	5,317		5,317		5,317	0	0% ⇔
Chiltern District Council	5,317		5,317		5,317	0	0% ⇔
Cafcass	550		550		550	0	0% ⇔
Oxford Health (CAMHS)	8,000		8,000		8,000	0	0% ⇔
TOTAL BASE BUDGET	**264,001**	**51,950**	**315,951**		**243,564**	**20,437**	**8% ⇩**