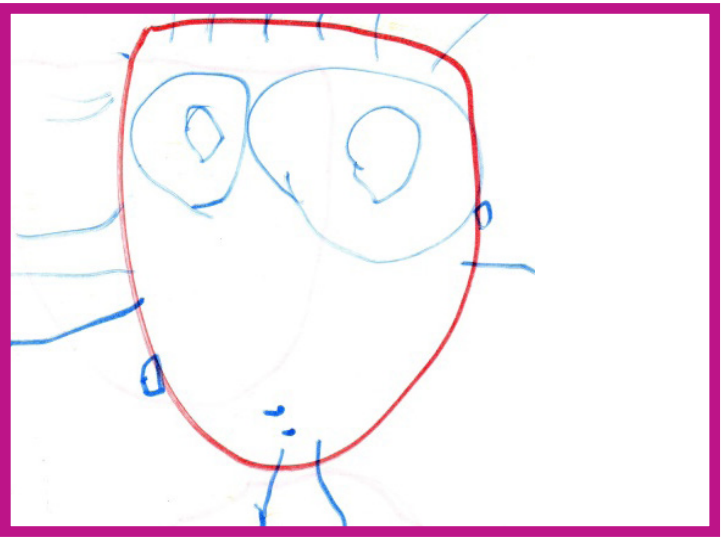
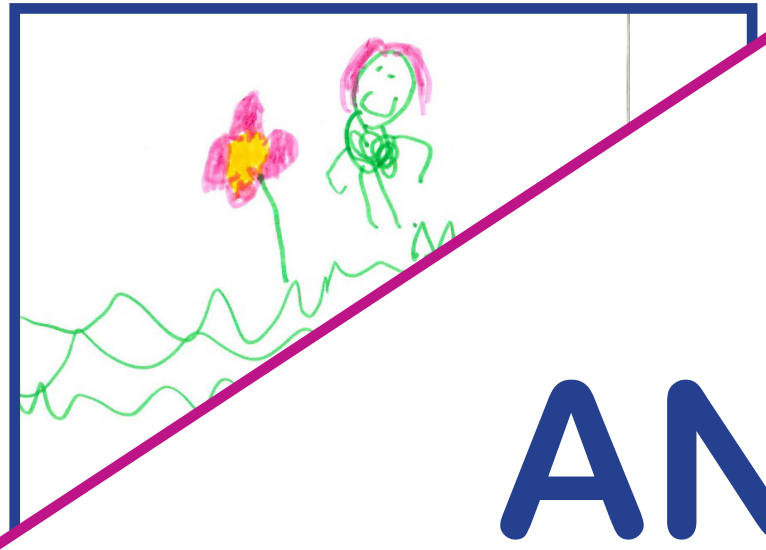
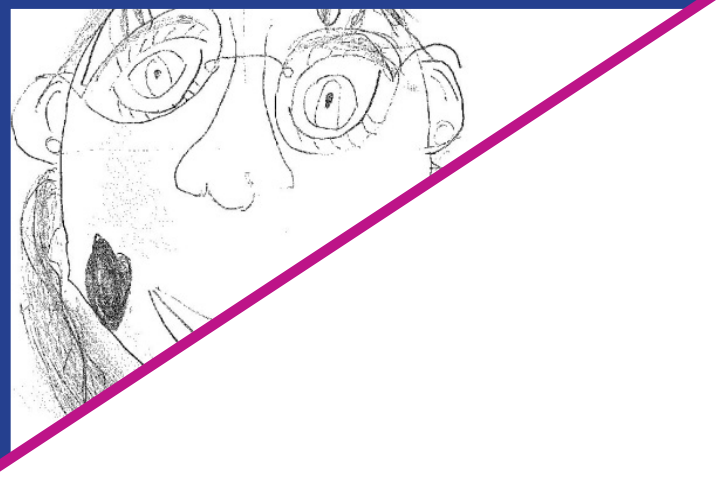






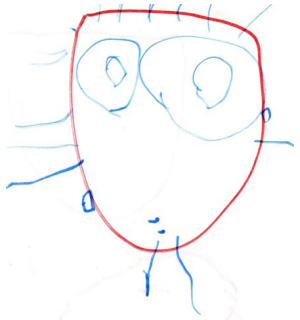
Buckinghamshire

BSCB

Safeguarding Children Board

ANNUAL REPORT

2017-18



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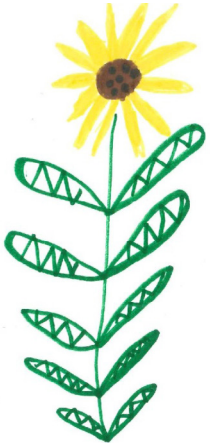


Forward

Welcome to the BSCB Annual Report

Welcome to the Annual Report of the Buckinghamshire Safeguarding Children Board (BSCB) for 2017/18. The report sets out the key activities and achievements of the Board during the year and those areas where further work is needed to deliver consistently better outcomes for children and young people in Bucks.

There is no doubt that it has been a very challenging year for the Board and its partners, with changes in managers in a number of the key agencies; the arrival of a new Board Manager and changes in the membership and chairing of the Board's sub-groups. In addition, we had the long awaited Ofsted re-inspection of Children's Services and a second Inadequate judgement which was disappointing but a fair reflection. These factors have inevitably slowed progress in some key areas. This has been frustrating for partners given their ambition and commitment to transform services for children across the County.

There is no doubt that the Board is in a significantly better place than it was in 2015 when the new BSCB was formed. Governance and processes have been strengthened, an annual programme of quality audits has continued and several new Serious Case Reviews have been commissioned. These have generated important learning which have been the focus of practitioner learning events and have been embedded into multi-agency staff training, which continues to be well regarded. The Ofsted Inspection commented positively on the impact of the more robust culture of challenge and support between agencies in the Board.

I would like to highlight the progress which has been made in some key areas. Examples include the work with secondary schools and parents on keeping children safe from exploitation including on-line safety; the reduction in children being subject to a child protection plan for a second time; the reduction in inappropriate referrals to children's social care; improved access to Child and Adolescent Mental Health assessments and the development of some new services to meet local needs such as the Eating Disorder service. There has been much closer joint working across the partnership to develop strategies, raise awareness in the community and roll out multi-agency training for tackling Domestic Abuse and Neglect which have such an impact on the lives of many children and young people.

A key strength has been the stronger involvement of schools (across sectors) in the work of the Board and recognition of the major contribution they make to keeping children safe. A large backlog of reviews of child Deaths has been eliminated and this is leading to more timely learning of lessons and action to reduce preventable deaths. Good progress has also been made to plan for the transition of Local safeguarding children arrangements, in 2019, in line with new central Government Guidance.

I would like to thank all the Board partners for their ongoing commitment to the Board, for their timely completion of agreed actions and for their work in the Board's sub-groups to progress specific areas. Thanks are also due to Matilda Moss, the outgoing Board Manager, and Jo Stephenson, her replacement, to Carol Gorley, Hilary Walker and Alison Martindale for their continued hard work. Thanks also go to Ann McKenzie, Julie Marshall and Emma Granville for their continuing work around the multi agency training. I would also like to recognise the particular contribution made by the Board's lay members who provide an additional layer of challenge and bring to the work their skills and experience as parents and as members of our local communities.

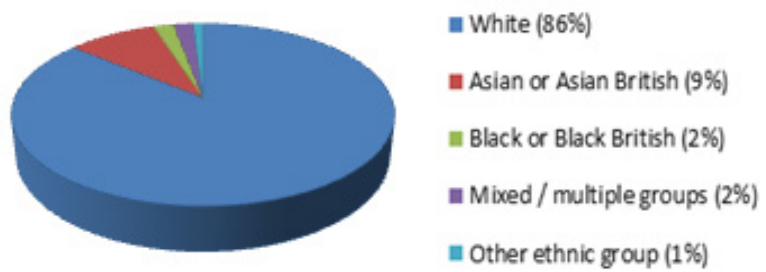
Fran Gosling-Thomas
BSCB Independent Chair
Bucks LSCB

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

Figure 1. Buckinghamshire Population by Ethnicity (2011 census)



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. 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 18.2% of children and young people have a first language other than English (England average: 21.2%) and in secondary schools the figure is 16.9% (England average: 16.6%).[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

[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.

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 nursery and primary schools (the England average is 13.7%) and 4.4% in secondary schools (the England average is 12.4%).[8] Overall, a number of 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 as of September 2018 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. Following the Wood report, the Board awaited the publication of the revised Working Together, which would set out in detail the proposed changes, including the move from a Board to a multi agency partnership safeguarding arrangement.

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 continued to be 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 in appendix 1. By the end of 2017 some of these groups had successfully completed their action plans and were therefore no longer needed.

The BSCB is funded through contributions from each of the partner agencies. The contributions from each partner agency for the 2017/18 year can be found in appendix 3.

The BSCB meets every two months and focuses its attention on areas of safeguarding challenge, concern or improvement particularly those areas set out in the last Ofsted inspection of children in need of help and protection undertaken in November 2017 and published in January 2018. 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

As part of the work of the Board, our meetings considered 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 2017/18, the BSCB agreed to focus on the issues which were affecting children in Buckinghamshire the most and also required an improved partnership approach. This year has seen a continued focus on driving improvement following the 2017 Ofsted inspection when the local authority services for children in need of help and protection, children looked after and care leavers were judged to be inadequate for a second time (https://reports.ofsted.gov.uk/local-authorities/buckinghamshire)

By March 2018, a Commissioner had been appointed by the Department for Education (John Coughlan CBE) to ensure that:

- the detail and basis of the Ofsted judgement are properly understood and accepted across the services;
- there is an agreement about what needs to be done to secure sustainable improvement;
- the right mechanisms and capacity are put in place at all levels to make the necessary changes and embed the improvement.

[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. This is the version of the statutory guidance current at the time that this annual report covers.

In response, 2017/18 has been an opportunity for the Board to concentrate on grip, pace and accountability, looking in more details about what data we collect and how the Board contributes to improving outcomes for children as a result. It has also been an opportunity to begin the change process following the Wood Review of Local Safeguarding Boards and the subsequent changes to the statutory framework for LSCBs 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. The Board responded to a national consultation in December 2017 and by February the three key partner agencies began a working group to address the transition. From March 2018 the Board has worked with the key partners looking at ways forward. The continued engagement of all the Board partners, lay members and experts by experience will continue to be integral to our work.

Priority 1 Domestic abuse

Priority 2 Child Exploitation

Priority 3 Neglect

Priority 4 Early Help

Priority 5 Board transformation

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."

Lay Members

Working Together 2015 requires all LSCBs to have two Lay Members. During 2016- 17 we recruited three new Lay Members to the BSCB, after our previous two long-standing Lay Members stood down during 2015/16. We are grateful for the strong commitments and contributions to the Board that our Lay Members demonstrated through 2017/18. In addition we have welcomed a strengthened contribution by our experts from experience within our sub group. The role of Lay Members and the planned introduction of experts by experience panels will be a strong feature of the new working arrangements.

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.**

3. Domestic Abuse

Our aim: children who are living in the context of domestic abuse have timely access to help and support to improve their outcomes.

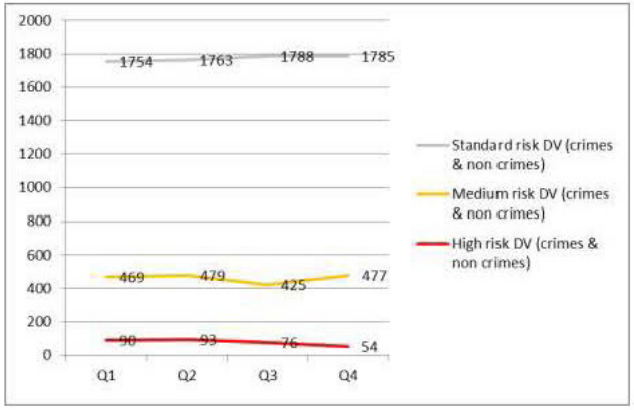
Children living in an environment where there is domestic abuse (DA) continues to be a key issue impacting the lives of children in Buckinghamshire. Nationally, figures indicate that around one in five children have been exposed to domestic abuse[13]. In addition the definition of DA was expanded in England and Wales in March 2013 to include victims aged 16 and 17 years old, which also includes victims of controlling and coercive behaviour. Barter et al (2009) stated that one in five teenagers had been physically abused by their girlfriends or boyfriends[14]. Safe lives stated that 130,000 children lived in households where there is 'high risk' domestic abuse[15]. 62% of children in households where domestic violence is happening are also harmed[15].

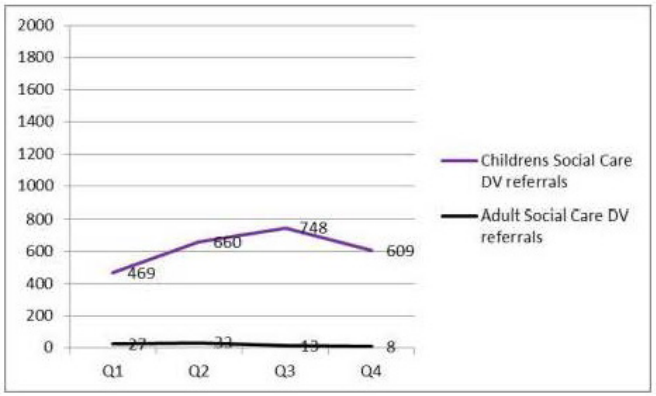
Locally, the number of referrals to Children's Social Care where DA is a primary concern varies month to month, but there was a 33% increase in Q1 2018 when compared to Q1 2017 (469 in Q1 2017, rising to 642 in Q1 2018). Police data has also indicated that there has been a rise in the number of incidences reported which are categorised as standard risk from 1,754 in Q1 2017 across the County, to 1,842 in Q1 2018. Research shows that a victim will have experienced on average 30 incidents before reporting therefore, children living in homes where an incident was categorised as standard may nevertheless have experienced significant negative impact.

Volume of incidences 2017-18

Thames Valley – Number of domestic crimes / non crimes per 1,000 16+ population

Slough – 44	Cherwell & West Oxfordshire – 22
Milton Keynes – 37	**Aylesbury Vale – 21**
Oxford City – 26	West Berkshire – 21
Wycombe - 23	South Oxfordshire & Vale of White Horse – 21
	Chiltern & South Bucks – 17





[13] Radford, L. et al (2011) Child abuse and neglect in the UK today

[14] Barter et al (2009) Partner exploitation and violence in teenage intimate relationships NSPCC and Bristol University

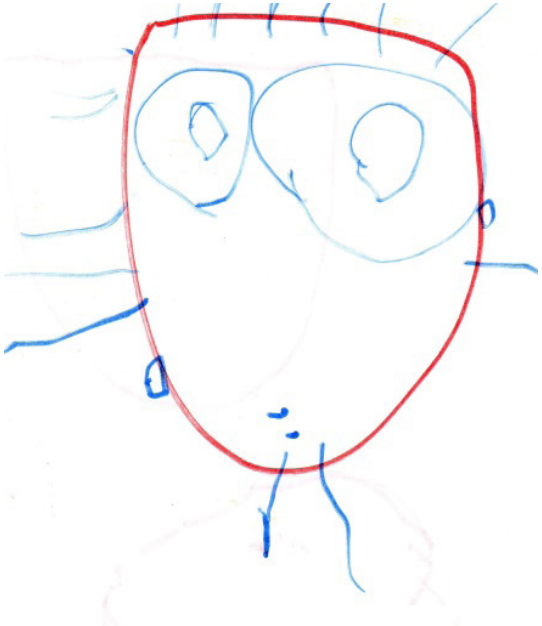
[15] Safe lives (2015) getting it right first time policy report .Bristol

The Board continued to offer domestic abuse awareness training which was accessed by 19 people and to promote training offered by colleagues in the community safety team, such as training led by Laura Richards (BSc, MSc, Asc. IA-IP, MBPsS), a criminal behaviour analyst focusing on stalking and harassment. Strong links were developed between the Domestic Abuse Strategy Group and the Domestic Abuse Champions Network to ensure that the Board established a 'think family 'approach to this issue. As a result BSCB was a key contributor to the development of the County Domestic Violence and Abuse strategy. A joint piece of work to capture and analyse data was undertaken between the BSAB Business manager (Buckinghamshire Safeguarding Adults Board), SSBPB (Safer Stronger Bucks Partnership Board) and BSCB. This will ensure moving forward all the relevant Boards have joint understanding and mutual challenge in Buckinghamshire. In addition, domestic abuse was a priority matter for the Joint Chairs meeting, who agreed that a 'big tent' event for professionals was needed to further increase the shared understanding of areas for improvement.

As part of the Board's aim to work in a more integrated way with the BSAB, a joint challenge event is planned to focus on the needs of people with an identified learning disability who are a risk of or who are experiencing domestic abuse.

Next Steps

- **To offer active challenge and seek assurance that the needs of children who are living with or subject to domestic abuse are more effectively recognised and responded.**
- **To make use of a shared data set across the relevant Boards.**
- **To ensure that the new arrangements have DA as a key priority, including the scrutiny of outcomes for children who are affected.**
- **To participate in the planning and delivery of the big tent event.**
- **To take an active role in the roll out of the strategy and the subsequent action plan.**



4. Child Exploitation

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

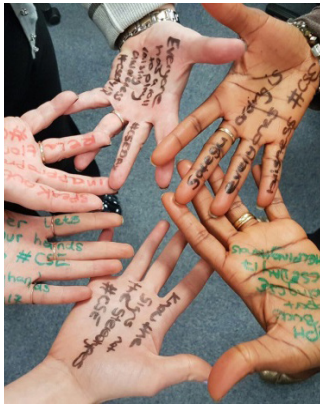
Last year the BSCB had a specific priority around Child Sexual Exploitation (CSE). This year, the priority was broadened to include the wider child exploitation agenda, for example radicalisation, human trafficking and modern slavery. This acknowledges the similarities between CSE and other forms of 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 achievements include:

- A refresh of progress against work plan and a review of the terms of reference.
- Broadening the remit of the group to exploitation.
- Embedding an expert by experience voice; one of the parents of a survivor is now a full member of our Child Exploitation Sub Group.
- A review of best practice of materials with the sub group looking at #nomorecsefilms campaign to inform next steps.
- Successfully gaining funding from the Police and Crime Commissioner to deliver a cyber crime production in schools – see safety section.
- Continued engagement with communities looking at key points of contact for awareness raising. Leaders have identified the need for a programme of engagement attended by senior figures from a range of agencies.
- Embedded the links between ASEN (anti-slavery and exploitation network, which encompasses all age groups) and joint boards meetings (including the Safeguarding Adults Board (BSAB) and Safer Stronger Bucks Partnership Board (SSBPB)).The focus has extended to children who are exploited as they become adults (transitions), and our response to adults who disclose that they were exploited in their childhood (delayed reporting).

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 shared responsibility for the



VICTIMFOCUS
CHALLENGE | CHANGE | INFLUENCE

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. See the data below from RU safe for more information.

- The Early Help Panel (which the Board business manager (BM) also shares chairing responsibilities for) seeks to identify and offer a coordinated response to children who have needs at level 3 of the threshold which may include early indicators of being at risk of exploitation.
- 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.
- 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.
- Effective links between the anti-slavery network (which includes the BSAB and SSBPB) and the BSCB sub group to ensure a coordinated approach to the respective Board work plans and tasks.
- As part of the Board's work on exploitation, the e-safety sub group has continued to be an active partner. Achievements by this sub group include:

The e-safety conference for professionals which went ahead on 23rd February and was well received with 100 delegates attending (60% from schools). The focus was on engaging parents/carers with internet safety. Planning is underway for the secondary school student's conference in July 2018. There will be three primary school conferences during Sept/Oct 2018

The **meeting of the working group** who are planning the roll out of the AlterEgo primary school input took place in January. A plan is in place with regard to venues, communication with schools and parents and members of the working group have had a preview of some of the content.

CEOP training for professionals

Along with the continued DSL training sessions, the E-Safety Sub Group decided to run a training session for any professionals in the County. The response to the invitation was overwhelming, including interest from professionals outside of the county, leading to further sessions. In total we trained over 150 professionals with a request for more dates to be put on.

E-safety conference for professionals

We hosted an e-safety conference for professionals at Green Park, which was fully booked with over 100 professionals attending to hear a wide range of speakers. The conference was opened by Fran Gosling-Thomas the Chair of BSCB and was followed by speakers from Internet Matters, Thames Valley Police, the Chief Executive of the PHSE Association, KiVA (research based anti bullying programme) and Wandsworth College. Topics included information on changes in the law around handling of nude images, promoting good mental health in schools, cyberbullying and sharing good practice.

All the speakers were well received and feedback from the audience showed that participants appreciated the time to share practice as well as learning from experts. All presentations, where possible, have been uploaded to the Schoolsweb, with a link from the BSCB site.

E-Safety Poster for parents.

Throughout the year Cyber Crime and E-Safety Sub Group experts have worked together to educate parents around their own internet usage and possible risks, in order to keep them and their children safe, this has included designing a poster for schools to display. This is available for download on the BSCB website.

Online Survey for Young people

A survey was designed by the group to be used by teachers and trainers, providing e-safety presentations in school, to inform them of particular topics to address. Princes Risborough School found it to be a really useful exercise as it highlighted areas of concern within specific year groups.

Joint Presentations with CyberCrime Team

The subgroup have been active with partnership work throughout the year, including working with the Cybercrime team, delivering presentations across the county around the dangers of online scams, phishing, etc. and advising professionals and the public on how to stay safe.

Data and analysis

We know that children who go missing are a key group in relation to the risk of exploitation. Locally ,Aylesbury Vale and Wycombe continue to have a significantly higher number of missing episodes for children compared to the other districts at 78% of the total number.

For the County as a whole in 2017/18:

- 80% of all missing episodes reported to Thames Valley Police were for children aged between 14 and 17.
- For the cases where ethnicity was recorded, 83% of missing episodes were children from a white background. However, ethnicity was not recorded or stated in 37% of cases, making it difficult to draw conclusions around this data.
- For children aged 0-18, girls have slightly more missing episodes than boys (51% and 49% respectively).

Our services – RU Safe

CSE service

Referrals:

- Referrals have remained at relatively static level, with the average being 21 per quarter. 84 CSE referrals were received over the year. This is down on previous years reflecting the change in threshold and a shifted focus towards the Return Interview Service.
- 57% of CSE referrals throughout the year came from Social Care (48 out of 84), 18% came from education.
- Six Q4 referrals received were Looked After Children, bringing the yearly LAC referrals to 12, equalling 14% as a yearly percentage of all referrals.
- Nine Q4 referrals received had a Child Protection Plan (CPP), which is higher than previous quarters. The yearly total of CPP referrals is 15, or 18%.
- This quarter saw a reduction in the average time on the waiting list, down to two weeks. The yearly average waiting time was five weeks, well within the eight week maximum target.

The total number of referrals for 2017-2018 totalled 84. This compares to 110 referrals received over 2016-2017, demonstrating a continued decrease. As mentioned above, this reflects the change in focus of service provision and the higher threshold now being applied to assess appropriate referrals. Other agencies within Buckinghamshire, such as the youth service and Safe! project, are now able to take lower level referrals that previously would have been supported by R U Safe.

Outcomes at exit:

- Of those children and young people that responded to the closing evaluation, 100% reported benefit and would recommend the service to others.
- Q4 outcomes showed 100% of clients at closure demonstrated improved knowledge of sexual health strategies, with the yearly average at 78%.
- Q4 80% had reduced association with risky peers or adults at the point of closure, with the yearly average at 83%.

Client data:

- Consistent with previous quarters, the majority of new clients opened were of White British ethnicity.
- Aylesbury accounted for 37% of new client's area of residence, followed by High Wycombe at 27%.
- Overall, 14% of new clients over 2017-2018 held Child in Need Plans, where this was known at the point of referral.

Prevention Service

- 13,282 = total number of young people reached via prevention work across schools in Buckinghamshire, including hard to reach sites, and counting grammar schools. This high number reflects the service providing brief awareness raising following the Chelsea's Choice drama production. R U Safe attended every performance in order to signpost and offer support to students after the show.
- Awareness raising sessions have reached 529 professionals including one group of parents in Quarter 2. This reach also includes the continuation of session delivery to all Safeguarding Leads within education, for both primary and secondary schools.

Participation by children and young people

We have held six client forums where the input of clients helps us to design a particular aspect of the service. For example, in Q4, clients met with some members of the team to plan and design an activity day based around photography, which is planned for July.

Missing Service

Summary:
This was the first year of the new contract, with the primary focus being the response to children who return from going missing.

- Over 2017/18, RUSafe received a total of 1506 missing referrals, across 708 individuals.
- Altogether, 245 referrals (16%) were deemed not appropriate to complete, which includes those who may have been from another Local Authority. The others would have been based on the child's needs at the time, and agreed with Social Care not to complete. For example, where there were mental health concerns that completing a return interview would have had a negative impact.
- The total number of referrals received for children who were looked after by Buckinghamshire County Councilwas 101.
- The total number of referrals for looked after children from other local authorities was 231.
- The split between female and male individuals worked with was roughly half and half at 51%, male, 49% female.

With the service realigning itself and developing new processes to ensure new targets are reached, this first year of data reflects the services transition, which has been a very challenging one.

Against the new target of achieving 85% of Return Interviews completed within 72 hours (of receipt of report), please see the summary of data pulled out on pages 14-15 to show the year-end figures:

Exploitation - Next Steps

There are a number of key areas of focus for the year ahead:

1. **Broadening our CSE Strategy and Practice Guidance to embrace the wider agenda.**
2. **Ensuring that the voices of those involved in the serious case review continue to be heard.**
3. **Undertaking a 'deep dive' audit to ensure that we understand what the experience of services is like for children who are currently at risk of or experiencing exploitation.**
4. **Ensuring that pathways are clear and agreed for the different forms of exploitation and are mindful of transitions.**
5. **Creating of an area scorecard and profile to inform the work.**
6. **Ensuring that the group completes the new streamlined work plan.**

R-U-Safe? DATA NARRATIVE Quarter 4 Jan-March 2017/18 YEAR END

CSE Service

Referrals:

- Referrals have remained at relatively static level, with the average per quarter being 21 per quarter. 84 CSE referrals were received over the year. This is down on previous years reflecting the change in threshold and a shifted focus towards the Return Interview Service.
- 57% of CSE referrals throughout the year came from Social Care (48 out of 84), 18% came from education.
- 6 Q4 referrals received were LAC, bringing the yearly LAC referrals to 12, equalling 14% as a yearly percentage of all referrals.
- 9 Q4 referrals received had a CPP, which is higher than previous quarters. The yearly total of CPP referrals is 15, or 18%.
- This quarter saw a reduction in the average time on the waiting list, down to 2 weeks. The yearly average waiting time was 5 weeks, well within the 8 week maximum target.

The total number of referrals for 2017-2018 totalled 84. This compares to 110 referrals received over 2016-2017, demonstrating a continued decrease. As mentioned above, this reflects the change in focus of service provision and the higher threshold now being applied to assess appropriate referrals. Other agencies within Bucks are now able to take lower level referrals that previously would have been supported by R U Safe.

Outcomes at exit:

- Of those clients that responded to the closing evaluation, 100% reported benefit and would recommend the service to others.
- Q4 outcomes showed 100% of clients at closure demonstrated improved knowledge of sexual health strategies, with the yearly average at 78%
- Q4 80% had reduced association with risky peers or adults at the point of closure, with the yearly average at 83%.

Client data:

- Consistent with previous quarters, the majority of new clients opened were of White British ethnicity.
- Aylesbury accounted for 37% of new client's area of residence, followed by High Wycombe at 27%.
- Overall, 14% of new clients over 2017-2018 held CIN status, where this was known at the point of referral.

Prevention Service

- 13,282 = total number of young people reached via Prevention work across schools in Buckinghamshire, including hard to reach sites, and counting Grammar schools. This high number reflects the service providing brief awareness raising following the Chelsea's Choice drama production. R U Safe attended every performance in order to signpost and offer support to students after the show.
- Awareness raising sessions have reached 529 professionals including one group of parents in Quarter 2. This reach also includes the continuation of session delivery to all Safeguarding Leads within education, for both Primary and Secondary schools.

Client Participation:

We have held six client forums where the input of clients helps us to design a particular aspect of the service. For example, in Q4, clients met with some members of the team to plan and design a activity day based around photography, which is planned for July.

Missing Service

Summary

This was the first year of the new contract, with the primary focus being the response to children who return from going missing.

Over 2017/18, RUSafe received a total of 1506 missing referrals, across 708 individuals. Altogether, 245 referrals (16%) were deemed not appropriate to complete, which includes those who may have been from another Local Authority. The others would have been based

on the child's needs at the time, and agreed with Social Care not to complete. For example, where there were mental health concerns that completing an RI would have had a negative impact. The total number of Bucks LAC individuals was 101. The total number of LAC referrals from other LA was 231. The split between female and male individuals worked with was roughly half and half at 51%, male, 49% female

With the service realigning itself and developing new processes to ensure new targets are reached, this first year of data reflects the services transition, which has been a very challenging one. Against the new target of achieving 85% of Return Interview completed within 72 hours (of receipt of report), please see the summary of data pulled out below to show the year-end figures:

% of RI completed within 72 hours	**Target 85%**	68%
% of appropriate RI completed within 72 hours		70%
% of RI completed outside of 72 hours		16%
Total % of RI completed		86%
% of YP that felt they have benefited from the service		100%
% of YP in care with reduced missing episodes	**Target 50%**	51%

This compares against 2016/17, where RUS was commissioned to offer RI's within 72 hours, and where the average time frame between receipt of referral and completion of RI was 11 days. 2016/17 contract maintained a focus on CSE, so RI's were not processed as effectively as they are now, under the new contract.

With processes now firmly established, the expectation is that the service will show continued improvement against the RI completion target. Quality Assurance is now part of the daily operation, and no Return interviews are returned to police or Social Care without having been checked by a senior member of RUS team. Additionally, random samples have been audited by senior Social Care managers, to ensure agreement on quality of content. Social Care are now satisfied with the quality of reports and are no longer auditing.

RUS senior team continue to Quality Assure every RI before it is returned. Additionally, RUS continue to monitor figures on a weekly basis to ensure any dips in performance are immediately recognised and addressed.

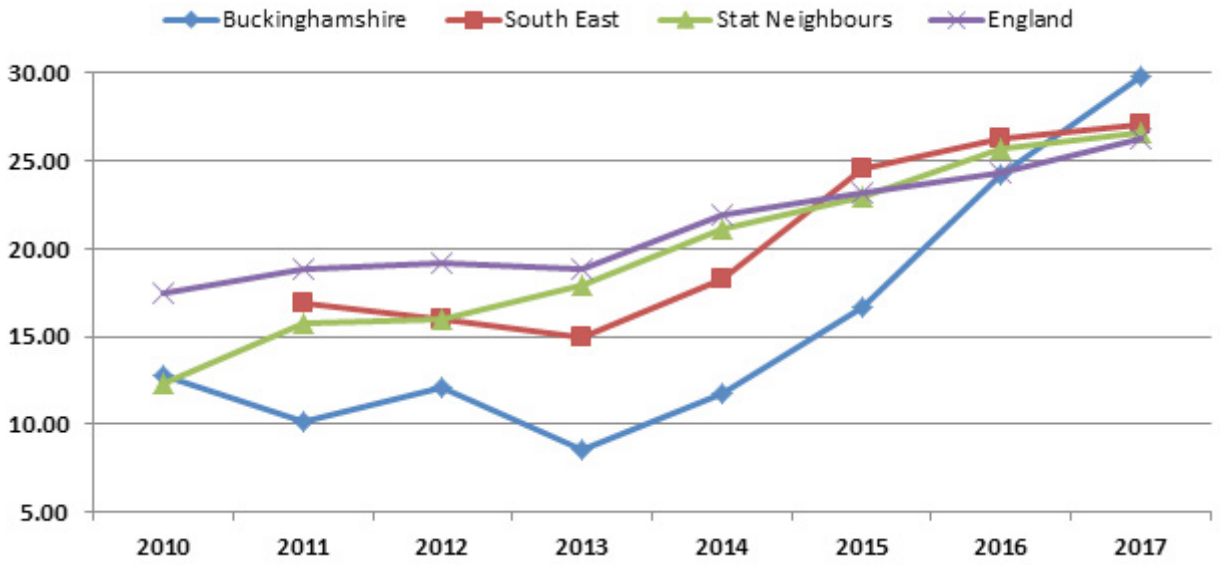
E-safety next steps

- **CyberCrime Theatre Production for Year 6 students**
  Following on from the success of Chelsea's Choice in Secondary schools, a play addressing child sexual exploitation, Thames Valley's bid to the Police & Crime Commissioners Office for funding was successful. AlterEgo have produced a play aimed at Year 6 age students, addressing awareness of cybercrime and online safety. The objective of the project is to develop an understanding of healthy online relationships, for young people, including addressing topics on grooming, sharing of inappropriate images and cyberbullying. There is a teachers resource pack to go alongside and is to be delivered across Oxfordshire, Buckinghamshire and Berkshire. 41 performances will take place in Bucks early in the academic year 2018.
- **TVP cop card in Marlow and High Wycombe**
  In the Summer Term board members are working with Thames Valley Police delivering their Cop Card scheme to KS2 in the High Wycombe and Marlow area, which includes a badge for Online Safety.
- **Junior E-Safety Ambassador course**
  An ambassador course has been requested for primary students to become e-safety ambassadors for their school. This will be delivered to a pilot school in the summer term. The e-safety conference for primary schools will then roll this out to delegates.
- **E-safety conferences for secondary and primary students**
  A conference for secondary school pupils in July is planned, with workshops being given by Equaliteach and McAfee. One for primary students will be held in the Autumn term, with a workshop training young ambassadors.

5. Neglect

Our Aim: To ensure that the needs of children at risk of or subject to neglect are recognised and responded to at the earliest opportunity

Research nationally identifies neglect as the most common reason for children to become subject to a child protection plan. By the end of 2017 our rates of children subject to a CP plan under the category of neglect were higher than the South East and statistical neighbours and climbing (rate per 10,000 of the CYP population) (see gov.uk). In order to re-inforce this priority, the BSCB held a conference in March 2018.



Graph of Child Protection Plans starting due to neglect (rate per 10,000 of the CYP population) available via the Gov.uk website

BSCB Neglect Conference - March 2018

82 delegates from a variety of agencies attended the second neglect conference held by the BSCB. The event took place at Wycombe Wanderers Football Club conferencing venue, the previous one having been held in 2013. The majority of the audience were front line practitioners.

The event was opened by **Fran Gosling-Thomas**, Independent Chair of Buckinghamshire Safeguarding Children Board. Fran explained the need for all agencies to work better at identifying and responding to the early signs of neglect.

The national trend for the number of children on a child protection plan has increased and it is no different in Buckinghamshire – currently running at 62% (as of 31st January 2018). The work completed with regard to neglect by the board includes writing a multi-agency strategy to tackle neglect, revising the neglect guidance, several audits and being a licenced provider of Graded Care Profile training.

Dr Lesley Ray, Designated Doctor for Safeguarding Children, then gave a presentation that had everyone scratching, as she showed some of the common infections, infestations and injuries some neglected children may present with. However the message was that ALL children may have these issues at some point in their childhood but, by not treating them parents/carers can become neglectful. Dr Ray discussed some of the cases she has come across in clinic and how the children presented, which included very smelly/dirty, displaying challenging behaviours and how the child interacts with their parent/carer. Dr Ray gave an overview of how neglect affects children's brain development and the implications this may have for later life. A very poignant slide was shown where a child becomes 'lost' due to the chaotic environment they are living in.

Delegates then attended one of three workshops.

Patrick Neil presented on the Graded Care Profile on behalf of the NSPCC. He described how the GCP version 2 came about and what research has told us from the 'pilot phase' and how families have benefitted from the tool.

Fran Gosling-Thomas

Dr Lesly Ray

Patrick Neil

Sue Woolmore

David Glover-Wright

Gerry Byrne

Sue Woolmore's workshop "sand stories". Sue set out to give people the space to reflect and to discuss where they were in a story that she powerfully created with sand and some figures (people who attended agreed not to share the content of the story in case others get a chance to experience it at a later date). It gave everyone a chance to put themselves into a child's lived experience and think about the barriers when working with families which lead to their needs not being met.

Kim Hinves and Karen Parker presented on neglect and children with disabilities on behalf of Action for Children. This workshop looked at attitudes and assumptions towards disabled children and being able to challenge parents. A discussion took place around how professionals may have different concerns in similar situations depending on whether the child has a disability i.e abled child verses non-abled child and how this affected their scores.

David Glover-Wright, Principal Social Worker (Buckinghamshire County Council) spoke about adolescent neglect and the difficulties of engaging with them and their parents. David provided some case examples of young people he has worked with and how he was able to break down the barriers that workers often perceive based on the young person's gender and societal stereotyping.

Gerry Byrne from Oxford Health gave an extremely detailed presentation on the relationship between a child and their parent and how this can be neglectful. His 'imaginative' drawings demonstrated how a simple discussion can cause an adverse reaction and how this can be perceived by the child and their parent as 'aggressive'.

After a short lunch break **DI Emily Allen and DS Ami Chapple** from Thames Valley Police gave an overview of the police responsibilities when investigating cases of neglect and how they have to prove 'beyond all reasonable doubt' that the neglect was 'wilful'. They explained the powers they have, how they use them and the variety of ways that they can collect evidence.

Next steps for the Board

- **Take up of the training offered on using the Graded Care Profile has been lower than anticipated. The Board will drive shared strategic direction on this issue. To support this BSCB is planning work to review the impact of evidence-based tools. BSCB is planning some work to look at evidence around the impact of using the tool with families.**
- **Review of progress against the recommendations in the partnership neglect strategy agreed in September 2017.**
- **The Board to review and agree a clear set of deliverable actions that will have a positive impact on the way agencies work with families.**
- **The new local multi-agency safeguarding partnership will continue to have neglect as a strategic priority.**

Neglect: a good practice story

Good practice story – using the Graded Care Profile assessment

Context-
The tool was used creatively by a social worker and children's family worker to support Mum and her three children under the age of five. The family were being supported under a child protection plan and the children had been impacted by previous domestic abuse and having some unexplained injures. The change required as a result of the CP plan was not happening and it was felt that Mum was not applying professional advice or sustaining change.

What did they do?
Over three planned visits and one unannounced visit, the social worker and the family worker completed the GCP2 assessment as a way of discussing and agreeing what needed to change in the home. Both workers had attended the BSCB graded care training and so, were licensed to undertake this. Pictures were used to support Mum to identify hazards on the diagram (diagram 1) and the children joined in!

Diagram 1

Mum was then able to choose an area to focus on and chose the garden (diagram 2) Alongside this, the family used a card sort activity called 'what kids need'. This helped to make the discussion more specific and to identify the gap between Mum understand the 'theory' and outing it into practice. In order to focus the outcome on the children, Mum was then asked to identify what made each child happy or sad and there were more things that made them sad… which was the same for Mum.

Diagram 2

What happened?
The workers fed back they felt more confident having the conversations with Mum as they were specific and there were agreed, measurable steps to take. Mum has taken steps in her own self care and workers saw that interaction with the children improved along with the home conditions.

The assessment helped the core group to create a more specific plan with clearer leads. BSCB continues to offer the GCP2 course so that more people in the workforce can work together to ensure families have plans which are evidence based and understood by them.

6. Early Help

Our Aim: The Board understands the role and impact of Early Help services on children and families and this is an integral part of our planning

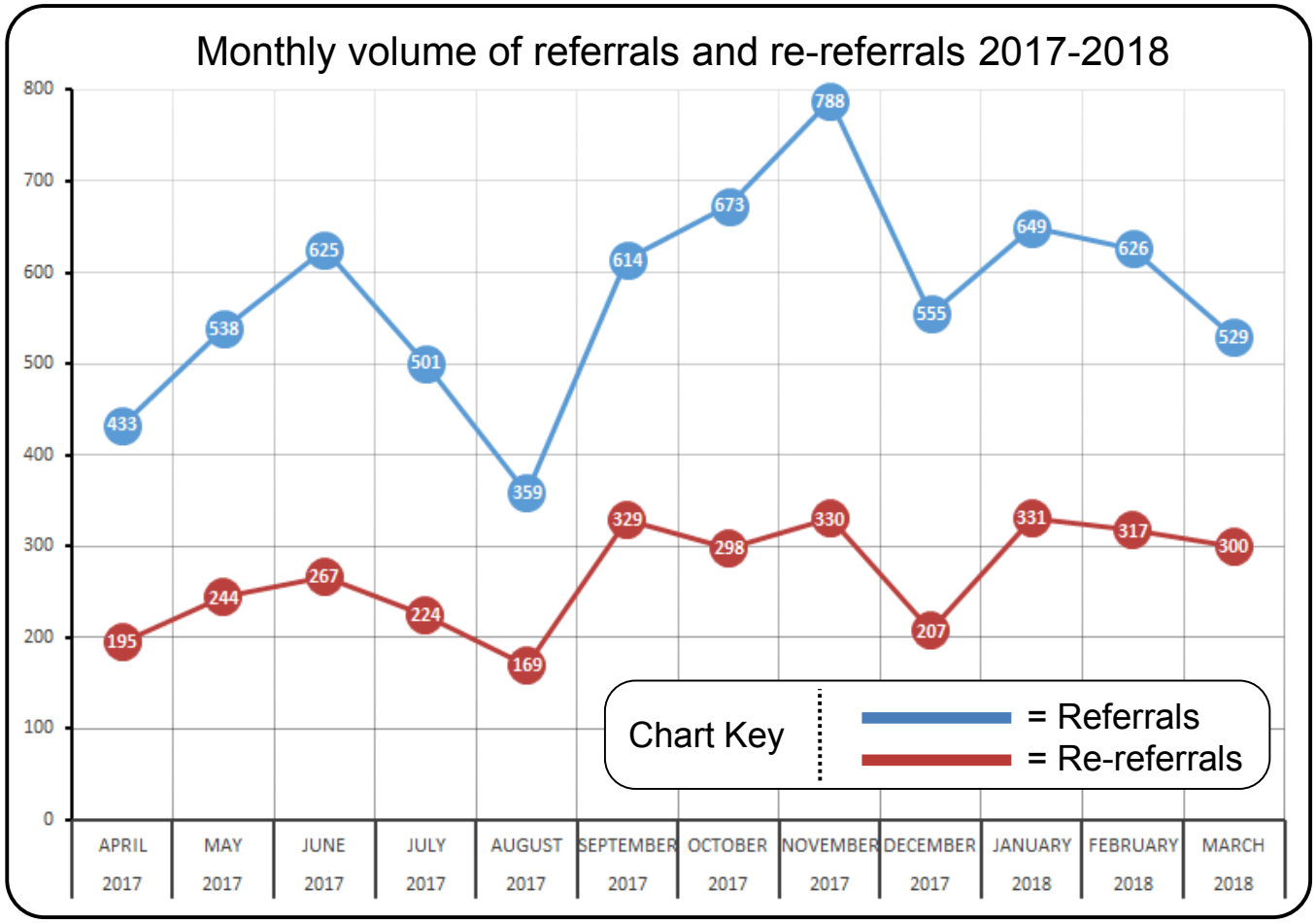
Working Together 2015 sets out a specific role for LSCBs to assess the effectiveness of the help being provided to children and families, including early help. Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life. Effective early help relies on local agencies working together to:

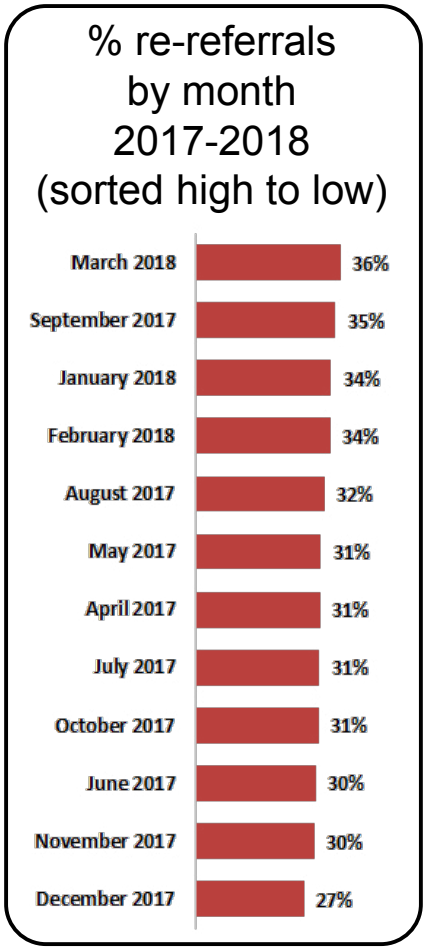
- identify children and families who would benefit from early help;
- undertake an assessment of the need for early help;
- provide targeted early help services to address the assessed needs of a child and their family, which focuses on activity to significantly improve outcomes for the child.

The provision of services in relation to early help came under review in 2017. However, the Board continued focusing on early help as a way of working in order to improve outcomes for children. A key driver for this was the rate of re-referrals into social care which was above the national and statistical neighbour average which means that:

- The rate of referrals in Buckinghamshire per 10,000 of the population is significantly higher than national, regional and statistical neighbour averages.
- In 2017 Buckinghamshire had the highest percentage of repeat referrals within 12 months of the previous referral compared to other authorities in the South East region.
- The main sources of repeat referrals are the police (36%) and schools (19%).
- The top three reasons for repeat referrals are domestic abuse, neglect and behavioural problems.
- Children first referred at age two or between five and nine are more likely to be re-referred.

Section 1: 'Front Door' referral activity
Volume of referrals and re-referrals

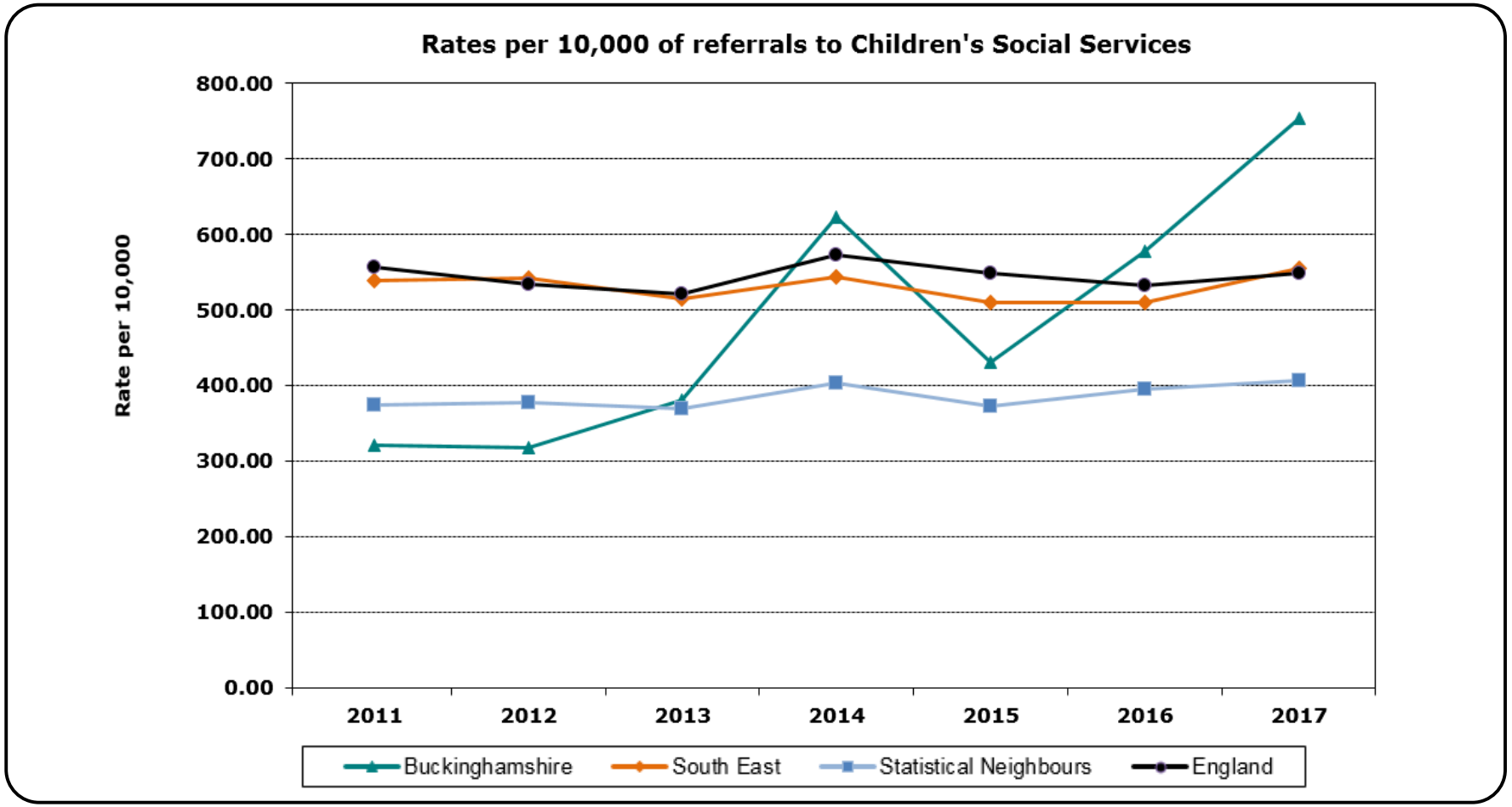




Source: BCC Internal data (Referrals Started_2017_18)

November 2017 was the peak month for referrals. The peak months for re-referrals were September 2017, November 2017, and January 2018. The pattern of referrals and re-referrals by volume is similar (i.e. the two lines on the chart track each other). However when calculating re-referrals as a percentage of all referrals volume is less of a driver with March 2018, January 2018, and September 2017 the busiest months by proportion.

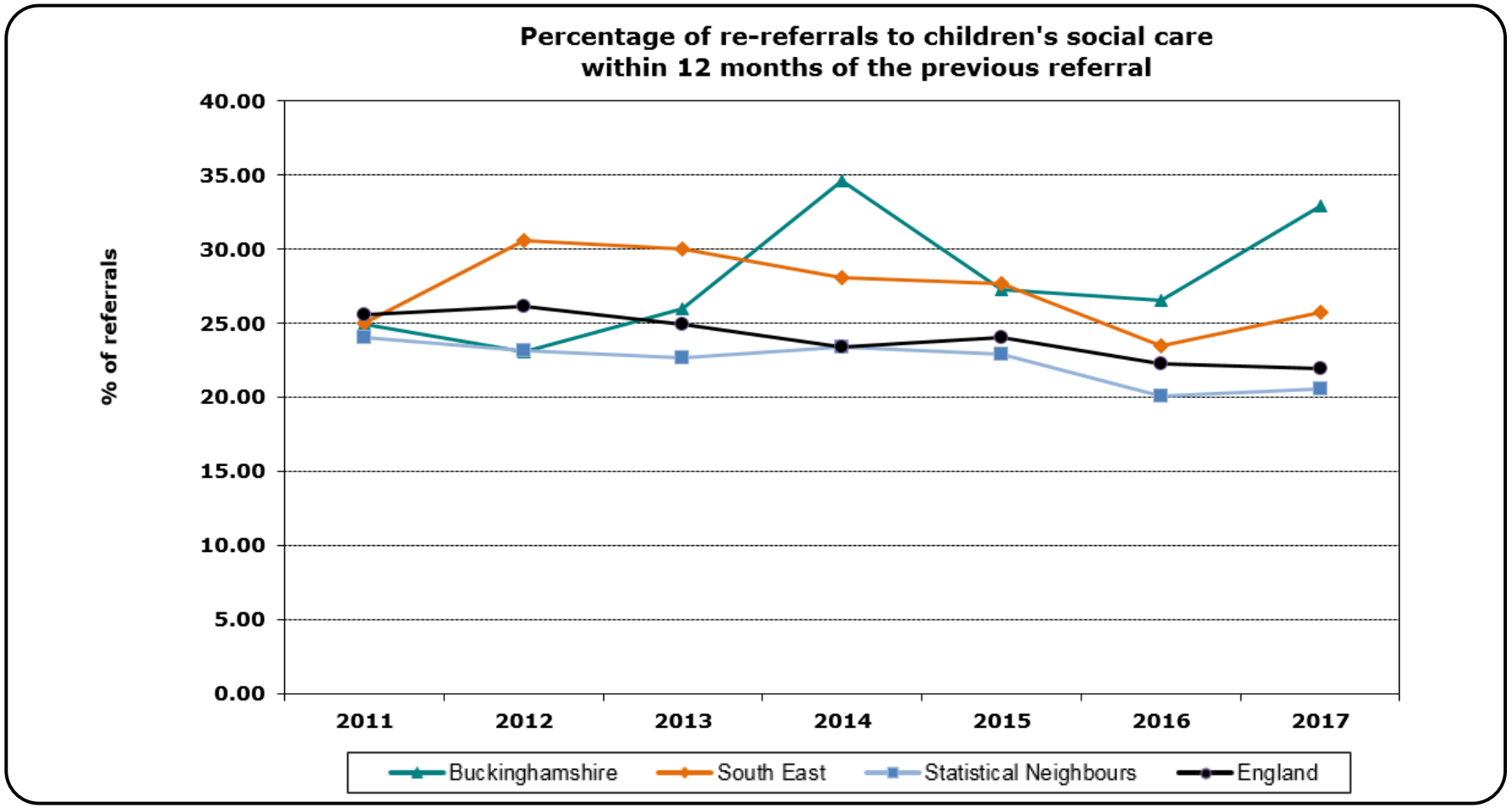
Section 1: 'Front Door' referral activity
Benchmarking performance - referrals



Source: https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

In 2011 & 2012 the rate of referrals to Children's Social Services in Buckinghamshire was below the national, regional, and stat neighbour average. In 2013 / 14 the rate of referrals increased sharply taking Buckinghamshire higher than comparators. The rate in Buckinghamshire dropped again in 2015 but has since steadily increased and is now notably higher than the national, regional, and stat neighbour average.

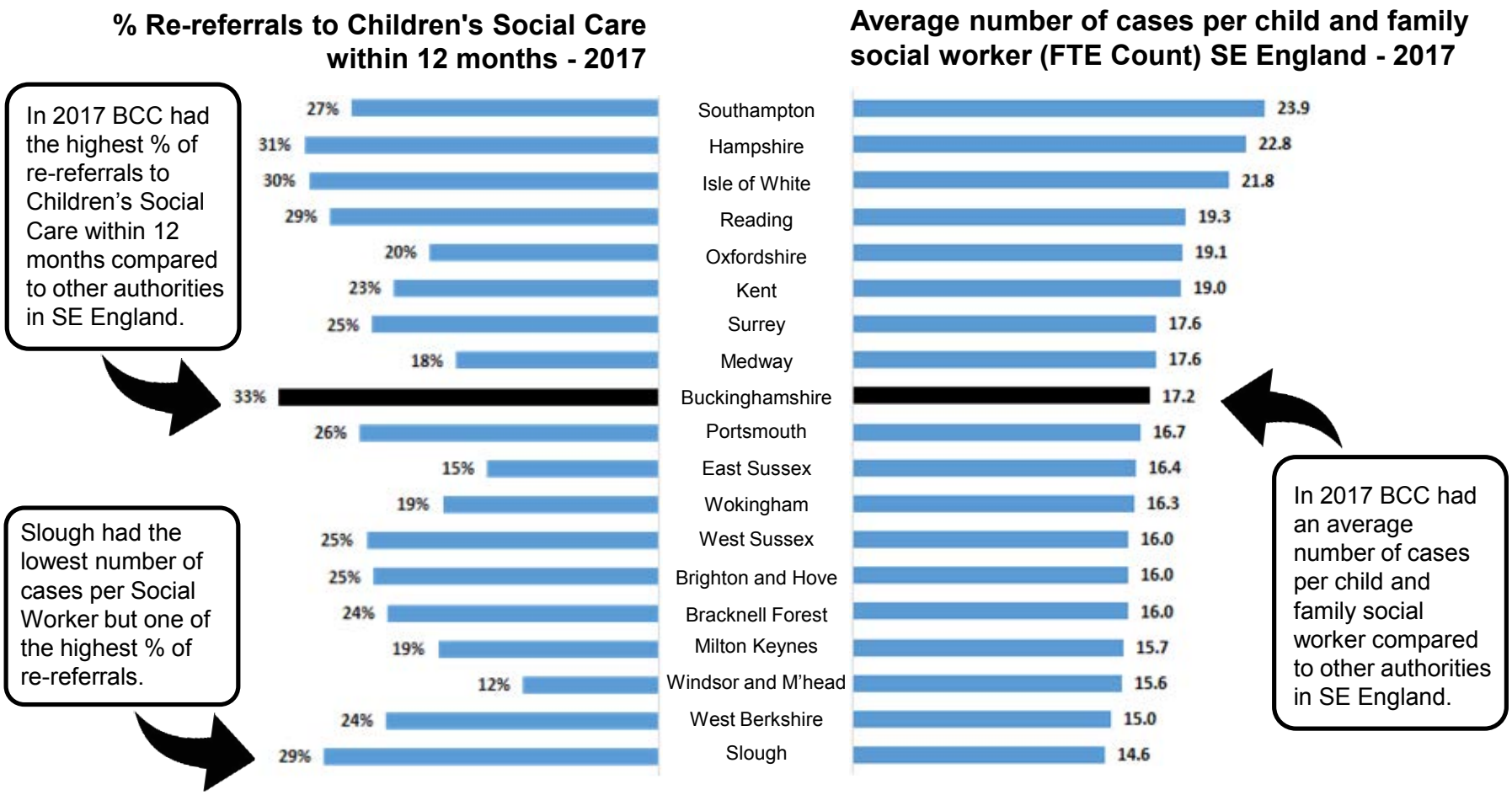
Section 1: 'Front Door' referral activity
Benchmarking performance - re-referrals



Source: https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

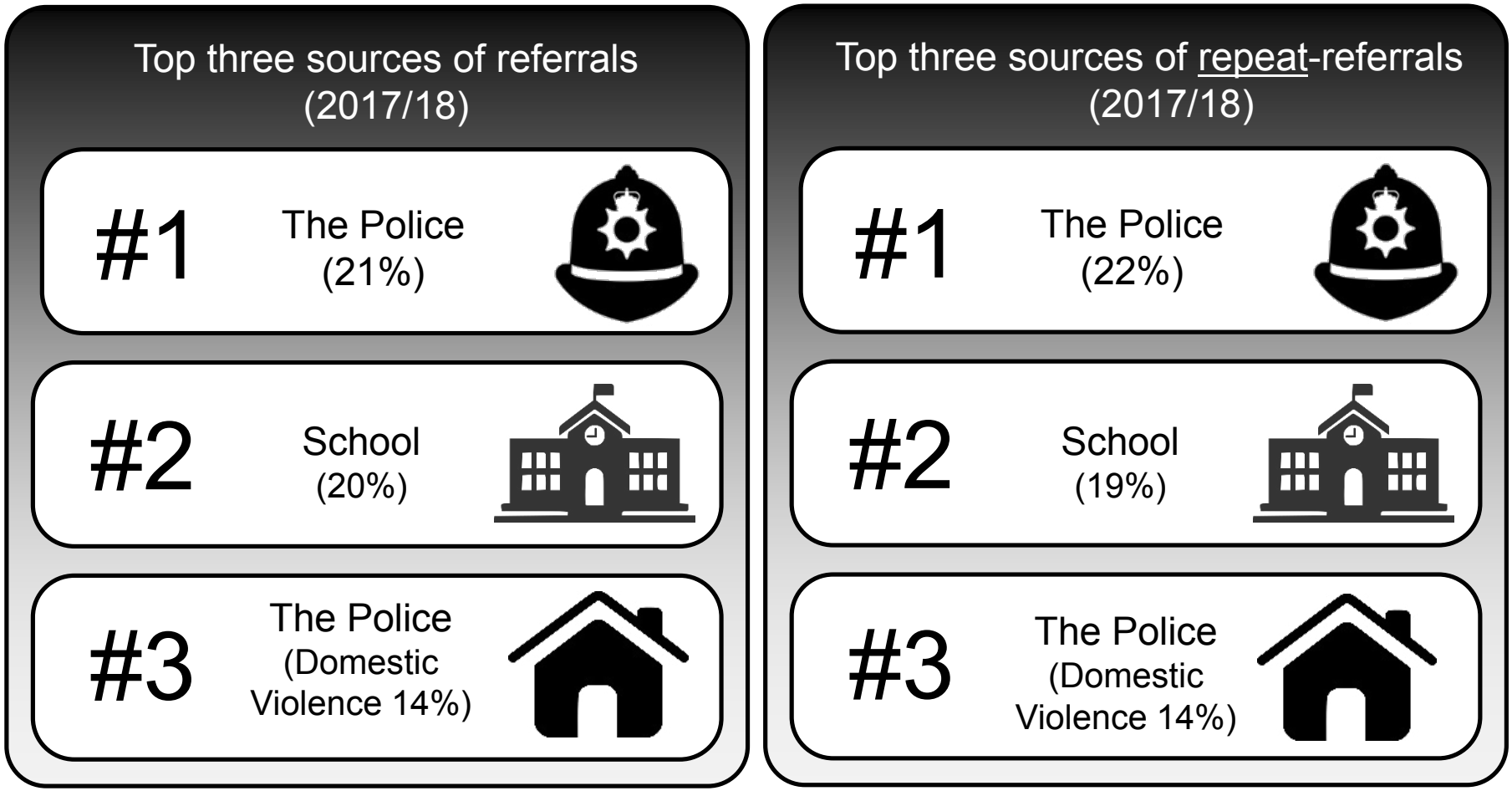
The re-referral rate in Buckinghamshire increased from a comparable rate to the authority's stat neighbours in 2012 to a higher rate than the national, regional, and stat neighbour average in 2014. The rate dropped to the regional average in 2015 but has since stayed higher than all comparator groups and has been particularly high in the latest available data for 2017.

Section 1: 'Front Door' referral activity
Benchmarking - case load ratio & re-referral rate



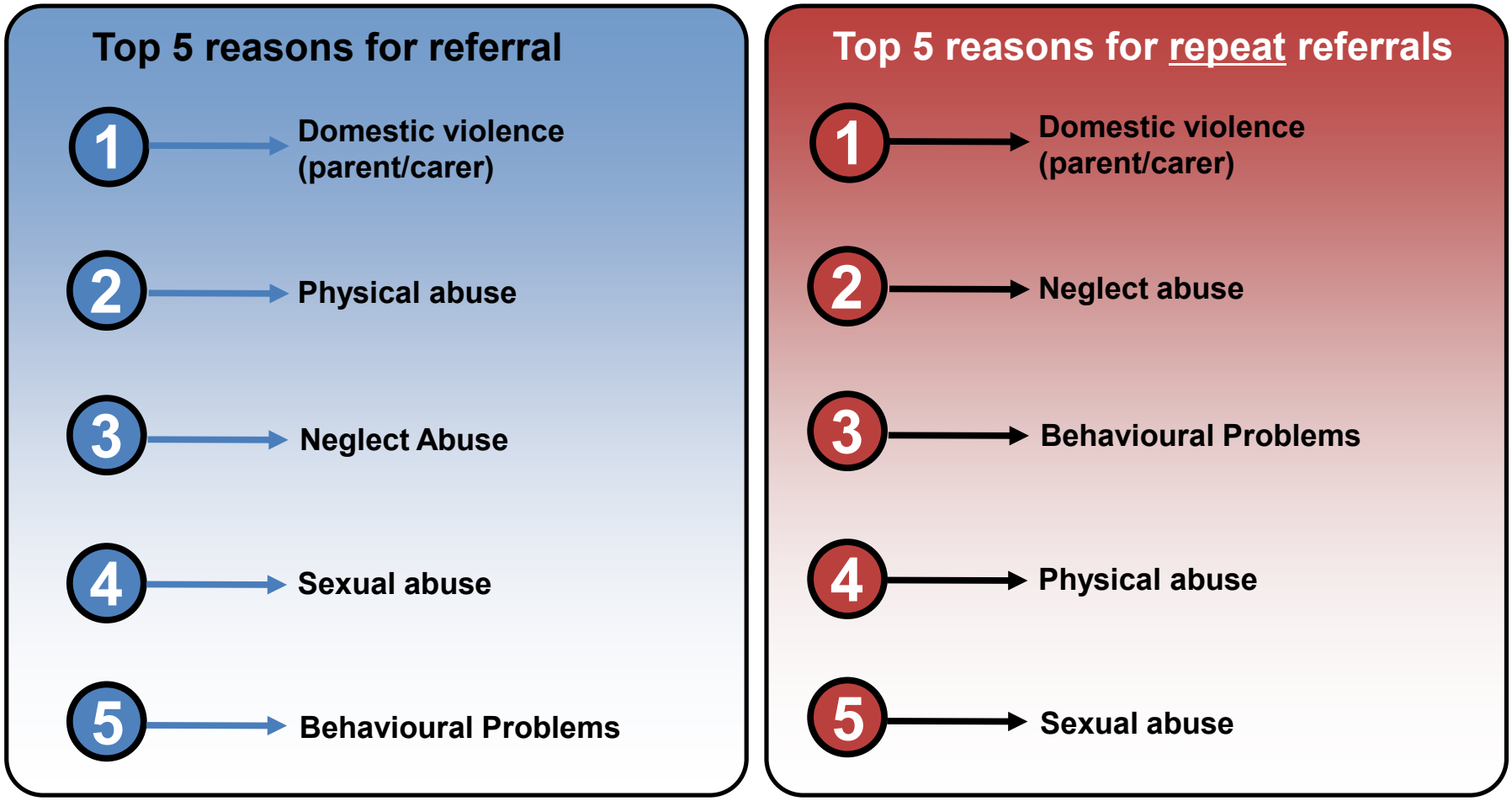
Sources:Gov.uk children's social work workforce statistics / the LAIT Tool
https://www.gov.uk/government/collections/statistics-childrens-social-care-workforce https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

The average number of cases per child and family social worker (FTE Count) is average in Buckinghamshire compared to all SE England constituent authorities. The % of re-referrals in Buckinghamshire is the highest of all authorities in SE England at 33% (data from 2017). There is a moderate correlation coefficient between case loads and re-referral rates (R=0.4). Buckinghamshire and Slough are notable outliers with high re-referral rates and average or low caseload ratios.



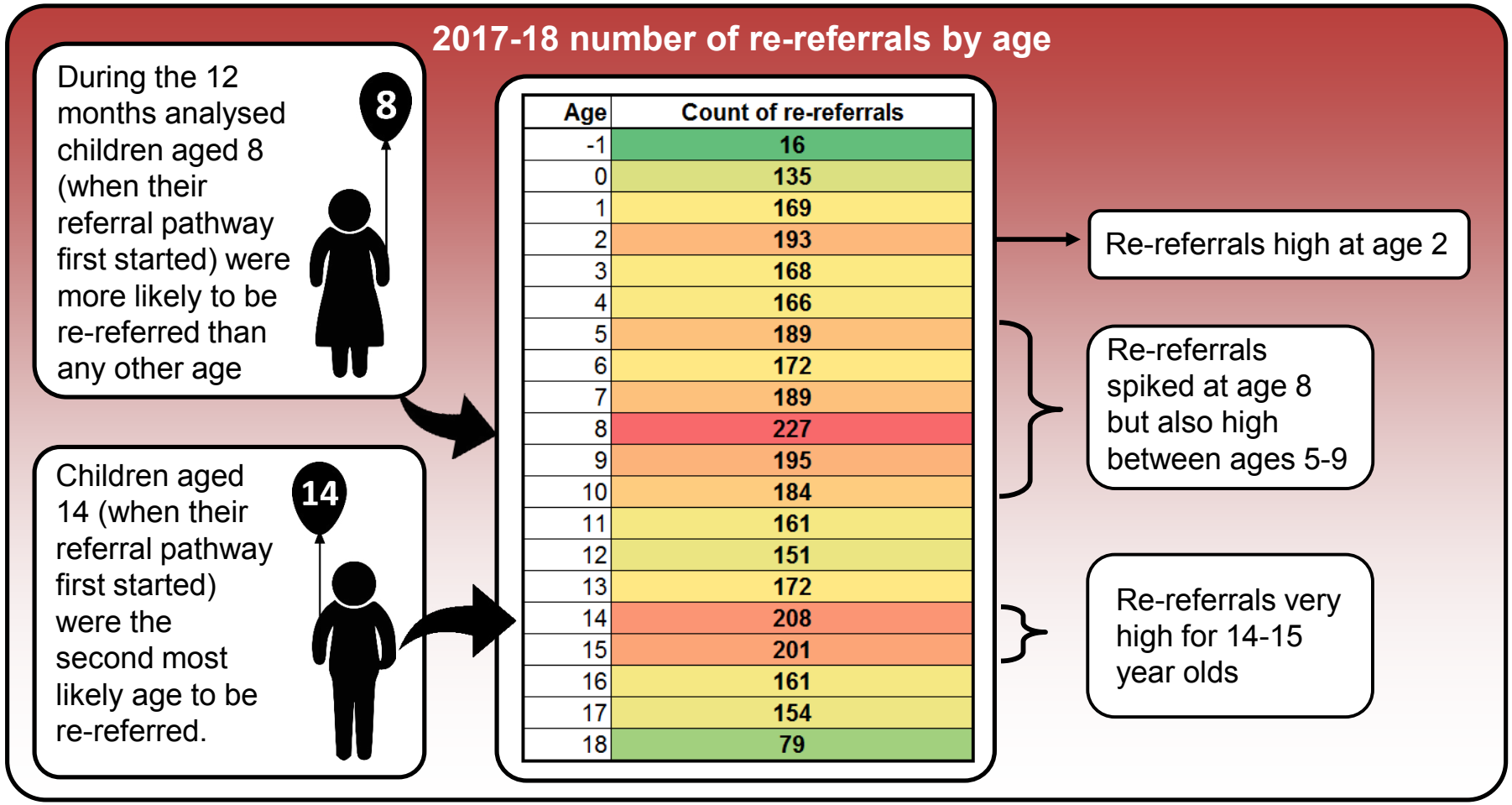
Source: BCC Internal data (Referrals Started_2017_18)

The top three sources of referrals and repeat-referrals in 2017/2018 were The Police, Schools, and the Police through DV channels. The proportion is the same for referrals and repeat-referrals with The Police accounting for approx. 20%, Schools approx. 20% and Domestic Violence channels 14%.



Source: BCC Internal data (Referrals Started_2017_18)

Domestic Violence is the most prevalent reason for referrals and repeat-referrals. The issue of behavioural problems is fifth in the list for referrals but jumps to third for re-referrals. Neglect Abuse also jumps up the order becoming the second most prevalent reason for re-referral.



Age	Count of re-referrals
-1	16
0	135
1	169
2	193
3	168
4	166
5	189
6	172
7	189
8	227
9	195
10	184
11	161
12	151
13	172
14	208
15	201
16	161
17	154
18	79

Source: BCC Internal data (Referrals Started_2017_18)

Analysis using 12 months' worth of data show that children first referred at age 2 were more likely to be re-referred as were children aged between 5-9 and 14-15. During the course of 12 months the two most prevalent ages for re-referral (age at pathway first starting) were 8 year olds and 14 year olds.

This key area will continue to be a focus for the Board and a multi-agency audit is planned for May 2018 to inform next steps for the partnership.

At a **strategic level**, the key areas of progress during 2017/18 have been:

- Embedding and establishing strong links with the governance arrangements (Early Help Operational Group) to drive early help at both a strategic and operational level.
- 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 (included in all our training and ongoing requests to Board for materials).
- Delivery of Family Outcomes Star Training to 43 people as well as GCP2.
- Focus of partner attention on the issue of re-referrals and how this relates to the developing early help offer.
- Supporting the planned re-modelling of the early help model, and include in next steps/actions for the 2018/19 consultation that's planned.

On an **operational level** the Board has focused on the continuing to refine the understanding of the role and impact of the 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.

Evidence of effectiveness:

- The panel process is now well embedded.
- BM for the Board is one of the panel chairs, ensuring effective information sharing.
- Strong partnership working has been a major contributing factor to the success of the Early Help Panel.
- The planned longitudinal study has now been completed and the overall conclusions were:
  1. "Key workers were very committed to providing intensive individual and flexible help and support to families using a consent-based approach.
  2. There was evidence of a persistent, assertive and challenging approach combined with practical hands-on support
  3. There was a variability of effect across sites and in approaches, but the overall effectiveness seemed to be improving
  4. Families appeared to find the intervention acceptable and it compared favourably with alternative interventions.
  5. Communication between agencies was mixed in effectiveness and use of the main outcome measure — the Family Star — was generally well regarded.
  6. There was also evidence that the Early Help Panel was beginning to have an impact on allocation and interagency approaches to work. Some workers were concerned, however, that the new early help processes will inhibit a speedy response, which could undermine the need for more timely response. (Oxford Longitudinal Study, Final report 2017). These recommendations are being addressed.
  7. Looking beyond the Early Help Panel, high level indicators for early help show that we continue to perform well in comparison to our statistical neighbours in relation to a high level of take up of targeted, free nursery provision for two year olds.

• Looking beyond the Early Help Panel, high level indicators for early help show that we continue to perform well in comparison to our statistical neighbours in relation to a high level of take up of targeted, free nursery provision for two year olds.

Next Steps

- While rates of unauthorised and persistent school absence were lower than statistical neighbours and the national average at both primary and secondary level. This year our unauthorised absence rates still compare favourably, but our persistent absence rates are higher than national at secondary, and are higher than many of our statistical neighbours at primary.
- Buckinghamshire's number of first time entrant to the criminal justice system is no longer lower than our statistical neighbours rates of 10-17 year olds entering the criminal justice system for the first time compared to statistical neighbours and the national average.

Pupil absence in schools in England: 2016 to 2017 DfE Statistical release

LA Code			State-funded primary schools					
			Pupil enrolments in schools during 2016/17 (1)	Percentage of sessions missed (2): Overall absence	Authorised absence	Unauthorised absence	Number of persistent absentees (3)	Percentage of persistent absentees (4)
		ENGLAND (5)	**3,909,500**	**4.0**	**3.0**	**1.1**	**325,230**	**8.3**
		SOUTH EAST (5)	**623,465**	**3.9**	**3.0**	**0.9**	**48,155**	**7.7**
E10000002	825	Buckinghamshire	37,836	3.8	3.0	0.7	2,631	7.0
E06000036	867	Bracknell Forest	8,889	3.5	2.7	0.8	522	5.9
E10000003	873	Cambridgeshire	44,654	3.8	2.9	0.9	3,201	7.2
E06000056	823	Central Bedfordshire	16,794	4.2	3.3	0.9	1,448	8.6
E10000014	850	Hampshire	92,113	3.6	2.9	0.7	5,704	6.2
E10000015	919	Hertfordshire	86,868	3.9	3.0	0.9	6,528	7.5
E10000025	931	Oxfordshire	46,179	3.9	3.1	0.8	3,462	7.5
E10000030	936	Surrey	77,419	3.7	2.9	0.8	5,322	6.9
E06000037	869	West Berkshire	11,704	3.6	2.9	0.6	689	5.9
E06000040	868	Windsor and Maidenhead	8,812	3.6	2.8	0.8	604	6.9
E06000041	872	Wokingham	12,671	3.4	2.7	0.7	709	5.6
		Average statistical neighbours				*0.8*		*6.8*

State-funded secondary schools					
Pupil enrolments in schools during 2016/17 (1)	Percentage of sessions missed (2):			Number of persistent absentees (3)	Percentage of persistent absentees (4)
	Overall absence	Authorised absence	Unauthorised absence		
2,895,975	**5.4**	**3.8**	**1.5**	**392,200**	13.5
450,890	**5.4**	**4.0**	**1.4**	**61,090**	**13.5**
30,165	5.4	4.4	1.0	4,216	14.0
5,990	4.9	3.8	1.0	684	11.4
29,223	5.1	3.8	1.3	3,217	11.0
19,498	4.9	4.1	0.9	2,282	11.7
68,582	5.2	4.0	1.2	8,997	13.1
66,982	5.0	4.1	1.0	7,862	11.7
32,209	5.6	4.4	1.2	4,448	13.8
53,378	5.1	3.9	1.2	6,523	12.2
9,256	4.8	3.8	1.0	1,065	11.5
8,800	4.7	3.7	1.0	877	10.0
8,744	5.0	4.1	0.9	1,034	11.8
			1.1		*12.0*

Early help - next steps

- The Board will encourage representation from early help leadership to ensure that this is an integral part of our planning and approach
- Early help data will continue to be developed as part of the review and the Board will seek to make best use of this
- 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, a large proportion of families referred to the Early Help Panel are already known to Children's Social Care. This has not decreased as the system continues to embed over time, with many referrals being at the 'edge' of statutory' This will be a key focus for early help services and is a priority area for attention for the Board.
- The local authority is currently reviewing its own early help services and this will be an area of increasing focus for 2017/18.
- The EH strategy has been agreed, this will need to be reviewed with a partnerships perspective along with any changes to the provision of EH.

7. Board Challenge, Scrutiny and Transformation

Our Aim: To implement positive change as a result of the requirements from working together
To support the required improvements from the Ofsted inspection
To make increased and more effective use of the voices of children and service users

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 what steps have been taken to support the Board to change in line with the anticipated changes to WT.

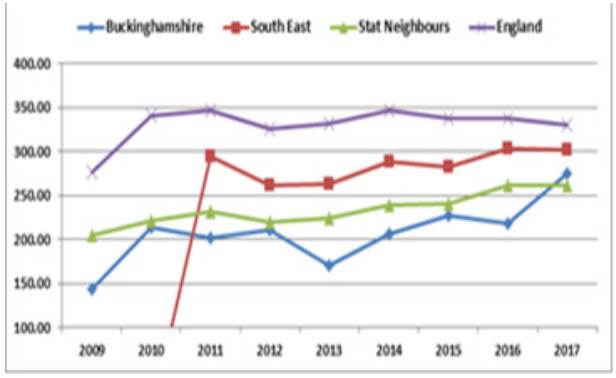
The child's journey

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. Since 2015 there has been an overall increase, which has been more significant than that across our statistical neighbours. A key feature if these are the high rate of re-referrals in Buckinghamshire compared to statistical neighbours and national. At the end of quarter 4 2017/18, our re-referral rate was 32% compared to a South East regional average of 24%. (At the end of March 2017 the Board agreed the re-referrals multi agency audit, the outcome of which will form part of the business planning for the next year).

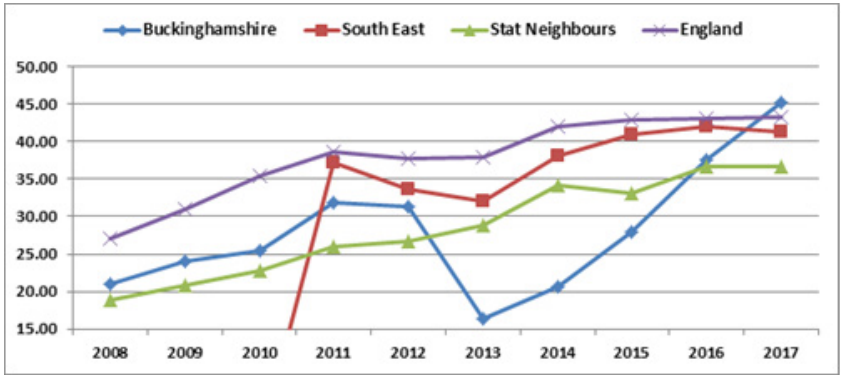
Nationally, there is evidence that demand on Children's Services continues to increase as a result of multiple and complex factors including system changes across different organisations, changes to funding and to the local child population.

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.

The following data shows the current areas of good performance and also some of the areas for improvement at different stages of the child's journey through our social care system. 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).



Rate of children subject to child in need plans per 10,000 of the population



Rate of children subject to child protection plans per 10,000 of the population

LA target:

100%

Current position:

82%

The proportion of Initial Child Protection Conferences which take place within 15 working days of the Strategic Discussion

Commentary

At the end of Quarter 4, 82% of ICPC's were held within 15 working days which has achieved the target. Our performance is equal to that of statistical neighbours (82%) and better than the South East (72%) and national averages (77%).

We routinely monitor and review all ICPC requests received to ensure these are conducted in a timely and efficient manner.

LA target:

18%

Current position:

18%

Children who are placed on a Child Protection Plan again after previously being on a child protection plan

Commentary

At the end of Quarter 4, 18% of children became the subject of a Child Protection Plan for a second or subsequent time. This has achieved our target of 18% (good to be low), and is better than our Statistical Neighbours (23%), the South East (22%) and England (19%).

Since March 2018 we have been conducting monthly reviews of children who are on a Child Protection Plan for a second or subsequent time and learning from these reviews is shared across the service.

LA target:

100%

Current position:

83%

The proportion of assessments which are completed within 45 working days

Commentary

At the end of Quarter 4, 83% of assessments were completed within 45 working days which is 3% below the target tolerance of 86%. Our performance is lower than statistical neighbours (86%) but equal to the South East (83%) and national averages (83%).

We are improving management oversight and offering targeted support to teams. We will be introducing an assessment tracking system to secure further improvement.

LA target:

20%

Current position:

36%

Children who have been referred to Children's Social Care more than once within a 12 month period as a proportion of total referrals received

Commentary

At the end of Quarter 4 our performance is 36%. This is above the 20% target and above our Statistical Neighbours (21%), the South East (26%) and National (22%) averages.

Action is being taken in partnership with Police and Health colleagues to implement a domestic abuse triage system as part of the MASH and review existing assessment tools to improve management oversight and reduce the number of repeat referrals.

At the end of April, performance had improved to 29%.

LA target:

100%

Current position:

90%

The requirement for children who are being supported through a Child in Need plan to be seen by a Social Worker every 6 weeks

Commentary

At the end of Quarter 4, 90% of Children in Need were seen in the last 6 weeks which is 5% below the tolerance target of 95%. Benchmarking information is not available.

An audit programme of all Children in Need cases is underway to ascertain the most appropriate way to meet their needs, and regular reflective supervision ensures that visits to children are purposeful and progress actions relevant to improve outcomes.

LA target:

100%

Current position:

80%

The proportion of Children in Need who are reviewed regularly

Commentary

Children and their families who are subject to a Child In Need plan are required to have a first review of this plan one month after it has been agreed, and subsequently the plan should be reviewed every 3 months.

At the end of Quarter 4, 80% of Children in Need had been reviewed within timescales, which is 5% below the tolerance target of 85%. Benchmarking information is not available.

We have identified lower performance within some teams and are developing remedial action plans with these teams to target all upcoming reviews.

LA target:

100%

Current position:

94%

The proportion of children with Child Protection Plans who are reviewed within timescales

Commentary

Children who are on a child protection plan are required to have the first review of their plan within 3 months of the initial conference and further reviews of the plan should be held at 6 month intervals.

At the end of Quarter 4, 94% of children with Child Protection Plans had been reviewed within timescales, which is 1% below the tolerance target of 95%. Benchmarking information is not available.

We are reviewing all Child Protection Review conferences to ensure these can proceed as scheduled, taking remedial action where necessary.

LA target:

100%

Current position:

94%

The proportion of children with a Child Protection Plan who are seen at least once every 4 weeks

Commentary

At the end of Quarter 4, 94% of children with a Child Protection Plan had been seen in the last 4 weeks which is 1% below the tolerance target of 95%. Benchmarking information is not available.

Team Managers receive twice weekly reports on visits that are due for children on Child Protection Plans, and weekly team meetings identify concerns and pressures which may affect visits. Contingency plans are put in place to support visits which may be at risk.

LA target:

100%

Current position:

87%

The proportion of children in care who are seen by a Social Worker every 6 weeks

Commentary

At the end of Quarter 4, 87% of children in care had been seen in the last 6 weeks which is 8% below the tolerance target of 95%. Benchmarking information is not available.

We are developing a targeted action plan to ensure that a consistent visiting pattern for all children is resumed without delay.

LA target:

56%

Current position:

47%

The proportion of children in care who are placed within 20 miles of their home address

Commentary

At the end of Quarter 4, 47% of children in care were placed within 20 miles, which is below our target of 56%. Our performance is worse than that of statistical neighbours (62%) and also worse than the South East (63%) and national averages (74%).

Through the Children Looked After Project Board we are focusing on increasing local in-house placement provision so that children can be placed closer to home when we become their corporate parent.

LA target:

24%

Current position:

15%

The proportion of children in care who are placed with in- house foster care, or within our Children's home

Commentary

At the end of Quarter 4, 15% of children in care were placed in our own provision, which is below our target of 24%. Our performance is worse than that of statistical neighbours reported in the 2016 CIPFA report (44%).

Action is underway to launch the new Fostering Recruitment & Retention Strategy, to deliver a year on year increase of internal foster places.

LA target:

100%

Current position:

56%

The length of time children who are placed for adoption wait before they move into an adoptive family

Commentary

At the end of Quarter 4, 56% of children in care were placed in our own provision, which is below our target of 100%. Our performance is worse than that reported by statistical neighbours (43%) and nationally (47%).

We continue to robustly implement planned recruitment for those children with complex needs for whom adoption in in their best interests, and are working closely with Social Workers to identify suitable adopters.

Next steps for the Board

- Planning around the latest Ofsted inspection. This highlighted improvements required in relation to the quality and effectiveness of plans and assessments, leadership and management as well as 'skills' issues such as professional curiosity. There have been significant changes in senior managers since publication of the report and the scale of change at this level along with some gaps in permanent appointments in some social work teams represents a potential risk (loss of organisational memory, loss of continuity for children). BSCB is seeking to align its business planning with the required areas for change to ensure.
- Re-referrals: This dipped below 30 to 28 % in December but has returned to 34% by 1st March. This is an area of focus for Social Care who have worked with the performance and quality assurance sub group on this and presented an initial paper to the Board in November 2017. The most significant pattern of re-referral process is those that have a referral and an assessment and then this pattern is repeated. One of the key concerns identified in the Inspection Report was the over-optimism with domestic abuse, and the reliance on self-reporting of the mother about how the situation has improved.
- Domestic abuse continues to be a contributing factor and the reconfiguring of the early help offer must be considered alongside this. Resourcing in relation to the work on DA is an issue; there are two members of staff who have the task of leading the work on the strategy and action planning. The Business Manager is also working with the joint chairs group to look at greater communication and mutual challenge between BSCB and SSBP. The Business Manager is working with BSAB and Community Safety Manager to ensure that the joint action plan, dashboard and training plan follows the sign off of the DA strategy which has now been circulated to partners.
- Number of referrals leading to assessment dropped significantly, however it should also be noted that threshold levels and quality of referrals may be influencing factors on this. Although this was not a feature of the Ofsted inspection report, demand on the service remains high with social care being required to assess when the end outcome was to signpost to early help services. There is no shared early help assessment in place and this is something along with links into the early help panel that the new early help service may address.

Areas where there has been improvement that the Board will continue to look at via its dashboard

- Notable increase in percentage of assessments completed in 45 days.
- Performance of both Children Looked After (CLA) and CP reviews completed on time has improved.
- % ICPC (Initial Child Protection Conference) held within 15 working days of the strategy discussion has improved.
- We have achieved our target on the % of children who became the subject of a child protection plan for a second or subsequent time.

8. Transformation of the Board in line with the changes to Working Together

Our Aim: To ensure that the Board maximises the opportunities afforded by the required changes
To ensure that we develop an effective model, making use of the lessons learned from the Ofsted report

The Children and Social Work Act 2017 replaces Local Safeguarding Children Boards with new local safeguarding arrangements, led by three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups). It also places a duty on child death review partners (local authorities and clinical commissioning groups) to review the deaths of children normally resident in the local area - or if they consider it appropriate, for those not normally resident in the area. Additionally, it replaces the current system for serious case reviews with new national and local review arrangements.

The Department for Education has statutory guidance which came into effect in April 2018 detailing the requirements for local transitional arrangements whilst the new safeguarding partnerships and processes for national and local reviews are set up. This guidance applies to local authorities, Local Safeguarding Children Boards, safeguarding partners, child death review partners, and the national Child Safeguarding Practice Review Panel.

The guidance stated that Local Safeguarding Children Boards must continue to carry out all of their statutory functions, until the point at which safeguarding partner arrangements begin to operate in a local area. They must also continue to ensure that the review of each death of a child normally resident in their area is undertaken by the established child death overview panel, until the point at which new child death review partner arrangements are in place. Detail of how the Board continued to do this are set out in the next section; “The Impact of the Board”.

In the period following the commencement of the Act’s provisions to establish new safeguarding partner arrangements, and before safeguarding partner arrangements begin to operate, Local Safeguarding Children Boards should plan how and when to hand over all relevant data and information they hold to the safeguarding partners. In doing so, they should ensure they comply with data protection law (seeking legal advice if necessary), and provide a clear audit trail on the handling of all documentation, any decisions made and any actions taken or outstanding at the time of handover.

Safeguarding partners will have up to 12 months to agree the arrangements for themselves, and any relevant agencies they consider appropriate, to work together to safeguard and promote the welfare of children in their area. The arrangements must be subject to independent scrutiny.

Safeguarding partners must publish their arrangements, and should notify the Secretary of State for Education when they have done so. They must have published their arrangements by the end of the 12 month period, but may do so at any time before the end of that period.

Following publication of their arrangements, safeguarding partners will have up to three months to implement the arrangements. Once the arrangements have been published and implemented, the Local Safeguarding Children Board for the local area will cease to exist.

With regard to serious case reviews, Local Safeguarding Children Boards must continue to carry out all their statutory functions, including commissioning serious case reviews, until the point at which safeguarding partner arrangements begin to operate in a local area.

Where serious case reviews have not been completed and published at the point that the new safeguarding partner arrangements begin to operate, the Local Safeguarding Children Board has up to 12 additional months to complete and publish these reviews.

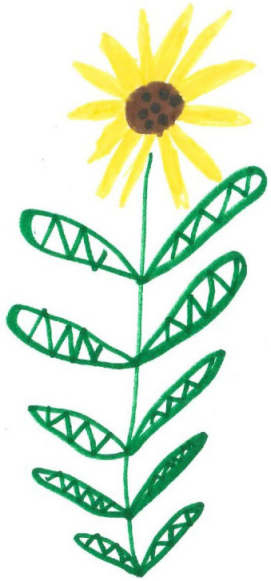
The Board recognised the following drivers for change locally:

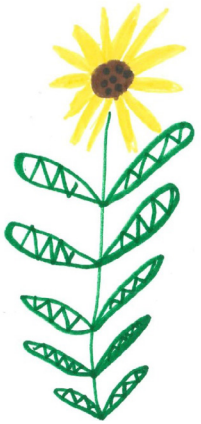
- Ofsted and Local Authority's improvement plan for Children's Social Care. Future business plans will have to demonstrate how the Board's plan and the proposed new arrangements will align with the Local Authority's improvement plan for Children's Social Care and deliver improved outcomes for children and families.
- A need for a sharper focus on shared priorities such as Domestic Abuse, Child Exploitation, Neglect
- A need to strengthen a family based integrated approach to Board business
- The need for the Board to evidence the outcomes and impact of their activity
- The need to make best use of resources across the partnership.

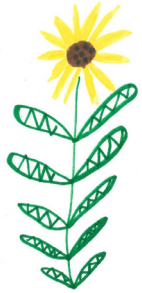
Representatives of the three agencies identified as "key partners" in the legislation (CCG,TVP and LA) began to meet in February 2018. An initial report was presented to the Board in March, setting out some of the options for change. To support this, the BM began the process of working with neighbouring Boards to look at opportunities around geographical mergers, emerging models and closer working relationships.

Next steps will be:

- **Key partners to meet with the Business Manager following the March Board discussion to look at models for the new partnership (April 2018).**
- **A preferred model to be identified and shared with Board members.**
- **Commencement of National (revised) Working Together, anticipated May 2018.**
- **The Board will have agreed a way forward on its revised structure by September 2018. The report for publication will be published by June 2019.**
- **By April 2019 the plan will be implemented and the new safeguarding arrangements will be in place.**
- **Regular meetings to continue between Buckinghamshire Milton Keynes and Oxfordshire Business Managers to explore opportunities for joint working.**







9. The Impact of the Board

Here we celebrate the hard work and outcomes achieved by our various sub groups.

Learning and Development

The Learning & Development Strategy was reviewed and revised to reflect the 2017-2018 Board priorities and signed off by the sub group.

The BSCB Training Programme was devised and approved by sub group members, ensuring a broad range of multi-agency training was available to all Board partners.

To make best use of resources and achieve some savings it was agreed to implement a joint online booking system for training with the adult safeguarding board. The sub group felt this was the way forward and a full business case was presented and approved by the Board.

As a result of an increase in the number of charity places being sought (due to this being offered free in the previous year) it had been agreed that charities should have two free places and then pay full price for any other places needed, during the financial year 2017-18. With the demand still high and the possibility of going to an online booking system a proposal was made that all charities would pay 50% of the training cost for courses from April 2018. This was agreed by the sub group as the best way forward.

Each member of the sub group gave feedback on how they felt their organisation was performing on the Governments 'Maturity model' as the partnership is expected to be 'mature' by 2020.

The following is how the partnership as a whole are developing:

- Training & Development: developing with some aspects of maturing
- Performance Objectives: early with some aspects of development
- Shared Opportunities across the Workforce: early with some aspects of development
- Keyworker/frontline worker view of services: developing.

Some agencies are 'virtual members' of the sub group. Some discussions had been held on the value of this and the BSCB were looking to see if other sub groups had this format. The role of this valuable workstream will be considered as part of the new arrangements.

Below is information about the impact of the BSCB training team.

Course title	No delivered	Self-assessed knowledge and confidence	
		Start	End
Child Sexual Exploitation	5	54%	84%
Domestic Abuse	1	57%	82%
Everyone's Responsibility	5	61%	81%
Family Outcomes Star	3	46%	84%
Graded Care Profile	6	53%	92%
Mentally Ill Parents	1	47%	78%
Neglect	2	64%	84%
Protecting Disabled Children	1	63%	82%
Working Together	10	63%	82%
Working with Challenging Families	2	61%	84%

All delegates are requested to complete an evaluation form at the end of the training session, the increase in their knowledge and confidence is shown in the table opposite. A sample of delegates and their line managers are also selected to take part in a second evaluation three months after the course to assess impact on practice. The impact of training is difficult to collect as several do not return the request plus line managers change/ leave. Attendance/non-attendance at training is available to agencies via the dashboard and a summary of feedback from evaluation forms is shared with the Learning & Development Sub. Group and Board.

Feedback from delegates :

"I have been able to work proactively with one of my most challenging families and as a result we have secured the right academic placement for this child".
Delegate – Working With Challenging Families

"Families feedback about their support and achieving outcome continues to be positive. K'S confidence in challenging has enabled her to support clearer plans and enhanced parents reflections on their achievements".
Line Manager – Working With Challenging Families

"Yes, it has helped me to make an evidence base decision and I intend to go to court to discharge a Care Order".
Delegate – Graded Care Profile

"I've had productive conversations with a young person about potential risks involved with social media, e.g. copying inappropriate language they've read".
Delegate – Child Sexual Exploitation

"I was able to instigate a referral for a student to be referred to social services which resulted in the family being able to access more support".
Delegate – Everyone's Responsibility

Performance and Quality Assurance

Achievements

The neglect audit explored how neglect is managed for children, as opposed to babies, the longer term impact of neglect and opportunities for earlier intervention. Findings from the audit:

- The need to have a clear chronology to look at history alongside the presenting issue.
- The focus on parental issues, in particular mental health, with neglect not always named and the impact of neglect on the child is not always sufficiently articulated or explored.
- The need for adult mental health services to consider the impact of adult mental health on the child, including when a case does not progress beyond assessment due to the lack of engagement.
- The need for adult mental health services to be included in multi-agency working.
- Insufficient evidence around the way the impact of domestic abuse on the children is being managed.

The domestic abuse audit explored the journey of six families where domestic abuse had been identified as a significant factor of need or risk.

- In all six families, the victim was female, and a mother and the key perpetrator of the abuse was an adult male. There was also evidence of adolescent to parent abuse from both female and male children towards the mother.
- In all six journeys, outcomes for the children and the victims were generally poor. Wider research demonstrates that outcomes for children experiencing domestic abuse are known to be poor, and living with domestic abuse over a long period of time will be detrimental to a child's emotional, physical and educational wellbeing.
- The audit highlighted the positive impact of an effective domestic abuse notification system to schools. Following the re-introduction of a notification system, the BSCB should continue to monitor whether this is effective, including through feedback from schools.
- There was some positive evidence across children's journeys of professionals having a good understanding of coercive control.

Section 11 Peer challenge allowed all Board members to participate in the challenge process and to better share areas of good practice and learning. This process gave a good insight into the functions of other agencies, and there was a good level of debate and healthy challenge about the responses provided by individual agencies. The Independent Chair requested additional information from each agency to provide a greater level of assurance to the LSCB.

An audit of Child Protection Plans was undertaken by Bucks County Council. The headline findings from this were:

- 68% of the children were on a plan for neglect and 32% for emotional abuse.
- Repeat Child Protection Planning was an issue in one family.
- Domestic abuse was evident in 70% of the families; parental mental health was identified issue in 30% of the families; and parental alcohol and/or drug misuse was a significant issue in half of the families.
- 80% of the families had previously been known to the Children's Social Care (within Buckinghamshire County Council or another local authority) for between seven and 16 years.
- A number of families had repeat referrals, short term interventions, case closure and then re-referral for the same concerns.

Barriers and challenges:

- Consistent availability of up to date and relevant data and information from all agencies to produce a meaningful analysis of safeguarding to support the LSCB's challenge and scrutiny role.
- The churn of staff in Police, Children's Social Care and Health over the last year has had a negative impact on the timely completion of key pieces of work.

Next steps 2018/19:

- **Introduce revised dashboard of performance indicators.**
- **Complete multi agency audit covering repeat referrals.**
- **Audit effectiveness of revised pre-birth procedures.**
- **Review and test impact of previous audit recommendations and actions.**
- **Completing an audit of children who are at risk of exploitation.**

Policies and Procedures

The group:

- reviewed and amended policies as required, ensuring that the workforce has an up to date resource. Key policies that have been reviewed are the joint working procedures and guidance, the joint protocol between Boards, escalation challenge and conflict and the anti-bullying policy;
- created a checklist to partners who are writing and reviewing of policies and or procedures;
- approved a safeguarding policy for a voluntary organisation which could only receive Home Office funding if the safeguarding policy was approved by the sub group.

Safer Employment

Achievements

- Managing Allegations Procedure updated, including clarity around transfer of risk.
- 'Safer Employment and the LADO' area of the BSCB website fully updated, including appropriate information, support documents, links and contact details.
- Safer Recruitment Standards - Safer Employment Toolkit updated and online.
- Contractors and Commissioned Service information, checklist and self-assessment tools created and on BSCB website.
- Allegations Training lunchtime sessions. Built into BSCB free training delivery for 2018-2019.

Sub Group priorities for 2018-19:
The meeting completed its workplan in November 2017 so is awaiting information about the new arrangements and where this work stream will fit in.

To increase the input from partner agencies regarding pinch points and opportunities for integrated working across the workforce as part of the drive to improve.

The sub group will continue to ensure that:

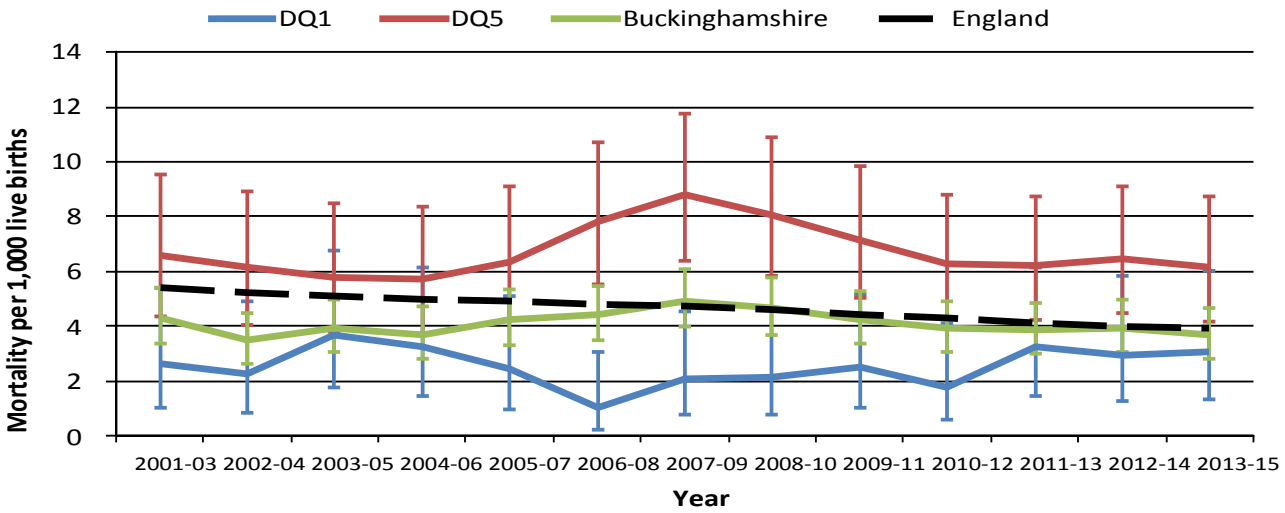
- A clear and up to date schedule for updates is being maintained.
- Policies, procedures and guidance documents are updated in line with the schedule.
- There is an effective mechanism for identifying when changes in national legislation or local practice will require policies, procedures and guidance documents to be updated. Policies, procedures and guidance documents are updated in line with learning and areas for improvement identified through SCRs, other reviews, auditing, other BSCB Sub Groups or feedback from other sources.

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 2017-18, but a summary of some of the key findings are presented below.

Trend in Infant Mortality by deprivation, 2001-2015



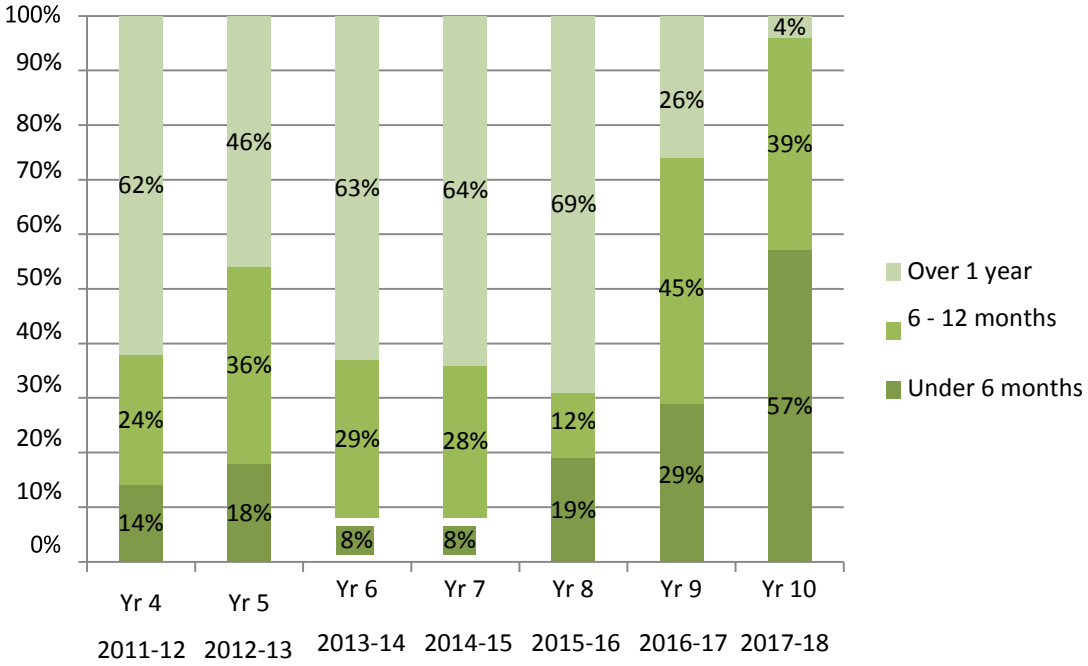
Source: Office for National Statistics Primary Care Mortality Database (PCMD) and Annual Public Health Birth Files.

Figure 1 above shows the trend in infant mortality by deprivation quintiles in Buckinghamshire. The data suggests that, while the number of deaths is small and fluctuates year on year, the overall trend in child deaths in all age groups shows a downward trend.

Total number of reviews and review time 2012-18

Duration	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18	National Benchmark 2016/17
< 6 months	9 (19%)	17 (29%)	16 (57%)	32%
6-7 months	1	9	4	44%
8-9 months	4	6	5	44%
10-11 months	1	9	1	44%
12 months	0	2	1	44%
Over 1 year	34 (69%)	15 (26%)	1 (4%)	24%
TOTAL	**49**	**58**	**28**	

Figure 2: Percentage of reviews and review time 2011-18



Number of child death notifications to CDOP and number of reviews per year, April 2013- Mar 2018

	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18
No of notifications	43	29	26

Number of deaths reviewed by gender:

14 cases (50%) were male and 14 cases (50%) were female, compared with the national average of 56% and 44% respectively (2016-17). Nationally, boys' deaths have consistently accounted for over half of deaths reviewed since the year ending 31 March 2011 (2016-17).

Number of deaths reviewed by gender 2008-2018

Gender	Yr 8 15/16	Yr 9 16/17	Yr 10 17/18
Male	29 (59%)	28 (48%)	14 (50%)
Female	18 (37%)	30 (52%)	14 (50%)
Not stated/ undetermined	2	-	-
TOTAL	**49**	**58**	**28**

Number of deaths by ethnicity

Information on ethnicity was known for all the cases. This is a major improvement from previous years as in 2014-15 and 2015-16 the information on ethnicity was unknown or not stated in 32% and 17% of the cases respectively. Nationally, in 7% of the cases ethnicity was either unknown or not stated in 2016-17.

Of the 28 cases reviewed in 2017-18, 15 deaths (54%) were in children of White (Any White) ethnic background combined. Eight deaths (29%) were in children of any Asian/mixed Asian background combined. A small proportion of deaths were in children of any black and mixed black background.

Category of deaths as determined by CDOP 2017-18

Category of death	TOTAL
Category 1: Deliberately inflicted injury, abuse or neglect	0
Category 2: Suicide or deliberate self-inflicted harm	0
Category 3: Trauma and other external factors	2 (7%)
Category 4: Malignancy	3 (11%)
Category 5: Acute medical or surgical condition	0
Category 6: Chronic medical condition	0
Category 7: Chromosomal, genetic and congenital anomalies	7 (25%)
Category 8: Perinatal/neonatal event	12 (43%)
Category 9: Infection	2 (7%)
Category 10: Sudden unexpected, unexplained death	2 (7%)
TOTAL	**28**

What did this mean for the sub group?

Review times for cases have improved significantly. Only one case (4%) took longer than 12 months to review, a significant improvement from 26% the previous year and much better than the national average of 24% in 2016-17. 96% (27 cases) were completed within 12 months of notification compared with 74% in the previous year and a national average of 76% in 2016-17. 57% (16 cases) were completed in less than six months compared to 29% in 2016-17, 19% in 2015-16 and 8% in 2014-15.

- Improvements in information gathering, particularly around ethnicity. In 2014-15 and 2015-16 information on ethnicity was unknown or not stated in 32% and 17% of cases compared with 7% of cases nationally (2016-17). In 2017-18 information on ethnicity was known in all cases.

- A detailed analysis of child mortality in Buckinghamshire was undertaken by the panel, focusing on ethnicity, prematurity and congenital abnormalities in order to help identify opportunities for improving health and reducing mortality among children in Buckinghamshire.
- All cases carried forward at the beginning of the year were uploaded to eCDOP and all new cases this year have been processed through eCDOP.

Barriers and challenges:

- Information sharing challenges between Oxford and Buckinghamshire CDOP on Buckinghamshire cases provided to them by Oxford Registrar. In 2017-18 38% of deaths of Buckinghamshire children were registered in Oxfordshire. This means that for a number of children we do not have registered cause of death.
- Following the review of a death of a Milton Keynes child resident in Buckinghamshire, Buckinghamshire CDOP and SCR sub group recommended that a SCR should be carried out. Improvements are needed in information sharing cross border about learning outcomes.
- Resources and capacity within the CDOP Co-ordinator role, extra hours that were available last year were not this year. It is anticipated this will come under review as part of the new arrangements.

Sub Group priorities for 2018-19:

- Implementation of new Child Death Review Guidelines.
- Increase the focus on wider safeguarding/ contextual factors and make better links with SCR subgroup to maximise use of learning opportunities.

Implement the following recommendations:

Recommendations for Buckinghamshire LSCB from CDOP:

1. Ensure close monitoring and surveillance of infant mortality continues and remains a top priority for all organisations in Buckinghamshire including the LSCB.
2. Championing improvement in 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.
3. Ensure that commissioners and providers have clear and agreed processes in place for referring and sign-posting at-risk women and children particularly those from areas of social deprivation including ethnic minorities to relevant services.
4. Ensure strong links between LSCB subgroups are established in order to ensure a coherent approach to reducing preventable death among children in Buckinghamshire.
5. The LSCB to ensure that actions to reduce child death as described above (Recommendations for commissioners) and in Appendix 1 of this report are implemented by the relevant agencies.

Serious Case Review

The Board is 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. Buckinghamshire continues to have a significant number of SCRs which involved babies under one year old, as a result the sub group agreed to undertake an independent audit into the partnership response to non accidental injuries (planned 2018).

Completed and ongoing reviews

In 2017/18 the BSCB published two SCRs (baby E and baby Q):

- Baby E summary http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/Executive_Summary_Baby_E.pdf
- Baby Q summary http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/Baby-Q-SCR-with-action-plan.pdf

As a result the following pieces of work were taken forward:

Baby E - see page 49

Baby Q: increase the resources available to professionals and families where parental learning difficulties are known or suspected. This means that in 2018, the BSCB website will commission a local charity to create east read materials, e.g leaflets, such as 'what is abuse/neglect', and also checklists for practitioners to help them recognise and respond to parental additional needs and understand what that means in relationship to parenting.

By the end of the financial year we were also in the process of completing the SCR for Baby S whose publication was delayed due to legal factors.

In addition to case reviews there has also been an increase in learning opportunities on common themes. Learning from SCRs continues to be embedded within BSCB core training. We have also used the BSCB newsletter to share learning with our partners.

Next steps

- **To extend the use of learning reviews where they don't meet the criteria for SCR.**
- **2018/19 aiming to make better connections with the learning from SARs and DHRs.**
- **To improve the links between CDOP and SCR group where there aren't medically modifiable factors but there may be learning.**
- **To look at better links with learning from DHR to ensure a think family approach.**
- **Respond to the findings if the NAI audit into babies.**

BABY E Serious Case Review

What did we do?

A serious case review into the event surrounding the injuries sustained by Baby E was convened.

Eleven agencies supported the work of the panel to ensure that any learning was identified in order to prevent a reoccurrence.

Why did we do it?

In Spring 2012 baby E was presented at hospital with a history of poor feeding and being unsettled. The baby was diagnosed at hospital as having suffered a fractured femur. Three weeks earlier the baby had been seen at the hospital with facial bruising which a consultant paediatrician had concluded was 'less likely to be accidental injury'.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of Working Together to Safeguard Children HM Government 2010.

The independent chair of Buckinghamshire Safeguarding Children Board decided on in May 2012 that the circumstances met the criteria for a serious case review because of the severity of the injuries and the initial evidence that agencies did not work effectively together, in particular in making the assumption that mother could protect children without adequate checks and assessments.

Evidence of impact and outcomes?

Over 50 recommendations were identified for a wide range of agencies including GP surgeries, Police. Adult social care and midwifery. There were 6 recommendations which were specifically for the Board.

An action plan was created which was monitored by the serious case review sub group. All of the actions have been completed.

Next steps?

The Board continues its focus on non-accidental injuries in babies, to ensure the effectiveness of the partnership response to it.

In 2018 a deep dive audit will be undertaken to check back on progress against previous audits and cases such as this one.

INFORMATION SHARING WORKSHOPS

What did we do?

We commissioned a series of workshops to explore 'effective information sharing'.

The workshops began in April 2018.

Why did we do it?

Information sharing between professionals and organisations is central and crucial to the effective safeguarding of children and young people. However, it must also be acknowledged that despite national and local guidance it continues to be problematic as evidenced by such things as serious case review reports.

In the triennial analysis of serious case reviews of the 66 review reports looked at in depth there was only one where information sharing was not specifically mentioned as an issue. In addition the authors of this triennial analysis also noted that 'in over ten years of analysing serious case reviews, we have not come across a single case where a child has been killed or harmed because a professional has shared information.'

Locally at previous challenge events practitioners had highlighted this as an area they wanted to explore further.

Evidence of impact and outcomes?

54 practitioners and managers attended and contributed to the discussion.

From the workshops we were able to collect evidence through the means of appreciative inquiry in order to understand the problems underpinning or preventing effective information sharing.

Engaging in 'live supervision' to work with the issues identified by participants.

Explore strategies to promote effective information sharing

From the feedback the facilitator provided the Board with a range of findings based on real experiences in Buckinghamshire along with suggested strategies for moving forward.

Next steps?

The performance and quality assurance sub group considered the feedback and have agreed a measureable action plan.

In 2018 the sub group will identify leads to take this forward and a will monitor progress.

Joint working

In early 2015, we agreed a Joint Protocol which set out arrangements for partnership working between the four strategic boards operating in Buckinghamshire (BSCB, BSAB, Health and Wellbeing Board [HWB] and SSBPB). During 2017/18 there was a updated version (draft) and regular meetings took place between the Board business managers/ support as well as formal meetings between the joint chairs. In January 2018 the Boards completed a 'health check' (canvassing the opinions of current Board attendees) and feedback was low. However, the Board took note of the comments which were received and these will form part of the ongoing planning.

These were:

- 'Better practice and awareness within my organisation as a result of the learning I bring back'.
- 'Committed chair and manager. Smaller board working more effectively together.'
- 'The independent Chair ensures that the Board's views and contributions are represented and heard. Matilda Moss and more recently her replacement have been vital in ensuring updates, documents, data dashboards are regularly updated and sent out to all members.'
- 'There are too many objectives and priorities, that it is difficult to focus meaningful work to improve practice.'
- 'good forum to maintain an over view of issues, however need to be convinced that it is effective to ensure positive outcomes for children.'

Examples of successful joint working:

It has been agreed that the Health and Wellbeing Board should act as the strategic lead for Female Genital Mutilation (FGM). The joint action plan was reviewed this year and the joint practice guidance on FGM including the pathways for both children and adults will now be reviewed by our policies and procedures group. The BSCB and HWB issued joint publicity campaigns ahead of the summer holidays. This included a joint press release from the chairs of all Boards.

Next steps

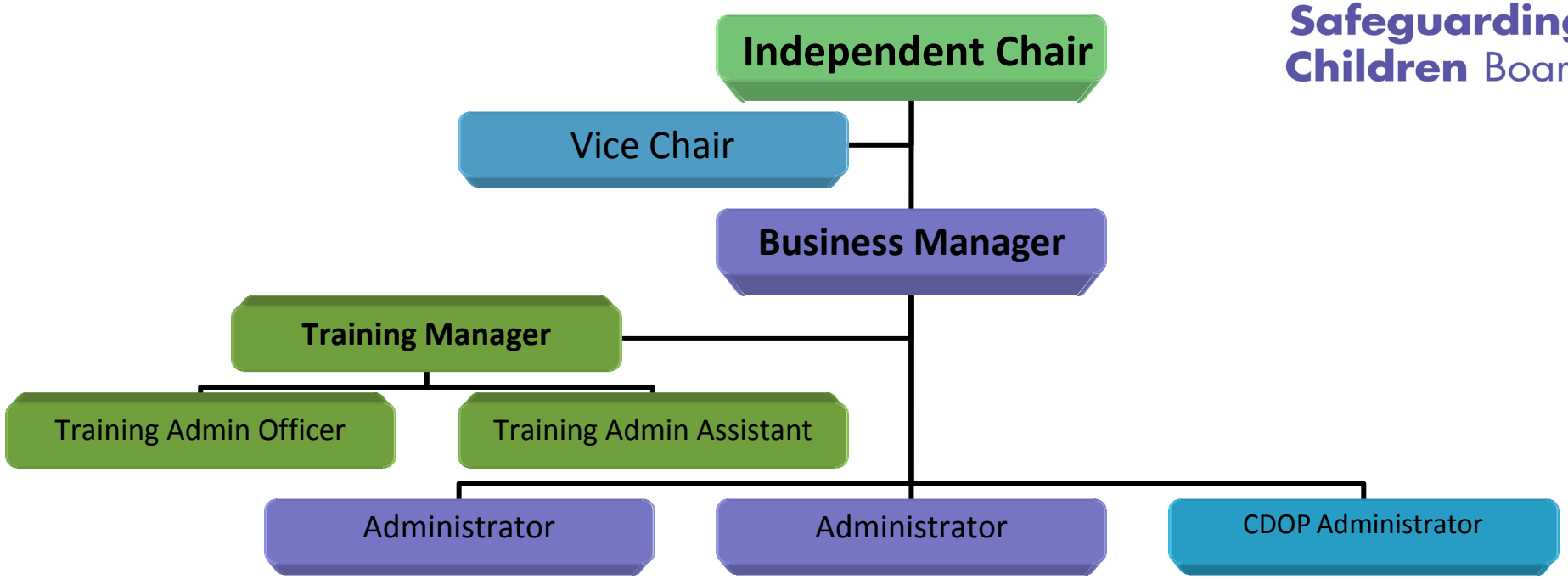
- **To ensure that our communications are informed by the latest research and voices of experts by experience.**
- **To hold a bi-annual joint children/ adult task and finish group to ensure action plans and processes are kept up to date.**

Other examples of joint work are:

- BSCB and BSAB have a planned challenge event regarding Domestic abuse and people with a learning disability. The learning from this will be shared on both Boards.
- BSCB and BSAB attend the DVA strategic group and ASEN to ensure that there is effective 'read across ' in terms of shared priorities.
- BSCB and BSAB are planning a series of 'professional curiosity' workshops which will be open to children and adult workforce members for 2018/19.
- A case which did not meet the threshold for SCR but the sub group decided requires a practice learning review (EM) will be held involving both adults and children workforce as the young person was 21 at the time of death but was receiving services from both workforces.

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.

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.

2017-18 has seen an improved focus on making a connection between the groups.

APPENDIX 2

BSCB Membership and Attendance

Organisations	No. attended out of last 7	Current % for 2017/18
BCC CHASC	4/7	57
BCC Children & Familes Service	7/7	100
BSCB Chair	7/7	100
Buckinghamshire Healthcare Trust	7/7	100
Cabinet Member for Children's Services	5/7	71
CAFCASS	0/7	0
Clinical Commissioning Group	7/7	100
District Councils (AVDC, WDC, CDC/SBDC)	5/7	71
Independent Schools	4/7	57
Lay Member	6/7	88
National Probation Service	5/7	71
NHS England Thames Valley Area Team	2/7	29
Oxford Health NHS Foundation Trust	7/7	100
Primary Schools	7/7	100
Public Health	6/7	88
Secondary Schools	3/7	43
Thames Valley Police	7/7	100
Thames Valley Probation (CRC)	2/7	29
Voluntary Sector	3/7	43
Youth Offending Service	7/7	100

BUCKINGHAMSHIRE SAFEGUARDING CHILDREN BOARD MEMBERSHIP
Main Board Members

First name	Surname	Organisation	Role
Ros	Alstead	Oxford Health NHS FT	Director of Nursing and Clinical Standards
Gillian	Attree	Buckinghamshire CCG	Safeguarding Lead
Kevin	Brown	Thames Valley Police	Superintendent
Jenifer	Cameron	Action4Youth	CEO
Pauline	Camilleri	Youth Offending Service	Head of Service
Stephanie	Clifford	Maltman's Green School (Ind Schls rep)	Deputy Head Pastoral
Gail	Hancock	Children & Family Service (BCC)	Service Head
Lou	Everatt	Community Rehabilitation Company	Head of Operations (North)
Felicity	Parker	Thames Valley Police	Detective Chief Inspector
Frances	Gosling-Thomas	BSCB	Independent Chair of Board
Harriet	Henry-Rapoz		Lay Member
Martin	Holt	Chiltern and South Bucks District Council	Head of Health and Housing
Elaine	Jewell	Wycombe District Council	Head of Community
Debbie	Johnson	National Probation Service	Senior Operational Support Manager
Sarah	Leighton	Hughenden Primary School (Primary Schools rep)	Head Teacher
Carolyn	Marsh		Lay Member
Fiona	Morey	Deputy Principal Learning & Quality	Buckinghamshire Colleges
Carolyn	Morrice	Buckinghamshire Healthcare Trust	Chief Nurse
Jane	O'Grady	Public Health, Buckinghamshire County Council	Director
Julie	Puddephatt	Adult Social Care, Buckinghamshire County Council	Head of Safeguarding
Lesley	Ray	Buckinghamshire CCG	Designated Doctor for Child Protection
Will	Ryesdale	Aylesbury Vale District Council	Sector Lead - Community Fulfilment

Cathy	Stancer		Lay Member
Juliet	Sutton	Aylesbury Vale CCG	Doctor (GP)
Vacant	Vacant	NHS England Thames Valley Area Team	Safeguarding Lead, NHS England South (South Central)
Tolis	Vouyioukas	Children's Services, Buckinghamshire County Council	Executive Director
Liz	Williams	CAFCASS	Service Manager
Rhian	Williams	Sir William Borlase Grammar School (Secondary Schools rep)	Headteacher

Advisors to the Board

Ann	McKenzie	Buckinghamshire Safeguarding Children Board	Training Manager
Hayley	Norman-Thorpe	HB Public Law	Assistant Director
Joanne	Stephenson	Buckinghamshire Safeguarding Children Board	Business Manager
Warren	Whyte	Buckinghamshire County Council	Cabinet Member for Children's Services

APPENDIX 3

BSCB Budget

Agency	2017-18			2016-17		
	Contributions (base budget)	Change from 2016/17 base budget	% change from 2016/17 base budget	Contributions (base budget)	Change from 2015/16 base budget	% change from 2015/16 base budget
Buckinghamshire County Council	105,683	0	0% ⇔	105,683	29,219	22% ⇩
Thames Valley Police	24,290	0	0% ⇔	24,290	9,290	62% ⇧
Aylesbury Vale CCG Chiltern CCG Buckinghamshire Healthcare Trust	70,180	0 0 0	0% ⇔	70,180	0	0% ⇔
Probation (CRC)	1,735	0	0% ⇔	1,735	0	0% ⇔
National Probation Service	1,227	0	0% ⇔	1,227	508	29% ⇩
Wycombe District Council	10,633	0	0% ⇔	10,633	0	0% ⇔
Aylesbury Vale District Council	10,633	0	0% ⇔	10,633	0	0% ⇔
South Bucks District Council	5,317	0	0% ⇔	5,317	0	0% ⇔
Chiltern District Council	5,317	0	0% ⇔	5,317	0	0% ⇔
CAFCASS	550	0	0% ⇔	550	0	0% ⇔
Oxford Health (CAMHS)	8,000	0	0% ⇔	8,000	0	0% ⇔
TOTAL BASE BUDGET	**243,564**	**0**	**0% ⇔**	**243,564**	**20,437**	**8% ⇩**

APPENDIX 4

Abbreviations

ASEN	Anti Slavery and Exploitation Network (Buckinghamshire)
BSAB	Buckinghamshire Safeguarding Adults Board
BSCB	Buckinghamshire Safeguarding Children Board
CDOP	Child Death Overview Panel
CE	Child exploitation (encompasses all forms)
CEOP	Child Exploitation and Online Protection (police-led)
CHASC	Communities, Health and Adult Social Care
CIN	Child in need
CP	Child Protection
CSE	Child sexual exploitation
DVA	Domestic violence and abuse
HWB	Health and Wellbeing Board
LA	Local authority
LSCB	Local Safeguarding Children Board
MACE	Multi Agency Child Exploitation (meeting)
M-SERAC	Missing-Sexual Exploitation Risk Assessment Conference
PSHE	Personal Social and Health Education
Q(1)	Quarter (1 or whichever quarter of the year)
SCR	Serious Case Review
SSBPB	Safer Stronger Buckinghamshire Partnership Board
TOR	Terms of reference
TVP	Thames Valley Police