Gloucestershire

Safeguarding Children

Board

Annual Report 2012/13
and
Business Plan 2013/14

Working together to empower and protect children

Contents

Introduction
by Roger Clayton, Independent Chair

Having previously been Independent Chair of Gloucestershire's Safeguarding Adults Board, I took on the role of chair of the Children's Board a year ago with a brief to align the two boards more closely, but with a determination that each should continue their individual journeys of improvement in order to best safeguard the most vulnerable in the county. I am pleased to report that progress has been made in both respects.

I hold the belief that an effective strategy to keep children safe can only be devised by listening to the views of children. That is why their influence on our business planning, their contribution to a website for young people, the appointment of children's ambassadors and the continued work of the participation group are of such importance.

The Children's Board has critically examined itself over the past year in an attempt to develop and has continually tried to find out what actual difference it makes to the lives of children and young people. It has also tried to achieve the right balance between strategic vision and greater knowledge of day to day service delivery.

A major focus during the year was the issue of child sexual exploitation. Disturbing media reports from various towns and cities across the country of wide scale, organised sexual exploitation strengthened our determination to ascertain the situation in Gloucestershire and be in a position to respond effectively. Whilst our full range of work is contained in the main body of this report, I would wish to specifically emphasise the play called Chelsea's Choice and the positive impact it had on so many young people.

Despite all that was achieved in this area over the past year, we cannot be complacent and CSE together with the issue of children who persistently run away from home and care will continue to be a focus.

It is my view that we are moving from a *talking* board to an *achieving* board and in doing so are better placed to evidence actual outcomes. Members have championed both serious case review findings and the participation agenda. They listened to a request from young people and went in to class rooms to deliver input on safeguarding.

The GSCB and GSAB now share the same logo, are directed by the same constitution and memorandum of understanding and have integrated some of their sub groups. Whilst efficiencies have resulted, the real benefit has been a tangible increase in effectiveness borne out of a genuine desire from the members of both boards to learn from each other.

This has resulted in a cross pollination of good ideas and best practice which ultimately will benefit children, young people and vulnerable adults alike. I will stress that none of this has been achieved at the expense of individual agendas and I have been keen to ensure that fusion did not result in any dilution of specific effort.

Examples of how board members have worked to increase their effectiveness include the completion of a safeguarding skills and knowledge questionnaire resulting in a bespoke training package to facilitate self- improvement. They have also adopted a more interactive style of working where rather than receive and rubber stamp recommendations, they consider findings then debate and formulate personal recommendations. Those recommendations are turned into actions which continue to be owned

thereby ensuring their ideas actually improve practice.

All this has obvious impact on the competing demands for their time and it is illustrative of their dedication to the cause of keeping young people safe from harm.

It would be wrong of me to give the impression that the board could not improve yet further as clearly it could. One such area is communication and I remain unconvinced that our young people, our practitioners and indeed our wider communities have a sufficient level of knowledge of our aims, objectives and achievements. Quite simply put, safeguarding can only become everyone's business if everyone knows what safeguarding is.

For this reason I consider the development and delivery of an improved communications strategy an absolute priority for 2013/14.

The wider training agenda has remained strong throughout the year and as well as conventional multi and single agency training, a number of one off seminars and conferences were held. A series of road shows across the county were extremely well attended. Their aim was to deliver the tenets of Professor Eileen Munro as contained in her analysis of child protection in England.

A reduction in the levels of bureaucracy and a move from an environment of compliance to one which focuses on whether the child is being helped or protected is to be welcomed. Similarly, freeing our practitioners to use their professional judgement rather than being preoccupied with meeting targets can only be a positive step.

Our examination of quality of service delivery has been effectively led by the Multi Agency Quality Assurance sub group. Amongst many notable achievements throughout the year, particularly worthy of note are the multi- agency case file audit and the development of child protection core standards.

There were no serious case reviews commissioned during the year but it gave us the opportunity to review cases which, whilst falling short of the threshold for formal review, allowed us to test new methodologies which will deliver greater potential for learning.

Despite commitment, motivation and experience, it would be wrong to assert that we have all the right answers within the county so I welcome the increasingly positive influences of peer support both in respect of neighbouring local authorities and the regional and national network of independent safeguarding chairs.

The ability of professionals from different agencies to share information effectively in order to protect children and young people is of the utmost importance. Failure to do so in the past has resulted time and time again in unnecessary tragedy. For this reason the board welcomes the development of a Multi- Agency Safeguarding Hub or MASH which will lead to enhanced information sharing, closer working practice and consequently improved decision making.

Whilst I am able to preface this annual report with a catalogue of positive features, I nevertheless feel it prudent to highlight forthcoming challenges which underline the fragility of multi- agency endeavours to safeguard children.

Service reorganisation combined with challenging budget reductions must be recognised as a threat. This threat is currently being faced by all our constituent agencies individually and therefore must also be addressed by the board collectively.

Despite the size and complexity the issues facing the public, voluntary and community sectors, we must consider the protection of children and young people to be paramount.

Necessity has always been the mother of invention. This has never been more relevant and we must all strive to ensure that whatever results from the current maelstrom of change, whilst possibly being smaller, it must no be less effective than what exists at present.

Roger Clayton
Independent Chair
Gloucestershire Safeguarding Adults and Children Boards
April 2013

For extra guidance if needed,
there is a “jargon buster”
on pages 46 to 47

Section 1:

The GSCB's Responsibility to Coordinate Safeguarding and Promoting the Welfare of Children

1.1 What is Gloucestershire Safeguarding Children Board (GSCB) here to do?

Gloucestershire Safeguarding Children Board (GSCB) is responsible for co-ordinating what is done by each person or organisation represented on the Board for the purposes of safeguarding and promoting the welfare of children in Gloucestershire - and checking that what they do is effective.

It is made up of senior representatives from many organisations, including the County Council, Police, 2gether Trust, Care Services and education settings.

For a full list of membership please see **Appendix 1.**

1.2 How does the GSCB work?

The Board function includes making sure safeguarding policies are in place; communicating the need to safeguard children; evaluating the effectiveness of what is done by Board partners to safeguard children; and making sure lessons are learnt from Serious Case Reviews.

The GSCB is not accountable for operational work. It holds partner agencies to account on the effectiveness of their safeguarding services for Gloucestershire's children.

The Executive of the Board is the committee that oversees the work of the sub groups, feeding information up to the larger Board. In the other direction, it takes information, ideas and concerns from the Board and considers how this should be actioned and which sub groups should be responsible.

The Executive has worked well, strengthening its role by having the same Independent Chair as the Board and by including senior officers from key partner agencies as its members.

The GSCB has worked to align structure and priorities as closely as possible with the **Gloucestershire Safeguarding Adults Board (GSAB).** Part of this has been to look closely at the work of both Boards, bringing them together wherever there is an overlap.

Both Boards have the same Independent Chair, but the GSCB retains its Executive and Business Unit which is now co-located with GSAB administrators to support a closer working relationship.

1.3 What do the GSCB Sub Groups do?

The **Workforce Development Sub Group** develops the quality of our workforce and multi agency safeguarding training.

The **Multi Agency Quality Assurance Sub Group** (MAQuA) evaluates work done by GSCB partners to make sure that it makes a difference for local children and young people and their families.

The **Child Death Overview Process Sub Group** (CDOP) reviews child deaths in the county and is responsible for development of arrangements around Child Death.

The **Communications Sub Group** of the GSCB and GSAB is responsible for making sure that safeguarding messages and learning are shared in the most effective way possible.

The **Serious Case Review (SCR) Sub Group** has been reinstated, taking responsibility back from the Executive. It is responsible for advising when a Serious Case Review should be considered and managing the process. The group is being aligned with the GSAB, so that SCR methods can be agreed using the same process for adults and children and young people. This Sub Group includes members from the Child Death Overview Process Group.

The **Domestic Abuse Sub Group** is responsible for making sure procedures are in place for Multi Agency Risk Assessment Conferences (MARAC) and for supporting victims of Domestic Abuse and their children. This includes aligning processes with the Multi Agency Public Protection Arrangements (MAPPA) where the perpetrator of Domestic Abuse is being managed under these.

The **Policy and Procedures Sub Group** meets when required to review policies and procedures from the South West Policy and Procedures Group. This group will now make sure any changes required now that the revised *Working Together To Safeguard Children* has been published are actioned.

The **Participation Group** is there to ensure that the voices of service users, both adult and children and young people, are heard.

The **Education and Learning Sub Group** sits slightly apart from the Board. This group reports directly to the Operations Director, Education Learning and Libraries, who is a member of the GSCB. The Sub Group role is to ensure that all educational settings including Early Years, Maintained, Special and Independent Schools, Academies, Colleges and Learning/Training Providers are working in line with GSCB priorities and Ofsted requirements.

During the year, 3 Task and Finish Groups were also in place for specific work:

1. **The Child Sexual Exploitation and Missing Children Task and Finish Group**
   - set up to examine the extent of issues in Gloucestershire, how best to educate professionals to recognise issues, give young people the tools to recognise when they are in a risky situation and a process for referral.

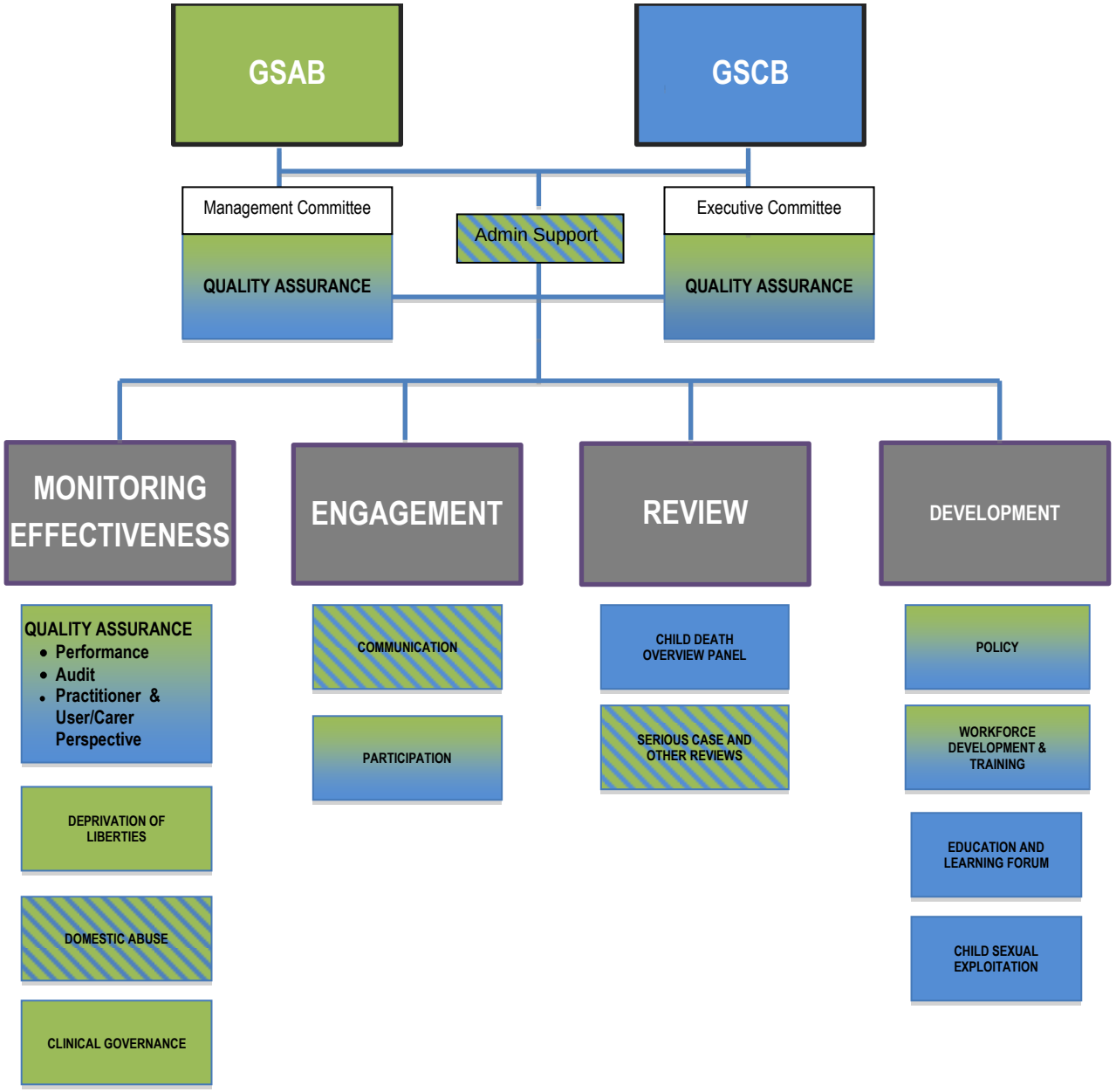
2. **The Child Suicide Prevention Task and Finish Group**
   - set up to look at ways of helping young people who may need to access help and support very quickly. The group also focuses on ways of helping Professionals recognise when a young person may need signposting to further help. The group includes representation from the Serious Case Review Sub Group and Gloucestershire's Suicide Prevention Group led by Public Health.

3. **The 'No Recourse to Public Funds' (NRPF) Sub Group**
   - set up in response to findings from a Serious Case Review, to write multi agency guidance about children and families living in the UK who have no recourse to public funds. The work of this group has been completed and is published on the GSCB web site.

The diagram on the next page shows the structure and groups within Gloucestershire Safeguarding Children Board and how they are being aligned as closely as possible with the Safeguarding Adults Board.

INTEGRATED SAFEGUARDING STRUCTURE FOR GLOUCESTERSHIRE

Working together to empower and protect adults and children who are vulnerable, as defined in legislation and statutory guidance



Safeguarding Children

1.4 How does the GSCB fit with other Partnerships?

The GSCB is a part of wider partnership arrangements. For example:

1) The GSCB is an equal partner to the **Gloucestershire Children's Partnership.**

The Children's Partnership *includes* a priority about keeping children and young people safe ...

...the GSCB *focus* is on safeguarding children and young people.

The work of the GSCB therefore contributes to the Children's Partnership goals of improving the wellbeing of vulnerable children. The GSCB has the authority to challenge the Children's Partnership and to call representatives to account for safeguarding activity.

2) GSCB works alongside **Gloucestershire's Health and Wellbeing Board (GHWB)**.

The GSCB *contributes* to the Health & Wellbeing Board goals to improve the wellbeing of all children and young people...

...the Health & Wellbeing Board role *includes* evaluating GSCB contribution to the wider health and well being agenda.

This Annual Report is therefore submitted to both the above Partnerships, as well as The Chief Executive, Leader of the Council and the local Police and Crime Commissioner. It is part of the way that the GSCB accounts for its work, celebrates good practice and raises challenge issues for partners to address.

Members of the GSCB provide a wide range of representation on other partnerships. This includes the Children's Partnership, Safeguarding Adults Board (GSAB), MAPPA, (Multi-Agency Public Protection Arrangements) and the Gloucestershire Domestic Abuse and Sexual Violence Board (GDASV). This in turn strengthens mutual support and challenge.

What difference does it make?

An example of such a challenge includes what happened when the GSCB questioned the Suicide Prevention Partnership about whether it was focused enough on the needs of children and young people. As a result, the SPP has set up a group specifically about young people, and has in its first months of existence designed supportive wallet sized cards/posters for young people who need advice and support if they are feeling suicidal. These have been distributed to all secondary schools and colleges.

1.5 What progress did it make, against what it set out to do?

In 2011 the GSCB set itself a three year plan. At the end of the first year, the Board's own self assessment, reflected by Ofsted Inspection findings, was that the Board had achieved its targets. To build on this the GSCB set itself three overarching strategic priorities for the second year (2012/13):

1) To have sustained and improved the Board's effectiveness

2) To have worked together to prevent harm to children

3) To have enhanced effective learning and development.

A similar review this year showed that by the end of the second year, we have completed all actions and made significant progress:

For Strategic Target 1, the GSCB set out where it would like to be in 12 months:

The leadership of the new Independent Chair has been effective. The Board fulfils its statutory obligations and we have made progress towards a single safeguarding system, informed by full partnership contribution and by the experiences and views of service users. We have developed and are able to demonstrate effective awareness raising and communication with all agencies, communities and other stakeholders in Gloucestershire.

To achieve this the GSCB has:-

Quality Assurance

Monitored achievement of Independent Chair objectives through regular discussions between the Chair, the Director of Children's Services, Director of Adults Services, Head of Quality and Head of Safeguarding Adults	Revised the GSCB Performance Dashboard, to build in a wider range of cross agency indicators and outcome measures

Scrutinised quarterly performance reports, including a "spotlight" on any indicators of concern and key performance issues.

Spotlights have included:
Children who have remained on a Child Protection Plan for 2 years or longer; Children subject to Child Protection Plans for a 2nd or subsequent time/18 months or more; Timeliness of Initial Child Protection Conferences; Protecting Disabled Children.

Monitored the impact of the previous year's Quality Assurance activity and Serious Case Review action plans. This has included reinstating the Serious Case Review Sub-Group of the Board and widening its role to include Serious Case Reviews for vulnerable adults and systems reviews. The methodology employed has been widened to include systems-based reviews such as the Social Care Institute for Excellence model (SCIE) and Serious Incident Learning Process (SILP).

Made sure that Subgroups have developed business plans which build in safeguarding priorities of children and young people, as raised by the GSCB, reviewing progress via reports to the Executive

Scrutinised an annual report and regular updates on child deaths, provided by the Child Death Overview Panel (CDOP).

Monitored a GSCB risk management framework in consultation with the Safeguarding Adults Board, so that key safeguarding risks across the safeguarding system have been identified, prioritised and controls put in place.

Commissioned themed audits, co-ordinated by the Multi-Agency Quality Assurance Sub Group.

Audits have included:
Outcomes for pregnant teenagers, Domestic Abuse, Safeguarding Practice Reflection and Children at risk of Sexual Exploitation

Reviewed learning from the Allegations Management process.

Workforce Development

- Compiled and circulated a training needs analysis for Board members in order to inform a training pathway to maximise skills.

- Monitored Section 11 action plans for improvement and Section 175 (157) responsibilities for Educational settings for improvement. See also Section 2 *Monitoring and Developing an Effective Workforce.*

Improving Processes/Practice

Established a multi-agency case review panel to increase opportunities for partnership scrutiny of areas of concern (such as children on Child Protection Plans for 2 years or more) and also learning from good practice.

Reviewed practice issues arising from Child Protection Case Conferences and safeguarding issues in relation to Looked After Children.

Reviewed links with other Partnerships, in particular between the Safeguarding Children Board (GSCB), Safeguarding Adults Board (GSAB), Gloucestershire Health and Wellbeing

Partnership and the Gloucestershire Children's Partnership. Models for closer working have been discussed, proposed and monitored at GSCB/GSAB Business Support level, sub-group level, Executive and Board level.	
Reviewed the process and key findings from safeguarding complaints, disseminating learning points across agencies.	Taken part in the review of the structure and effectiveness of the Public Protection Bureau in consultation with all relevant multi Multi Agency Safeguarding Hub (MASH) is now in progress.
Overseen the progress of Task and Finish groups including a new Suicide Prevention Task and Finish Group to examine and raise awareness on concerns about teenage suicide.	

For Strategic Target 2, the Board agreed to focus on three areas:

Effective intervention and prevention in early years; effective intervention and prevention for adolescents; and prevention of child sexual exploitation.

By the end of the year, the Board wanted to be able to demonstrate that it understands the range and quality of intervention by and between agencies and is able to support or challenge existing or planned arrangements for achieving improved outcomes in Gloucestershire.

To achieve this the GSCB has:

Workforce Development

Developed a training programme through the Work Force Development Sub Group for Early Years practitioners, specifically focussing on Child Minders and offering training courses at weekends to ensure easy access for professionals.

Strategic Planning

Reached agreement on the areas of priority for work and the outcomes required of any work undertaken.
Reviewed the priorities highlighted at the Business Planning Day to confirm how they should be included in the work programme, including themes raised by young people; cyber-bullying, feeling safe at home, feeling safe outside of school, and physical/verbal bullying. This included children with complex needs with a particular focus on transition to adulthood, providing good information to young people, and the effectiveness of services for adolescents in need.
Mapped where the agreed priorities are already being addressed and linked with this work where appropriate. Reporting arrangements have also been agreed to check that the outcomes required by the Board have been achieved. We have agreed how to address those priorities which are not being picked up elsewhere with an agreed programme of work triggered by the GSCB.

Improving Processes/Practice

Provided guidance for professionals working with families with no recourse to public funds (NRPF), setting out entitlements, services available and details on where to signpost individuals for information and support. The NRPF Task & Finish Group made sure the guidance was widely consulted upon and contained information for all agencies, about how to recognise such families and what support to offer them. The guidance was widely disseminated through training courses and the GSCB web pages.
Overseen the business plan of the Child Sexual Exploitation Task & Finish Group, which included the launch of a new Screening Tool and Protocol at a conference for a wide range of professionals and the launch of the Missing Children Protocol. Both were widely publicised to all professionals. The group joined forces with the Education and Learning

Sub Group to provide an interactive Theatre presentation called "Chelsea's Choice" to over 9000 Year 8/9 pupils.
Held 7 Safeguarding Road Shows with the Munro theme of 'Early Help', which shared learning about the Government's priorities taken from Eileen Munro's recommendations and Gloucestershire's response to this, including younger children and adolescents.
Overseen the work of the Education and Learning Sub Group with Early Years professionals, to ensure all are provided with a self assessment audit document outlining their responsibilities under the Early Years Foundation Standards (EYFS). The Education and Learning Sub Group set up a day for Colleges and any educational setting with a 6th Form to focus on adolescence and the transition between children and adult services.

Quality Assurance

☑Implemented year two of a three year Safeguarding Quality Assurance Framework, devised with support from an Independent Chair from London and overseen by the GSCB Multi-Agency Quality Assurance Sub Group. This Framework includes case file audits and drawing on the experience of parents, children and front line staff.

☑Taken part in the Social Care Institute for Excellence (SCIE) pilot scheme across the South West, by testing out *systems-based methodology for learning.* The case used for this pilot involved at least one child in Early Years and was successful enough for the GSCB to implement a further SCIE study.

☑Completed multi agency audits on children at risk from harm including children at risk from Sexual Exploitation; the extent to which partners are meeting their duties under Section 11 of the Children's Act; a review of education settings' self assessments of their Safeguarding processes (section 175); and practitioner views on the support they get to help them safeguard children and young People through supervision and peer support (Safeguarding Practice Reflection).

☑Scrutinised and discussed reports in key areas including Private Fostering, participation of children and young People, the Looked After Children Annual Report and a summary of learning from complaints.

☑Carried out Child Death Reviews, with regular reports to the GSCB Executive.

For Strategic Target 3, the GSCB set the task to:

Raise awareness of information, advice and support available to children and young people on safeguarding issues; have a clear programme of awareness raising and communication across all partners and workforce; Ensure high quality safeguarding training is delivered or commissioned across all sectors.

To achieve this the GSCB has:

Communication

- Hosted a safeguarding communication and learning event about issues common to, or cutting across, vulnerable children and adults, promoting locality working and early help has been delivered.
- Continued to develop GSCB website information, posters and leaflets for young people, parents and professionals.

CYP Involvement

Worked with the Participation Group to complete a series of 'Board Members into schools' visits which provided pupils with information about child protection and the work of the GSCB; make sure that young people took part in the GSCB business planning day to get their views across to Board members; and supported two young people to re-write the young people's GSCB website pages.

Made sure young people were invited back during the year to meet with the four GSCB Participation Champions, to discuss the Business Plan, what the Board had done and what it plans to do next, including listening to children and young people.
Agreed the next steps in implementing the GSCB's "ladder of participation" .
Considered the level and effectiveness of places to go to for support, advice and information for young people and reported their finding and views to the leaders who provide and plan for these types of services

Workforce Development

☑Reviewed training content at levels 1 - 4 as well as specialist training modules, developing online e-learning training and assessment tools, producing a training impact tool.

☑Produced Core Standards for practice in relation to Child Protection Conferences, to be applied across the partnership, which in turn informs the quality assurance framework and audits.

1.6 How was the GSCB funded and what was the budget spent on?

"Working Together to Safeguard Children" says that Local Safeguarding Children Board members should collaborate to provide sufficient resources for it to function effectively. Local Authorities, Health Trusts and the Police are expected to be core contributors.

The GSCB budget was set by estimating costs and agreeing a funding formula, where partners agreed what percentage or fixed amount they would contribute.

A separate funding formula was agreed for training, in a way that secures current training provision in a sustainable way, but that has further reduced costs of training for agencies which contribute to the running of that training.

The estimated budget to support GSCB activity in 2012/13 was £275k. The GSCB monitored spend through regular reports on the cost.

Significant savings were made due to staff vacancy savings, good financial monitoring and reduced spend on areas such as printing, catering and venue hire for meetings or events. The latter was achieved by agencies offering venues free of charge.

The Board recognised that not all partners would be able to contribute financially. A significant number provided resources 'in kind' through extensive work on GSCB Sub Groups or initiatives at locality level.

Contributions to resourcing the work of the Board were as follows:

Organisation	Researched Range of % Contribution	% Recommended to the GSCB	Commitment Made
Local Authority	31 - 77%	68.3%	£187,487
Health	8 – 40%	19.4%	£53,200
Probation	1 – 6%	1.9%	£5,300
Police	0 – 20%	10.2%	£28,000
CAFCASS	0 - 1%	0.2%	£550
			£274,537

The table on the next page sets out spend against GSCB functions and business plan in 2012/13.

2012/13 Budget: Funding the GSCB Statutory Functions and Business Plan	The Cost Elements That We Planned For	Original estimate	Spend
GSCB Business Plan Priority One: Sustaining and Improving the Board's effectiveness.	Work of the Independent GSCB Chair; Lay Members; Catering & Venue Hire; GSCB Business Support Staff activity, salary & training; travel; office costs	£198,650	£146,000
Statutory Function: Communicating the need to safeguard and promote the welfare of children and participate in local planning	Shared learning events and communications	£2,000	£768
Statutory Function: Undertaking a Serious Case Review where abuse or neglect of a child is known or suspected, a child has died, or 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.	Serious Case Reviews; Other Case Reviews	£24,500	£11,947
Statutory Function: Developing local policies and procedures as specified in the regulations for how the different organisations will work together on safeguarding and promoting the welfare of children.	Contribution to the South West Child Protection Procedures	£1,500	£750
Statutory Function: Reviewing the deaths of all children who are normally resident in their area and put in place procedures to ensure that there is a coordinated response by relevant organisations to an unexpected death of a child.	Staff costs for the Child Death Review Process and administration; research support from the University of Bristol	£42,887	£42,887
Risk management for unforeseen costs	Contingency Buffer	£5,000	£0
Totals		£274,537	**202,352**

1.7 How Effective was the GSCB?

The following provides an assessment of how effective the GSCB has been in delivering the work set out above**.** The assessment is based on Board discussions during the year, progress against the Business Plan and evaluation during the Annual Business Planning Day.

a) Effectiveness of Chairing, Governance and Accountability

The new Independent Chair has built on the work of the outgoing Chair, providing strong leadership and challenge and moving the GSCB towards greater links with the GSAB and to having more of an active role – from a 'Thinking Board' to a 'Doing Board'.

Accountability of the Chair has been effectively maintained through the contract to the Council jointly managed by the Director of Adults Social Services (DASS) and Director of Children's Services (DCS). 2012/13 is the first year of a 3 year contract, with a review at the end of the first year noting good progress against Board and personal goals. From 2013/14 the Chair will be accountable to and appointed by the Chief Executive working with LSCB partners and the Lead Member.

The GSCB has strengthened its outward looking approach to making connections with other key partnerships, strengthened by the Independent Chair's experience and position as the Chair of Gloucestershire Safeguarding Adults Board (GSAB).

Board members were expected to prepare for, attend, and engage in four Board meetings and a GSCB Business Planning Day during the year. Board members were also asked to take a lead in championing the findings of the SCIE Systems-Based learning review and to take a lead in going into schools to talk to Year 10 pupils about safeguarding.

It has been pleasing to see the continued range of representation on the Board. More invitations to Board meetings were made this year than last, but overall attendance fell by approximately 3%. The method of monitoring attendance has been reviewed to ensure consistency of approach with the Safeguarding Adults Board. More information about attendance at the GSCB meetings over the last year can be found in **Appendix 2.**

Board members have been well supported by a number of senior professionals who act in the role of advisors and coordinate business support. These include the GSCB Business Manager and the Gloucestershire County Council (GCC) Head of Quality (Children & Young People).

b) Clarity of Structure

The GSCB has a clear structure for its Board, Executive Committee and Sub Groups, with clear lines of accountability and reporting mechanisms. Each has clear terms of reference to support roles and responsibilities. The structure reflects the range of partnerships across the County, including the voluntary and community sector.

Board, Executive and Sub Group members have had appropriately strategic roles in relation to safeguarding in order to speak for their organisation with authority, commit on policy and practice matters, hold their own organisations to account and hold others to account.

The Board has a number of VCS members on its Board and Sub Groups but they have not had sufficiently robust structure to represent the whole Sector. This year, this will be addressed through joining the Safe Network.

There is a clear induction pack for new members and each Board member has completed a Training Needs return.

c) Clarity of Priorities and Planning Process

The Board has strengthened its approach to Quality Assurance and performance reporting further, to ensure challenge across the partnership, building on the work highlighted as required in the Ofsted report from 2011.

The GSCB has established clarity of purpose through a Programme, last year's Business Plan and ensuing meetings and activity, to be further strengthened in the year ahead. The Board has a clear vision for 2013-14 which includes strengthening the clearer links between the GSCB and Gloucestershire

Safeguarding Adults Board (GSAB) to further increase the effectiveness in all areas of common interest.

Each of the Sub Groups has had clear business plans for the delivery of their area of work, aligned to the GSCB Business Plan. Continuing this for 2013/14, the GSCB and Sub Group priorities will be mindful of the revised *Working Together 2013* and our local needs analysis.

The GSCB's Quality Assurance process has been strengthened and includes a quarterly performance report and themed audits which include the views of Children and Young People, families and practitioners. In its second year, the work undertaken is coming to fruition and embedding in practice but this will continue to be monitored and quality assured, forming a large part of the new Business Plan.

d) Effectiveness of Communication

The GSCB has maintained strong links with Safeguarding operational services through regular, open communication with Safeguarding leads across the organisations within the Partnership.

The year has seen a clear communication focus on the Government's Munro findings and Implementation Plan for Early Help. This has been dynamically communicated to practitioners by the GSCB during Road Shows and a successful 'Child's Journey Conference' based on Munro's findings. The conference included the views and experiences from a service user and her family, which attendees found powerful and thought provoking. The young person who took part in the GSCB 'Child's Journey Conference' has moved on to become one of the County Council's six new Ambassadors for Vulnerable Children and Young People, and plans to continue her links with the communication work of the GSCB.

The series of GSCB Road Shows were extremely well received. Participants across the six Districts learnt more about child protection outcomes in their particular locality; workshops on the child's journey through offers of early help to child protection; the continuum of need, assessment and service delivery; and the impact of parental substance misuse on children and young people, early help and crisis interventions.

Overall, Board members have worked well individually and jointly to support communication across the Partnership. However, the GSCB recognises it needs to continue to strengthen its communications. Building on the work of the existing Communications Sub Group, the Independent Chair will lead the group to develop a stronger strategic approach to awareness raising in ways that reach out further to our local practitioners and communities.

e) Effective use of Resources

The difficult economic climate has continued to provide challenges, but the GSCB has built on its funding analysis and formula to make sure it had the resources and capacity to fulfil its responsibilities.

The GSCB also strengthened the 'payment in kind' formula which is being rolled out and has enabled partners who cannot fund to instead provide training, venue or materials in order to contribute to or attend training.

During 2012/13 the GSCB has been supported by an Interim GSCB Business Manager who has covered the work with the assistance of the Head of Quality, as an additional role. This has worked well but the level and volume of work is not sustainable in the long term. The GSCB has now recruited a full time Business Manager on a 12 month secondment. The GSCB is also supported by a full time administrative post, matrix managed with the GSAB for consistency, a GSCB Support Officer and a Training Co-ordinator.

The Board and its Business Support Team worked hard throughout the year to keep its costs down and largely this has been successful.

f) Effective involvement of Children and Young People

In 2012, the GSCB agreed that the update of its website would be done by young people. Two Care Leavers worked with the Participation Team on a voluntary basis to develop child friendly pages on the GSCB

website. They consulted groups of young people to find out what information would be useful and the style preferred by different age groups. They carried out extensive research on other websites to get a better understanding of what works and what doesn't. The new pages being finalised and will be launched when the GSCB new look website goes live.

The GSCB has acted upon the thoughts of the children who took part in last year's Business Planning Day and made sure that Board Members visited schools across the County. The Board invited young people to contribute to the GSCB Business Planning Day in February 2013 in order to listen to their views and priorities. These have been included within the Business Plan for 2013/14.

g) Training Scope, Quality and Impact

Scope

During 2012/13 the GSCB continued to fulfil the requirements outlined in the guidance in Working Together 2010, which states

"*It is the responsibility of the LSCB to ensure that single agency and inter-agency training on Safeguarding and promoting welfare is provided in order to meet local needs. This covers both the training provided by single agencies to their own staff, and multi-agency training where staff from more than one agency train together."*

The scope of training includes Level 1 and 2 training within individual agencies. A clear message to the childcare and adult care workforce about the importance of early help and intervention is being provided in all training, including Level 2 Single Agency.

The GSCB continued to deliver an extensive multi-agency training programme which incorporates current legislation, national and local evidenced based research and local trends, findings from the systems approach to learning from case reviews. All training now includes an element of the recommendations of Professor Eileen Munro. In addition, bespoke training in Child Sexual Exploitation is now available and receiving a good response.

The total number of delegates trained last year 2012 /13 by the GSCB was almost 2,300. This represents an average increase of 35% year on year and a 25% increase on last year, which spiked at 1,850.

Further information about the courses delivered over the last year and the number of staff who have attended can be found in **Appendix 4.**

The GSCB Training Co-ordinator and Workforce Development Group were fundamental to delivering the GSCB Road Shows, promoting early help, locality working, use of the levels of intervention guidance and the importance of early help when working with families where drug use is an issue.

Quality and Impact

The Ofsted inspection in February 2012 noted

"Good quality multi-agency training which is well attended is underpinning this strategy, leading to a shared sense of responsibility in respect of early intervention work and Safeguarding generally".

The GSCB has maintained and improved the quality of this training, Road Shows and Conferences using evaluations that ask participants to rate their level of understanding both before and after, with an assessment of whether training will change their practice. A full Training Impact Assessment Framework has also been developed.

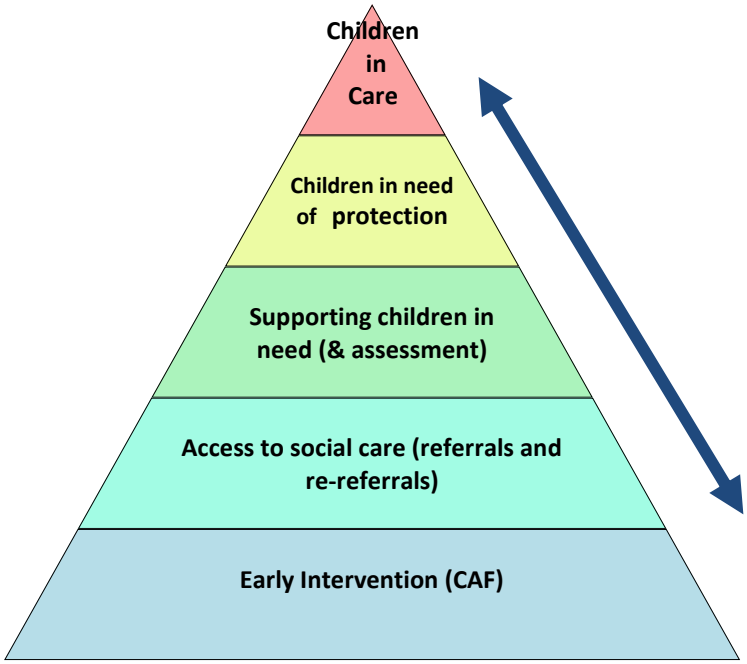
Through the CSE Protocol and training programme launched by the GSCB, attended so far by 200 practitioners, professionals have a much clearer framework for supporting children who are vulnerable to exploitation and good access to information about vulnerability, risk factors and the tailor made screening tool.

To maintain the high standard of training at each level, (including single agency safeguarding training), work has been completed this year to develop a clear training pathway, core standards and content for each course.

Section 2: GSCB's Responsibility to ensure that Local Work to Safeguard and Promote the Welfare of Children and Young People is Effective.

2.1 Identifying Children at risk

GSCB routinely examines and discusses data from 21 agreed performance indicators, across the following range:



Early Help

There are a wide range of services which fall within the definition of early help. Many of these are offered by voluntary and community groups and an increasing range of leisure and activity providers. Health provision, including health visitors, school nursing, and primary mental health care workers also plays an important role in identifying issues early on and providing a range of interventions. Services such as children's centres, community health services and some youth support services are specifically commissioned to identify needs early and provide intervention services.

The Common Assessment Framework (CAF) is well developed locally with support coordinated by the Targeted Support Teams within operational Children's Services. These teams also undertake work with families within and outside the statutory framework of Children in Need.

The GSCB performance report will be revised in 2013/14 to include a broader range of early help indicators. This will strengthen the board's ability to monitor the effectiveness of the early help offer.

Referral and Assessment

Contacts to Social Care	Contacts that became referrals	Rate per 10,000	% going on to initial assessment
16,062	4977	418	89%

This means that 31% of all contacts made to Children's Social Care between the 1st April 2012 and 31st March 2013 became referrals for intervention, which the GSCB notes at a rate of 418 per 10,000 of the under 18 population is , significantly above the local threshold and the statistical neighbour average for 11/12 (380).

The GSCB has commended good direction of travel for the percentage of referrals receiving an Initial Assessment of Need, compared to 81% the year before and the statistical neighbour average of 85% for 11/12.

The GSCB noted a slight drop from 82% to 80% in completing Initial Assessments during the year, still above local target and known national/statistical neighbour averages. At 79%, Core Assessments completed within timescale shows an improvement on last year and is similarly above known national and statistical neighbour averages.

Child Protection

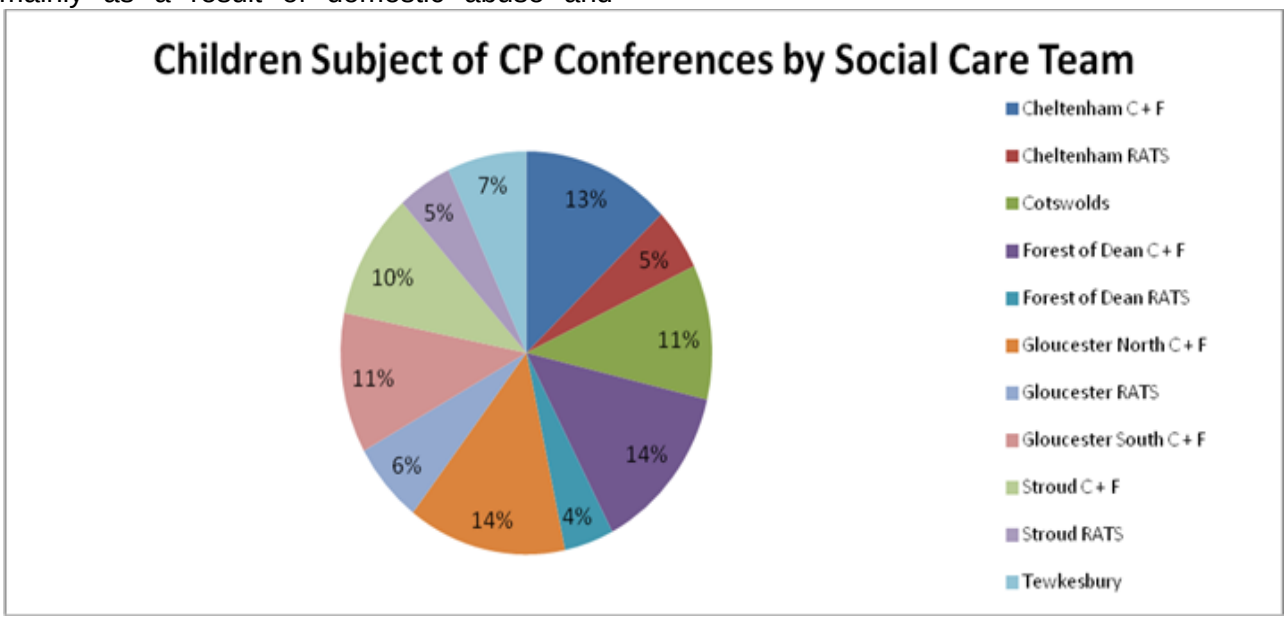
At the end of March 2013 there were 444 children subject of a Child Protection Plan. The previous year it was 400. This means that

agencies working with children in Gloucestershire considered that approximately 36 children out of every 10,000 are suffering or likely to suffer significant harm.

The GSCB notes that the largest proportion of these children were between 1 and 4 years old (34%). This points to the continued need for safeguarding partnerships to focus on early help and intervention.

The most common categories were Neglect and Emotional abuse, followed by Physical abuse or Sexual abuse. Concerns about neglect or emotional abuse appear to be mainly as a result of domestic abuse and parental substance misuse, which the GSCB recognises as a consistent pattern over recent years that continues to follow trends nationally.

The chart below shows the spread of conferences throughout the county. As urban areas with some significant pockets of deprivation, the higher percentage from Gloucester and Cheltenham is to be expected. However since last year, the number of children on Plans in Cheltenham has dropped slightly and is now on par with the Forest of Dean which, in comparison to other rural areas, has a significant number of children subject of child protection plans.



A particular area of scrutiny for the GSCB this year has been the number of children subject of a child protection plan for over two years, or for a second/subsequent time. It recognises that Child Protection Chairs continue to provide a good level of support and challenge, and as the Ofsted inspection of 2012 noted,

"*Child Protection chairs are providing an appropriate level of challenge in respect of work quality, leading to appropriate analysis and decisions in most cases."*

However, the Inspection also noted that

"Outcomes and planning objectives are being increasingly set but in some cases there is a lack of clarity in the objectives of continued child protection planning when children and young people have been the subject of plans for over 18 months...in some cases the LA and partner agencies have agreed to children and young people remaining the subjects of CP plans when lower level services could have been provided."

Multi-Agency action overseen by GSCB:

1. The **Reflective Model for Professional Meetings** was built into GSCB Core Standards requiring professional reflective meetings on any child subject of a plan for more than 12 months.

2. **Child Protection Chairs** active support in the multi-agency context, with the

expectation that exit plans are discussed at the first conference and alternative plans robustly sought for children on a plan for more than 12 months.

3. The GSCB **Multi-agency Case Review Panel** focus on children subject to Child Protection Plans for a second time or more, or for more than 12 months. Professionals are invited to the Panel to discuss the child's circumstances, core group views about effectiveness, and barriers to effecting sustainable change.

What difference did it make?

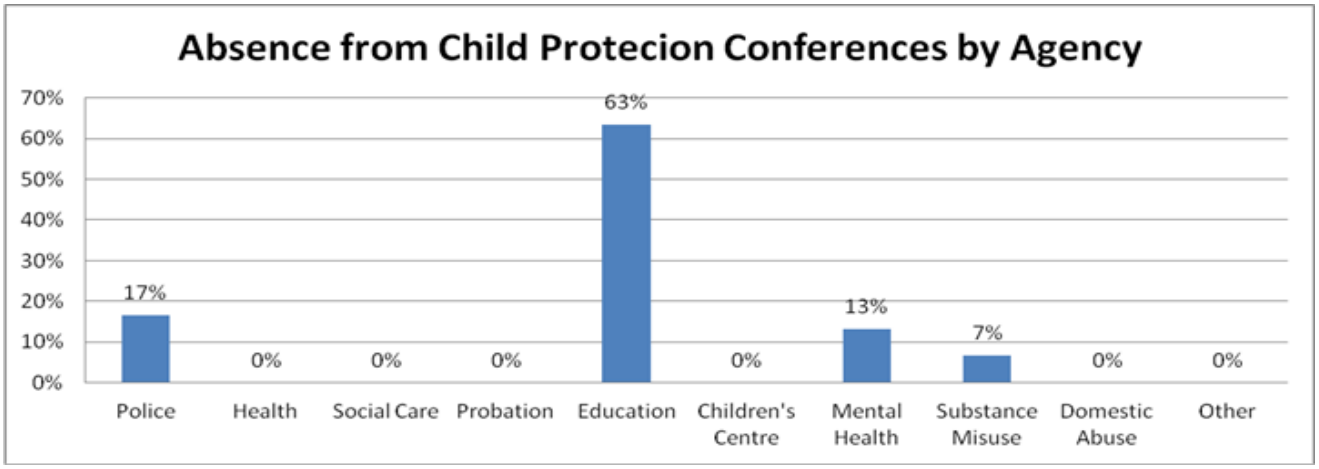
The initiatives set out are about ensuring the right children are on the right plans for the right amount of time. The impact has been positive. Professionals meetings are being encouraged. Team Managers are questioning seriousness of need and effectiveness of plans. Social Workers and Panel Members have fed back positively about the experience of the panel, with suggestions for improving the process being taken forward to next year's GSCB work programme.

The evidence of impact was demonstrated in the June 2012 performance figures where those on a plan for more than 24 months had reduced by 22% from 22 to 17. However progress is not yet reflected in year end figures; 6.7% against a target of 6%.

The end of year figures show a drop in repeat Child Protection Plans, from 19% to 15%. This was the lowest figure in four years, despite a rise in the overall number subject of Child Protection Plans. It is still however above the local target set and above known data for statistical neighbours.

2.2 Working with Children who have been identified as experiencing or at risk of harm

Child Protection Chairs use a *Standards Checklist* at each Conference in order to quality assure and drive up good practice. They aggregate data from this to report good practice and any themes of concern to the GSCB. This year, Chairs raised concerns about the absence from Child Protection Conferences by key professionals. The table below shows *where Chairs had concerns* about attendance, the percentage spread across key professional groups.



Percentage distribution, where the Child Protection Chair noted absence

Safeguarding Children

What difference has it made?

Police: Attendance at Child Protection Conferences has improved significantly following the introduction of a dedicated team of Safeguarding Officers who aim to attend all Initial Child Protection Conferences.

Education Settings: The GSCB looked to address this by asking the Education and Learning Sub Group for views on how best to ensure attendance. Schools responded advising that sometimes Initial Conference are held within the school holidays, and so they are not aware of them prior to the end of term. However, they also stated that because invitations are sent through the postal system, sometimes invitations arrive following the date of the Child Protection Conference and attendance is missed.

To address this, the GSCB supported improvement to the use of secure encrypted e mail for invitations and minutes. Plans have been agreed and the effect will be monitored over the next 12 months.

The importance of attendance at Child Protection Conferences was included within the 8 Designated Child Protection Officer (DCPO) Forums across the County. Section 175 (Education Act 2002) Audits sent out to all schools annually, this year also included a question to help reinforce schools' understanding of the number of Conferences they were required to attend and the actual number attended by staff at the school.

Health Settings: A similar improved use of secure e mail information sharing will also be introduced first for GPs and then other settings, to help resolve concerns.

The number of Conferences being cancelled due to them being inquorate has reduced this year from last but still requires careful monitoring.

Timeliness of Conferences

By the end of the business year the percentage of Child Protection Conferences held within statutory timescales had dropped significantly to 44.5%, compared to 82% the previous year. The GSCB rigorously checked and challenged this. It found that at the same time as the steady rise in numbers of Conferences to hold, the team of Child Protection Chairs has had significant staffing issues coupled with conferences moved to fit court proceedings or moving conferences to fit around family need. The GSCB sought assurance that risks were being managed. It has commended the systems in place to risk assess delays:

- The number of Conferences held within timescales is reported as part of the regular Performance Report to each Executive and Board meeting.
- At case level the Child Protection Conference Chairs manage risk in discussion with the Social Care Team Manager, making sure that children most at risk are being prioritised.
- Meanwhile Conference Chairs continue to monitor the quality of multi agency work within the child protection process through the Standards Checklist completed after every conference.
- Capacity is being addressed through recruitment of another 2 Full Time Chairs to work across the Independent Reviewing and Child Protection Conference processes.

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2.3 Promoting the welfare of vulnerable children

Following the introduction of the new Request for Service form in 2011, examples of good practice have been provided to professionals across agencies to support practice.

The GSCB has endorsed the partnership approach brought about by Locality Teams across the County, this year developed into the Targeted Support teams. These have a range of roles including CAF Coordinators, Family Support Workers, Lead Professionals for Disabled Children, Community Social Workers and Educational Psychologists (co-located). The teams work in close partnership with all partners to identify children who require early help and to provide support, in line with the Gloucestershire response to the Munro recommendations.

As a further development, each Targeted Support Team now has a Community Social Worker. These are qualified and experienced social workers who work in partnership with professionals in the community, enabling them to feel more confident in their role. The Community Social Workers offer professionals from a wide range of agencies advice and guidance, particularly around assessing and managing low level risk in the community and preventing the needs of children and young people from escalating.

Being based locally has meant that staff and services are better placed to recognise and respond to local needs, are part of the community, and act as a focal point for co-ordinating support for the most vulnerable. The teams also help to support social care cases that no longer require acute services.

This year the Forums for Designated Child Protection Officers (DCPOs) within schools, including Academies, Independent Schools and Special Schools concentrated on partnership working with the Targeted Support teams and Community Social Workers. They invited each Team to send a representative to support working with schools.

Last year, the GSCB recognised the promising start to improving recognition of children who might be at risk at an earlier stage, but also felt that we should not be complacent and that change would need constant reinforcing. Building on the work of last year when Board members visited their front line practitioners to see how the new arrangements were working, Board Members this year assisted with presentations at the GSCB Road Shows, attended by over 450 professionals from a wide variety of agencies. During the Road Shows support for partners to aid understanding of early help and locality working was provided, including case studies of families needing help and a chance to use the Levels of Intervention guidance and tools.

What difference has it made?

A sample of feedback from participants feedback was analysed by the GSCB Business Unit. 98% said that their understanding of Munro report themes including Early Help had increased. Comments included:

"I have a much greater understanding of what signs to look out for in a YP living in a home where there is substance abuse and why early help is so important" (Early Years Setting).

"I would consider substance misuse as a possible factor in a child's presentation at secondary healthcare" (Health Setting)

"Sharing info with colleagues and reviewing our policies and procedures will now be a priority" (Housing Group)

Children in Care

All children in care (looked after children) in Gloucestershire have an allocated Social Worker responsible for their safety and wellbeing. Their work is closely monitored by operational managers through supervision and regular audits of case records. The Local Authority acts as Corporate Parent to children in care and is responsible for their safety, and a Corporate Parenting Committee made up of local councillors oversees that the local authority is fulfilling its responsibilities.

Independent Reviewing Officers make sure that appropriate care plans are in place for

children in care. They chair regular review meetings involving the child and significant adults in their lives, as well as monitoring the case in between reviews. Safeguarding needs are scrutinised and any drift challenged through this care planning and review process.

The GSCB received an annual report from the Manager of Independent Reviewing Officers at the beginning of 2012/13. The GSCB examined a number of safeguarding challenges raised during the year that had successfully addressed. The GSCB was concerned about slow progress through care proceedings, but reasonably assured that children in care were being adequately safeguarded. This assessment was supported by a multi agency audit checking safeguarding issues for a sample of looked after children.

By the end of 2012/13 there were 535 children in care. This was just over a 16% increase on numbers the previous year. This means that the rate of children in care is 43 out of every 10,000 of the population of children and young people in Gloucestershire. The increased rate has been a challenge for social care teams and Independent Reviewing Officers, but is nevertheless still substantially lower than the national average of 59 per 10,000.

Two indicators are particularly linked to safeguarding children in care; age, and stability of placement.

- The GSCB notes that 67% of children in care were under 10 years old, with 45% being under school age. This reflects an increased tendency towards earlier intervention where abuse and neglect has been identified, and more decisive planning.

- As for placement stability, children in care who have had three or more placements during the year is not routinely monitored by the GSCB, only through the end of year report. This needs to be put right in 2013/14.

No safeguarding challenges were formally raised by Independent Reviewing Officers with the Director of Children's Services, CAFCASS, or brought to the attention of the GSCB during this year. However a number of informal challenges were raised and addressed with team and operational managers. The Manager of the Independent Reviewing Team has been asked to present their annual report to the GSCB for discussion of any safeguarding themes and patterns, as soon as it is available.

In response to the rise in children in care as well as those subject of a child protection plan, a consultation with staff has resulted in a restructure, in which the Independent Review and Child Protection teams will be co-located. The 2 full time Chairs currently being recruited will work across both functions.

Privately Fostered Children

The GSCB recognise that privately fostered children are a diverse and potentially vulnerable group. They include children who are placed with friends or family because of work or study commitments, teenagers staying with friends having fallen out with their family, children who stay with families to attend schools away from their homes, and children whose parents are overseas.

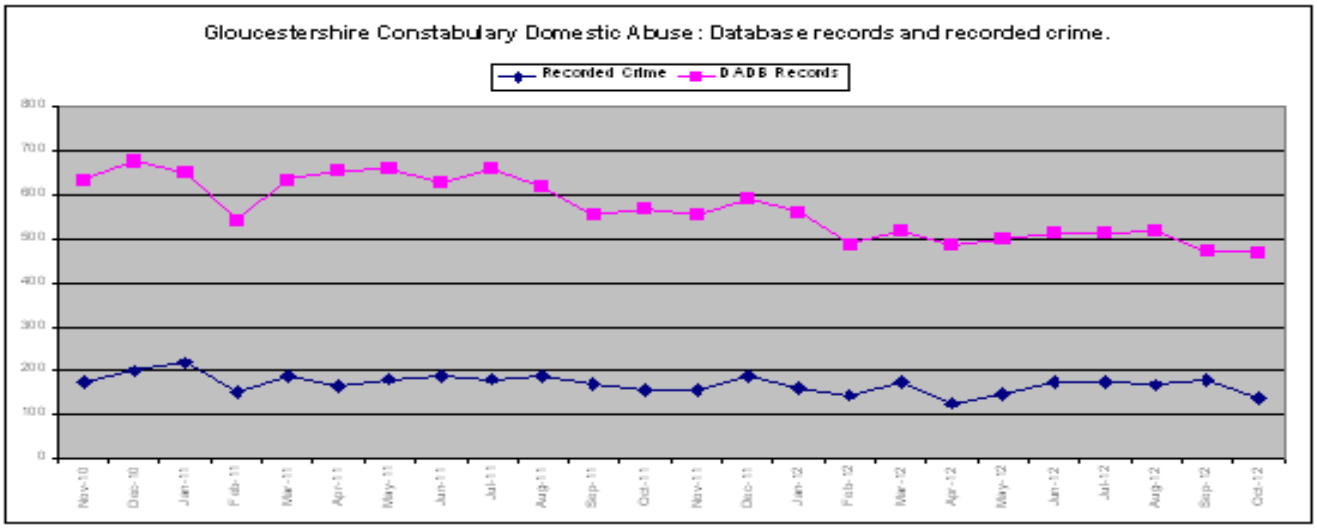
The GSCB is satisfied that the Local Authority is meeting its responsibilities under the *Children (Private Arrangements for Fostering) Regulations 2005*. However, more could be done to build on the good work in promoting awareness in the local community of the need to notify the Local Authority when a Private Fostering arrangement is planned. The GSCB recognises it has a key role in helping to protect children who are privately fostered and raise awareness in the community. It includes information about private fostering on its website and scrutinises a report each year.

The GSCB notes that during last year, there were 51 notifications of new Private Fostering arrangements within the County and a total of 42 such arrangements known to the County Council Fostering Service at the end of March 2013. This is no significant increase in the number of new notifications from the previous year, though national figures show a slow but steady year on year increase.

Children and Domestic Abuse

In Gloucestershire schools, the On-Line Pupil Survey this year found that 6% of Children and Young People reported they witness domestic abuse and violence either daily or weekly. While this is a concern, it is half of last year's figure of 12%.

Over the last 12 months, Gloucestershire Constabulary has recorded 6,194 incidents onto the Domestic Abuse database. This is a fall in the level of reports compared to the previous 12 month period, with 17% (1,295) fewer reports being made. As illustrated on the graph below, the reduction in reports made fell gradually until February 2012 and since then has been stable at a level of approximately 500 incident/reports per month.



There is a peak in the number of women victims of domestic abuse between the ages of 15 and 30 years. Over the last few years there has been a significant decrease in domestic abuse incidents reported to the police where Children and Young People were within the household.

The GSCB welcomed the work of the Gloucestershire Domestic Abuse Support Service (GDASS), which had been contracted since July 2012 to provide countywide specialist support services to victims of domestic abuse. The service provides outreach support, group-work programmes, telephone support, an Independent Domestic Violence Advisor service and access to 'places of safety'/emergency accommodation for victims fleeing from domestic abuse. It was unfortunate that in November 2012, the lead provider of the consortium went into administration, therefore the contract is out for re-tender at time of writing.

The GSCB endorsed the investment in the last year, for the first time in Gloucestershire, in domestic abuse perpetrator interventions. One intervention was piloted with a small group of men in Cheltenham, working with them for 12 consecutive weeks on a one to one basis. The pilot found that this particular programme did have some positive impact on behaviour, however there was only a 50% completion rate. Another pilot involved a number of men being referred to attend the Integrated Domestic Abuse Programme (IDAP), a court mandated programme for those convicted of a domestic abuse offence, however the pilot is for a sample of non-convicted perpetrators to attend the programme with convicted individuals. This pilot is ongoing.

The last pilot which the County has invested in is a Voluntary Community Group Programme for male perpetrators of domestic abuse. The GSCB notes that this is a model delivered in Wiltshire and other surrounding areas, but is currently in its infancy in Gloucestershire so it is too early to evaluate.

The Multi Agency Risk Assessment Conference (MARAC) process involves discussion of high risk cases of domestic abuse in Gloucestershire, to ensure that the victims and their children are safeguarded from serious harm and homicide. The GSCB notes that partner agencies are highly committed to this process and the concept of early intervention. Continuous improvement is required. The process is currently being revised to consider how best support can be offered to safeguard the victim and children as soon as a case is identified as high risk.

GSCB Task and Finish Groups had been formed in 2011/12 to support Children and Young People who experience or witness Domestic Abuse, and this work has been build on during 2012/13:

A pilot programme supporting seven children aged between 8 and 11 whose parents were victims of Domestic Abuse ended in December 2011. Their mothers were also supported as part of this programme through a specially tailored mother's group. The facilitators for both groups were from a range of agencies including the voluntary and community sector; Youth Services; Locality Teams; and Local Authority Children Centre staff.

An educational resource pack for secondary school teachers has been developed and shared, to use as part of PSHE lessons addressing **Domestic Abuse and Honour Based Violence.** Put together by a range of professionals including a teacher, youth worker and voluntary and community sector workers, the pack includes local and national statistics on domestic abuse; a robust lesson plan; handouts; and a list of support agencies that can assist teachers and support staff. The pack was piloted in the summer term of 2012 at six secondary schools with the help of professionals working in the field of domestic abuse and honour based violence.

What difference did this make?

Use of the resource pack was felt to be effective by the piloting schools and pupils, was endorsed by the GSCB Education and Learning Sub Group and endorsed by the GSCB Executive. The toolkit is therefore being rolled out to all schools.

The programme supporting 7 children was evaluated by the GSCB Executive, but despite feedback being very positive, it felt a wider scoping using a higher number of children should be carried out. This is now underway.

Child Sexual Exploitation

The GSCB continues to "lift the stone" on child sexual exploitation (CSE), by publicising the issue and seeking to establish the scope of the problem. A Constabulary Crime Analyst has completed the first analytical assessment of CSE in Gloucestershire. This was shared across agencies to better inform those who work with children and young people. To the same end, the GSCB developed a training programme around the risk indicators of sexual exploitation and the response to it. This has so far been delivered to 200 professionals from a range of settings across Gloucestershire.

The GSCB has also established a multi-agency protocol in respect of Child Sexual Exploitation, setting out responsibilities of each agency in relation to this issue.

The Child Sexual Exploitation Protocol is firmly based on three strands of a child-centred approach;
- a shared responsibility
- recognising criminality
- early proactive intervention.

The protocol was launched at a major countywide CSE Conference attended by 250 professionals who work with young people on a daily basis. Building on the CSE Referral Pilot of 2011/12, the protocol consolidates the Risk Assessment and Referral Process in respect of CSE as 'business as usual.'

The number of referrals through the newly launched CSE referral process will now form part of the Performance Report to each GSCB Executive and full Board meetings.

In order to help young people to be aware of and understand the threat posed by sexual exploitation, the GSCB also commissioned a series of performances of *"Chelsea's Choice",* which is an interactive Theatre Production performed by young actors within schools.

What difference has it made?

Over 9,000 young people saw this production. The feedback showed:

- 98% of young people said they now have a better understanding of the issues surrounding CSE and the different forms that it can take

- 97% said they now have a better understanding of 'The Grooming Process'

- 96% said they now have a better understanding of safe internet use 96%.

- 97% said they have a better understanding of what a healthy relationship should be.

- 99% said they are now aware of what they could do and who they could contact should they or a friend encounter similar situations to those covered in the production.

The GSCB firmly hopes the theatre production will continue to be rolled out to next year's Year 8 pupils through their educational setting.

In 2013/14 work will also be done with venues where staff may see the signs of CSE, so that all opportunities are taken to prevent it.

Children who go Missing

From 1 April 2012 to 31st December 2012, there were 105 children who ran away and went missing for longer than 18 hours. This is an increase from 2011.

The GSCB knows that when a child or young person runs away and goes missing, this can be indescribably worrying for parents or carers. It recognises that prompt and well coordinated actions by safeguarding partners is essential. To support this,

- The **Child Sexual Exploitation and Missing Children Sub Group** launched a joint protocol between the Police and the County Council for Children who Go Missing. This was widely disseminated to professionals from all agencies. Representation on this sub group includes that of ASTRA (Alternative Solutions to Running Away), which operates from within the Youth Support Services, and continues to work with the police to minimise harm to those children who have been frequently running away.

- **Frontline police officers** received updated training on Missing Person Investigations and the Constabulary introduced a specialist role for 'Lost Person Search Managers'. These Officers provide immediate advice on searching for missing people, to maximise chances of locating people shortly after they have gone missing. The GSCB endorses their availability 24 hours a day, 365 days a year.

What difference has it made?

Gloucestershire Police have confirmed that the immediate safety for all missing children is checked as soon as they are found. There are no cases of children that have gone missing during the past year who have not now been safely found.

However, the GSCB has identified it would like to investigate deeper into the quality and effectiveness of "Return Interviews", above and beyond police safe and well checks. With this in mind, its Multi Agency Quality Assurance Sub Group will audit a sample cases in 2013/14 in a way that includes feedback from a range of practitioners, families and young people.

In the year ahead further analytical work will be undertaken to establish the existence and nature of any links between children going missing in the county and being sexually exploited. Also, the Association of Chief Police Officers (ACPO) has recently introduced a new definition for missing people which distinguishes between those who are missing

and those who are 'absent'. Whilst this change is a national one, all agencies in the county will be working together before any changes are implemented to ensure that all children in the county are kept safe and not inappropriately classified.

Safeguarding Disabled Children

It is estimated that children and young people under the age of 19 with a disability or long term illness account for about 4% of all under 19s in Gloucestershire.
(Joint Strategic Needs Analysis 2012)

The GSCB is aware that most disabled children and their families in Gloucestershire receive good multi-agency early support. In most cases, early support is well coordinated and plays a valuable role in tackling early emerging safeguarding concerns. Disabled children and their families have access to a range of support services including parenting support, short breaks and accessible activities.

When disabled children *do* become subject to child protection plans, effective action is taken to reduce risks and in the majority of cases children made good progress.

However, the GSCB was concerned that there appears to be a disproportionately low percentage of disabled children recognised through the child protection planning process. The GSCB decided a deeper understanding of this was required locally in response to national research which suggests that disabled children, sadly, are more likely to be abused than children without disabilities, yet they are less likely than other children to be subject of child protection plans.

The GSCB welcomed the Ofsted national report *"Protecting disabled children: thematic inspection report August 2012"*. The GSCB responded to the Ofsted call on Local Authorities and Safeguarding Children Boards to make sure thresholds for child protection are well understood and rigorously applied in work with disabled children, and to establish robust systems to assess and evaluate the quality and impact of professionals' work with them.

The GSCB therefore contributed to and endorsed Gloucestershire's *Safeguarding Disabled Children Action Plan*, which is firmly rooted in the findings of the national report. GSCB actions in the local plan are embedded in the GSCB Annual Business Plan 2013/14.

Children affected by Parental Substance Misuse

The GSCB launched a revised *Countywide Joint Protocol for Parental Substance Misuse and the Impact on Children and Young People.* The original protocol had been launched by Gloucestershire's Hidden Harm Forum in 2010, in response to recommendations from the Government's Hidden Harm Document (2003), National Drug Strategy (2002, 2008), Every Child Matters (2004), Working Together to Safeguard Children (2010) and Hidden Harm (2006)(2007). It was developed for any worker within the local area working with parents or carer's, whose misuse of substances is impacting on children and young people.

The GSCB also launched a new training course addressing young people's substance misuse issues, with a focus on local support services for young people and the referral process. Professionals complete this training before accessing the screening tool used in the referral process.

2.4 Learning from Child Deaths

The Gloucestershire Child Death Overview Panel (CDOP) is accountable to the Gloucestershire Safeguarding Children Board and as such is required to report on its work annually (Working Together 2010).

Gloucestershire has held a CDOP since 1st April 2008. Effective arrangements for a rapid response following an unexpected child death have also been place since that time. The core responsibilities of CDOP are to;

(a) Collect and analyse information about each death with a view to identifying -
- Any case giving rise to the need for a Serious Case Review;
- Any matters of concern affecting the welfare of Children in the area and

- Any wider public health or safety concerns arising from a particular death or from a pattern of deaths.

(b) Put into place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

During the year the panel was notified of a total of 44 deaths. This represents a slightly higher figure to 2011/12.

Schools experiencing the unexpected death of a child or sibling attending their school continue to be signposted to the guidance written on sudden or traumatic death. Feedback from this guidance throughout this year has been good. Head Teachers continue to provide learning points from their own experience which are added to the guidance to aid others in the future.

This year, the role of the Child Death Review Co-ordinator has moved from Health to the GSCB Business Unit. The Co-ordinator is a member of the regional co-ordinators' forum which meets quarterly and shares good practice and learning for an improved service.

2.5 Learning from Serious Case Reviews

During this year there have been no new serious case reviews undertaken by the GSCB.

However, Gloucestershire built on its experience of one of the ways to do a case review through "systems learning", from its involvement in the South West Pilot with the Social Care Institute for Excellence (SCIE).

Case Review One - "Ben and Amy"

Findings from the case study were discussed by the Executive and the full Board, and a Board level 'champion' identified for each Finding. A poster was circulated through GSCB members across their organisations to disseminate the learning, which was also built into GSCB multi agency safeguarding training, published on the GSCB web site, and discussed at the Forums attended by all Designated Child Protection officers from Schools.

The case review provided a fresh and in depth way of exploring the emotional toil of working with chaotic families who have significant and competing needs, and the need for partners to guard against applying layer on layer of services in response to lack of parental change. The systems approach supported healthy questioning about the potential distorted sense of security that can happen if a Child Protection Plan is put in place, and the importance of good quality risk assessments informed by using integrated chronologies.

Crucially, it also led to lots of discussion by practitioners about making sure that partnership work with families is not done in a way that stifles opportunities for shared reflection between professionals.

Those involved in this style of case review saw it as positive, very different from the traditional approach to Serious Case Reviews. Gloucestershire's use of the systems approach to case review went on to feature at a national Conference about Serious Case Reviews, and was included in a SCIE training course.

What difference did it make?

The GSCB put together a "Case Review Response Plan" and the benefits included:

- The Findings were used to strengthen GSCB **Core Standards for Child Protection Conferences.** A check with practitioners from the original case group confirmed that most, but not all core groups are aware of the core standards. Child Protection Chairs are therefore increasing their circulation of the standards. They are included as a priority for communication by the GSCB Communications Sub Group.

- Social Care Team Managers initiate a **reflective multi agency professionals meeting** in all cases where a child has been subject of a Child Protection Plan for 12 months or more. This allows for focus on outcomes and healthy challenge, without taking away from usual engagement work with families.

- The findings informed a **Framework for Safeguarding Practice Reflection** launched by the GSCB**.** This supports professionals to apply outcome focussed critical reflection to the way they think through safeguarding issues and the quality of their practice.

- The case study shaped **Neglect workshops** rolled out to practitioners. This training has received good feedback from practitioners. As a result of the case review and the workshops, Gloucestershire has been recognising and responding much more effectively to chronic neglect cases.

- The GSCB set a clear expectation that each partner agency ensures a **system in place for collating a chronology** and providing it at the **first multi-agency meeting** about a child. Practitioners from the original case group met with GSCB representatives and reported that although fraught with ICT limitations, many are directly improving their practice through sharing chronologies. Child Protection Chairs are sharing good practice and supporting core groups in this.

Case Review Two - "Beth"

Meanwhile, a child's case was identified for a second systems review, and was completed using the SCIE methodology. The experience of practitioners was again that the shared learning starts right at the beginning of the process. The GSCB is in the process of formulating its Response Plan.

Serious Case Reviews: Planning Ahead

This year, the Serious Case Review Sub Group of the GSCB has been reinstated, where its role had previously been held by the GSCB Executive, in order to align with the work of the GSAB. This work is in its infancy but both Boards recognise it has the potential for work involving the family unit in ways that have not been the case before. The Sub Group will report regularly to the GSCB Executive to ensure ownership at senior level of any recommendations which are made.

Last year, the Board reported that it found the approach to Serious Case Reviews in Working Together 2010 both cumbersome and restrictive. The publication of *Working Together 2013* in April 2013 has made it possible for Safeguarding Children Boards to choose the method of review when a case meets the criteria for a Serious Case Review. The decision on whether to undertake such a review remains with the Independent Chair, but the creation of a quality assurance group for Independent Chairs means peer challenge and an overview for Local Authorities.

At the end of the year, the Sub Group advised the Independent Chair of a case that should be scrutinised as a Serious Case Review. The planning stage has just been completed, with the GSCB trialling another systems model, to expand local knowledge in applying different methods of case review. This method is called the Serious Incident Learning Process (SILP)

2.6 Monitoring and Developing a Safe Workforce

A Safe Work Force

GSCB highlighted the need for practitioners to be clear on policy for acceptable use of the internet, mobile phones and memory sticks. It ensured that this was raised in training, at forums and the GSCB Road Shows.

This year, the GSCB has also looked at the requirement for practitioners to have systems in place for robust Safeguarding Practice Reflection. As already noted in the section on case reviews, this was recognised as good practice following the recent SCIE Review.

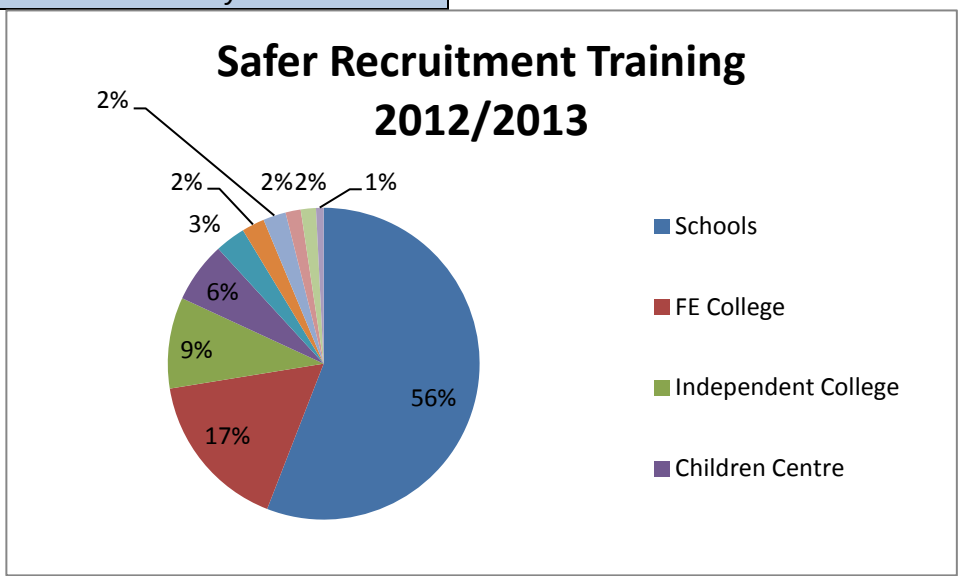
Professor Munro emphasised the need to build on working together by ‘sharing the lessons and reducing the risk’. As a result, in Gloucestershire “Professional Reflective meetings” are encouraged for cases where a child has been subject to a child protection plan for over 12 months, but not exclusively; it is also recommended for use in any case where professionals feel ‘stuck’.

Safer Recruitment

The GSCB updated its Safer Recruitment Training; continuing from the Road Shows on Safer Workforce last year, this year development of *A Safe Work Force, Safer Recruitment and Allegations Management* training throughout the County.

Between 1st April 2012 and 31st March 2013 the GSCB ran 6 *Safer Recruitment* Courses using Department for Education materials. These were attended by 127 delegates from a wide range of settings. All passed the ongoing assessment to receive the Safer Recruitment Accreditation, which lasts for 5 years.

The graph below shows a breakdown of settings attending the training. Although most are educational, this includes a range of types of setting, such as Independent School, maintained school and Academy, Early Years, Residential Homes and Hospital Education Services. The number of voluntary sector professionals has reduced. However, continued dialogue and anecdotal evidence from the voluntary sector shows that they are undertaking the training on-line, which although difficult to pass, currently remains free of charge.



The DfE course retains the original training materials from 2008 when the course was first run by the National College for School Leadership. As professionals are now renewing their accreditation after the first 5 years, the GSCB has updated the training to take account of changes to the Disclosure and Barring Service (DBS) and Regulated Activities.

Safer Recruitment is publicised during whole school training, on the GSCB website, via Section 175/157 audit and through the Education and Learning Sub Group. However, amendments to the Government Guidance *Safeguarding Children and Safer Recruitment in Education 2007* is currently out for consultation and removes the mandatory requirement for Safer Recruitment training, instead relying on settings to decide whether they require the training to ensure that their processes are robust. This might have an effect on the numbers of professionals seeking to gain the accreditation next year.

Managing allegations against people who work with children

Working Together 2010, Appendix 5 stated that *"LSCBs have a responsibility for ensuring there are effective inter agency procedures in place for dealing with allegations against people who work with children, and monitoring and evaluating the effectiveness of those procedures".* Working Together 2013 retains this responsibility.

The framework for managing cases under Allegations Management procedures is broader than the remit for criminal investigation

or situations where there is reason to believe a child is suffering or likely to suffer significant harm (Sec.47 Children's Act). The procedures also look at allegations that might indicate someone working or volunteering to work with children is unsuitable to do so or, under the new Guidance for Education Staff (2011), those whose behaviour indicates they might pose a risk of harm to children if continuing to work regularly or closely with them.

The Allegations Management process within Gloucestershire is managed through the GSCB Business Unit. The Local Authority Designated Officer (LADO) for Gloucestershire is also the Safeguarding Children Development Officer (education) and the post is funded by Gloucestershire County Council. The LADO provides advice and guidance in relation to allegations as well as monitoring the progress of cases to ensure they are managed consistently across agencies and private employers and are brought to a close as quickly as possible. *Working Together 2013* also includes the role of the LADO.

Last year, the LADO has managed 240 allegations made between 1st April 2012 and 31st March 2013. Of these 102 met the thresholds from Working Together to Safeguard Children 2010 and a multi agency meeting was called. This compares to 232 allegations made and 112 meeting the thresholds for the same period last year. Similar figures were recorded for 2010/11 so it appears that figures have risen over previous years as the process became established, but have now settled.

There have been several high profile Allegations Management cases within the last 12 months. The system for issuing on demand joint press releases for the Police and Gloucestershire County Council has continued to work well between the LADO, the Child Abuse Investigation Team (CAIT) and their respective press offices to ensure a clear message is given that agencies are working together to safeguard children.

The Gloucestershire LADO has continued to chair the South West LADO Group consisting of LADOs from 13 Local Authorities who have come together since the closing of the Government Office South West. This group looks to ensure a common set of standards is applied across the South West, compares good practice, shares knowledge and resources and assistance with complex cross authority cases. This year, the group have also received direct assistance and information from the Police, Churches Child Protection Services (CCPAS), Cadet Forces Associations on the management of allegations within their services. The group has also followed closely the changes arising from the merging of the Criminal Records Bureau (CRB) and independent Safeguarding Authority (ISA) to form the Disclosure and Barring Service (DBS) and the new definition of a Regulated Activity.
For further information and data about allegations management see **Appendix 5.**

Areas of Planned Further Work

Allegations Management receives referrals from a wide range of agencies and representation at meetings is good. A Social Care representative from locality teams at team Manager or Deputy team manager level attends every meeting, as does a Detective Sergeant from the Child Abuse Investigation Team (CAIT).

This year, the LADO has raised a concern that Employment Law and Child Protection Law do not sit well together. This has resulted in a larger number of employers accepting the resignation of members of staff and then failing to make a decision about what course of action they would have taken had the allegee not resigned. Unfortunately this means fewer referrals to the Independent Safeguarding Authority (recently changed to the Disclousre and Barring Service). This remains a concern because should the allegation not meet the criminal threshold (beyond all reasonable doubt) the person remains at liberty to seek employment elsewhere with no further investigation having been carried out.

LADOs across the South West have also all raised the concern that currently they are being asked to run a dual process under Allegations Management; one for schools and one for other services. The guidance remains different for schools, with no requirement for repeat allegations to be relayed to new empoyers within references. The South West group have raised this with the DfE and the matter has recently been picked up by the Association for Directors of Children's Services (ADCS).

Section 3: What will happen next? Key challenges and priorities

The Challenge to GSCB

The revised *Working Together to Safeguard Children* strengthens the role of the GSCB, in its unique ability to challenge the effectiveness of local services. Yet the GSCB is operating at a time when partners face great challenges in the coming year, with significant budget cuts and major organisational restructures. Despite these changes, agencies in Gloucestershire remain highly committed to improving safeguarding standards. To protect progress made and to build on it, the GSCB challenge is to:

- Deliver more dynamic communications that help local professionals, communities and children
- Meet its statutory safeguarding functions, holding partners to account for work in relation to the help and protection of children
- Make sure quality assurance activity by all partners focuses on the *effectiveness of help provided* and *children and young people's experiences.*

Our priorities for action are set out in the following Business Plan.

Progress will be reviewed by the business meetings of Safeguarding Children Board; reported to the Children's Partnership and the Health and Wellbeing Board; and will be critically appraised in the Annual Report for 2013-2014.

The GSCB will continue to support the Gloucestershire Health and Wellbeing Strategy aims of giving every child the best start in life and helping them to develop well in young adulthood. It will play a full part in delivery of Gloucestershire Children's Partnership actions to keep children safe from injury, exploitation and harm.

The Challenge to Partnerships

Based on the issues raised in this report and its reflections on the year ahead, the GSCB calls on Gloucestershire Children's Partnership and Health and Well Being Board to:

- Continue the focus on early help
- Give professionals scope to exercise their judgment within the complex safeguarding work they do, and to take up opportunities provided by the GSCB to explore further improvements
- Work alongside the GSCB to drive a culture of reflective practice and healthy, outcome focussed challenge.

Gloucestershire Safeguarding Board Annual Business Plan 2013/14

Introduction

This Annual Business Plan needs to be read alongside the Gloucestershire Safeguarding Children Board (GSCB) Annual Report for 2012/13. It has been prepared in the context of Board findings during the year, the Ofsted Inspection of Safeguarding, our Business Development Day and feedback from children and young people. Having made good progress on strategic priorities in year one, this year our strategic priorities are to:

1) Communicate the need to safeguard and promote the welfare of children

2) Ensure Agencies are holding each other to account: Evaluating how well partners are working together to safeguarding children and young people, building on good practice and challenging poor.

3) Ensure the safeguarding needs of particularly vulnerable children and young people are being addressed

4) Ensure that Multi agency learning, as informed by the Systems Approach to Serious Case Reviews, is used to improve working practice and is monitored though Multi Agency Quality Assurance, incorporating priorities 1-3 above.

How our sub–groups will support the achievement of our priorities:-

Each Sub-Group and any Task and Finish Group will have an annual plan of activity, setting out how it will support the Board to achieve the GSCB business plan. Each sub-group will consider the following cross-cutting themes for 2013/4: learning from best practice, partnership links, communication, participation of young people and their families, and equality & diversity. Considering equality and diversity issues is an important part of the sub-groups' support to the Board in evaluating whether access to, and delivery of, child protection services are fair, consistent, reliable and focused on individual outcomes for children and young people, and to challenge discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief.

How We Will Evaluate How Well We Delivered the Plan:-

To manage a well co-ordinated and effective process, our GSCB Executive Committee will monitor progress against achieving the plan. The GSCB Business Unit will provide the framework for monitoring and reporting on sub-group progress and delivery of the business plan. At the end of the year the GSCB will produce a public report that assesses the effectiveness of safeguarding in Gloucestershire and the progress of the Board against this business plan.

Priority 1	Communicate the need to safeguard and promote the welfare of children		
Why is this important?	The job of the GSCB includes making sure that there are clear thresholds, policies and procedures in place for how the different organisations will work together on safeguarding and promoting the welfare of children. It also includes communicating the need to undertake such work.		
What are we going do by the end of the year?	**Evidence that we have achieved this (So What?)**	**By when**	**Lead/ Sub Group**
Monitor Effectiveness of GSCB communications about safeguarding	The GSCB will have tested awareness and understanding of 3 key areas within partner agencies, voluntary sector organisations and the wider public, learning from concerns and highlighting good practice: a) Children who go missing or run away b) Child Sexual Exploitation and c) the work of the Multi Agency Safeguarding Hub	March 2014 Missing Children – Jun 13 CSE – Nov 13 MASH – Feb 14	Cathy Griffiths - MAQuA Sub Group
Engage practitioners, partners and young people in accessible information	The Board will have identified practitioners working on the periphery of safeguarding and engaged them in assisting to develop relevant communications. Children and young people's groups or forums will have been engaged to provide a check on the quality and accessibility of information provided by the Board, including the GSCB website Partners will have provided feedback on the information provided to them by the Board.	Jul 2013 Sept 13 Jan 14	Phil Sullivan - Work Force Development Sub Group Della Price/Phil Sullivan - Participation lead (with Work Force Development Sub Group)
Review the content and quality of safeguarding information in the light of engagement	The Board will have reviewed the information provided by practitioners work on the periphery, partners and children and young people and used it to quality assure safeguarding information provided, linking with GSAB communications where appropriate. This will include: • The GSCB Website and Young People's pages • Publications and Alerts distributed by the Board • Accessibility of policy • Printed and on-line material available to the public The Board will have determined minimum requirement for publicity required for different 'audiences' in different formats.	Oct 2013	Roger Clayton - Communications Sub Group

Develop specific policies where there are gaps in outward facing communications	There will be a clear communications strategy taking account of information from engagement and review which will align communications with the GSAB where possible. Gaps and areas of strength in policy will have been shared with the South West Policy and Procedures (SWPP) group for inclusion in the shared procedures.	December 2013 Jan 14	Roger Clayton - Communications Sub Group Jane Bee – SW PP

Priority 2	**Hold each other to account: Evaluate how well partners are working together to safeguarding children and young people, build on good practice and challenge poor.**		
Why is this important?	It is important to strengthen systems for ensuring quality, both for practice and then for training leading back into practice. In order to drive up standards, partner agencies need to challenge areas of weakness and foster a culture of effective change leading from challenge. At the same time, it is important to share good practice in order for all to build on this, further exposing weaker areas for development.		
What are we going achieve?	**Evidence that we have achieved this (So What?)**	**By When?**	**Lead/ Sub Group**
Monitor Effectiveness of tools to do the job and how well applied using Results Based Accountability (Friedman (2005). *Trying Hard is not Good Enough*. Trafford Publishing)	Quality Assurance of safeguarding training will have confirmed it is to a high standard through positive feedback from course evaluation forms (e.g. monitoring of the training attendance statistics and evaluation feedback of **impact in the workplace**) The arrangements made by all relevant organisations to discharge their **statutory functions under Section 11 of the Children Act 2004**, will have been monitored and evaluated in order to advise the GSCB. The GSCB will have monitored effectiveness of the use of the GSCB Resolution of Professional Disagreements Policy – feeding in learning.	Dec 2013 Nov 2013 Sept 2013	Phil Sullivan/Isobel Dougan - GSCB Business Unit & Workforce Development Sub Group GSCB Business Unit/MAQuA Sub Group Cathy Griffiths/MAQuA Sub Group
Engage practitioners in healthy challenge of each other's practice to drive up standards	Training will have included the importance of challenge, to help ensure it remains part of multi agency culture. Chairs of multi agency meetings will have engaged with attendees, and invite and record healthy challenge which will inform the production of	July 2013 Sept 2013	Phil Sullivan/Isobel Dougan – Workforce Development Sub Group Workforce Development Sub Group and

	robust plans for children and Young People (cross reference; priority 1).		Communications Sub Group.
Review multi agency challenge in key system areas.	• Challenge and results based effectiveness of the Multi-agency Risk Assessment Conference (MARAC) process will have been reviewed in order to evaluate the effectiveness of partnership work, how it interacts with Multi Agency Public Protection Arrangements (MAPPA) and to inform development of the Multi Agency Safeguarding Hub (MASH). • Child Sexual Exploitation (CSE) cases will have been reviewed, building on the launch of the CSE Protocol in Nov 12 and the audit completed in 2012/13, in order to check awareness, practice and impact and report areas of good practice. • The effectiveness and impact of Core Groups will have been reviewed, ensuring that the "Seven Lessons" launched last year are embedding and taking effect.	Report to the GSCB Dec 13 Nov 13 Throughout 2013	Cathy Griffiths/Mark Chicken and the MAQuA Sub Group Cathy Griffiths – MAQuA Sub group Cathy Griffiths – Multi Agency Case Review Sub Group/MAQuA
Develop specific areas where weakness/gaps have been identified in order to effectively challenge, foster change and any share good practice that enables this change.	• Links and healthy challenge between services for Adults and Children to ensure 'family centred' approach will have been evidenced. • ESafety advice will be in place – for children, staff and parents plus raising awareness of the impact on families of adults involved in looking at indecent images of children	Throughout 2013 . Oct 2013	GSCB Executive/GSAB, Communications Group and Serious Case Review Sub Group. Jane Bee/Education and Learning Sub Group.

Priority 3	Ensure the safeguarding needs of particularly vulnerable children and young people are being addressed.		
Why is this important?	All children and young people are vulnerable but particular groups are more so. It is important that these groups are identified and their specific safeguarding needs are addressed using a targeted approach as part of our 3 year plan.		
What are we going achieve?	**How will we know when we have got there? (So What?)**	**By When?**	**Lead/ Sub Group**
Monitor effectiveness of Agencies' ability to identify, communicate with and address the needs of particularly vulnerable groups across a range of specific areas: **Children and YP:** LAC, CWD, BME, Bullied Children, CP Plan, Children we may be missing e.g. those with a parent in prison, Missing Education, EHE. **Areas:** CSE, DA, Substance Misuse	The GSCB will have been assured that the particular needs of the most vulnerable children and young people are being addressed by: • Positive assessment of the impact of LAC Schools Pack & Bullying DVD circulated to all schools in January 13 • Positive feedback from LAC that their voices are heard re areas of placement, gangs/drugs (as raised in the Business Planning Day) • Evidence from the CSE referrals process that the particular needs of the most vulnerable children who are also identified as being at risk of CSE are being addressed • Evidence that the Protocol for Missing Children is embedded and working across agencies. • Evidence that work with Black and Minority Ethnic children & young people are being addressed, with particular reference to the use of the Translation Guidance and work with Faith Groups.	September 2013 Oct 2013 Oct 13 Nov 13 Jun 13 Oct 13	Jane Bee/Education and Learning Head of Children in Care/Workforce Development Sub Group CSE/Missing Children and MAQuA sub groups Cathy Griffiths/MAQuA Sub Group Phil Sullivan/Workforce Development Sub Group
Engagement with the most vulnerable children and young people, routinely asking for their views and listening to them.	Multi Agency Audits will evidence that the views of children and young people are routinely asked for and used to inform actions and outcomes Evidence participation groups will show that LAC, BME, CWD, Children on CP Plans and Bullied Children will have been asked how they are	Throughout the year	Cathy Griffiths/MAQuA Phil Sullivan/Della Price Workforce Development Sub Group

	particularly affected by CSE, DA and Substance Misuse.		
Review outcomes for children improve over time (culture across all orgs)	The GSCB will have reviewed the guidance to working with children with a parent in prison and taken into account issues raised from the closure of Gloucester Prison As part of the MASH development, the GSCB will have reviewed how information about the most vulnerable young people is shared across agencies.	Sep 13 Sep 13	Phil Sullivan/Workforce Development Sub Group Executive/Suzanne Fallon/MASH Development Steering Group
Develop	• The Performance Report to the GSCB will have been developed to include stats evidencing the above and will include figures from a wider cross section of agencies working with children and young people. • The GSCB's approach to case review/QA will have clearly included issues affecting the most vulnerable children and young people, including cross cutting themes of Domestic Abuse, Parental Substance misuse and Child Sexual Exploitation	July 2013 Throughout 2013/14	MAQuA Sub Group

Priority 4	**Ensure that Multi agency learning, as informed by the Systems Approach to Serious Case Reviews, is used to improve working practice and is monitored though Multi Agency Quality Assurance, incorporating priorities 1-3 above.**		
Why is this important?	It is always important to learn from serious incidents. Lessons from Serious Case Reviews can help prevent further incidents. Development of a new systems approach (via SCIE or SILP) enables lessons about process to also be addressed, further strengthening safeguarding procedure and policy.		
What are we going achieve?	**How will we know when we have got there? (So What?)**	**By When?**	**Lead/ Sub Group**
Monitor Effectiveness of the learning from systems reviews using an evidence based process.	• The findings from child deaths will have informed local strategic planning on how best to safeguard and promote the welfare of children. • Learning from a systems approach to Serious Case Reviews will	March 2014 March 2014	Child Death Overview Panel and Serious Case Review Sub Group

	have been disseminated, informed local safeguarding practice and will be monitored via Section 11 Action Plans. • Learning will have been incorporated in Safeguarding Practice Reflection for front line staff working with children and young people across agencies.	March 2014	
Engage with practitioners from every agency involved to form part of Case and Review Groups to look at Multi Agency Systems.	• Information about how Systems Based Reviews differ from SCRs will have been widely disseminated and practitioners will have an understanding of their role. • Completed Review reports will have evidenced how views from front line practitioners working with children have been fully taken into account as part of the review, whether it's SCR or Systems Based.	October 2013 March 2014	Serious Case Review Sub Group
Review	• The Child Death Overview Process and Child Death Review meetings will have reviewed all child deaths in the year and the GSCB will have been made aware of trends and local or National issues. • Learning from local, regional and national CDOP findings will have been disseminated and appropriate action taken within agencies. • The GSCB will have initiated Systems Approach Review or a Serious Case Review where the Working Together requirements to do so are met. If a SCR is undertaken it will have been completed within timescales and complied with Ofsted descriptors and Working Together guidelines.	March 2014 March 2014 March 2014	Child Death Overview Panel and Serious Case Review Sub Group
Develop	• Use of different Systems Based Approaches will have been appropriately tested, as confirmed by the SCR Chair and GSCB • Links between the CDOP and SCR Sub Group will have been developed to evidence clear distinction of role and complimentary functions.	March 2014 October 2013	Child Death Overview Panel and Serious Case Review Sub Group

Appendix 1: GSCB Membership List

2gether NHS Foundation Trust

Action for Children

Barnardos

British Army

Cheltenham Borough Council

Children & Family Court Advisory & Support Service (CAFCASS)

Churches Together in Gloucestershire

Cotswold District Council

County Councillor

Diocese of Gloucester

Forest of Dean District Council

Further Education

Gloucestershire Association of Primary School Heads (GAPH)

Gloucestershire Association of Secondary School Heads (GASH)

Gloucestershire Association of Special Schools Heads (GASSH)

Gloucestershire Care Services NHS Trust

Gloucester City Council

Gloucestershire Clinical Commissioning Group

Gloucestershire Constabulary

Gloucester County Council

Gloucestershire Crown Prosecution Service

Gloucestershire Fire and Rescue Service

Gloucestershire Magistrates Courts Service

Gloucestershire NHS Hospital Foundation Trust

Gloucestershire Probation

Great Western Ambulance Service

Independent Chair

Lay Members x 2

NHS England

Stroud District Council

Voluntary Sector – County Community Project

Appendix 2: Attendance at GSCB Meetings

Attendance at the Board meetings has been monitored though the year. Patterns of attendance at individual Board meetings are shown below:

Attendance at GSCB Board meetings 2012/13

	22.06.2012	21.09.2012	14.12.2012	26.03.2013
Numbers who attended or sent deputies	26	29	29	22
Numbers who did not attend	13	14	16	25
Numbers invited	39	43	45	47

Individual attendance:

Represented at all meetings	Represented at 3 meetings	Represented at 2 meetings	Represented at 1 meeting	Represented at no meetings
10	14	6	8	6

During 2012/13 the method of monitoring attendance has been reviewed to ensure consistency of approach with the Gloucestershire Safeguarding Adults Board.

Appendix 3: The Involvement of Young People in the Work of the GSCB

As a result of young people from Cleeve School attending the GSCB Business Planning Day in January 2012, five participation actions were agreed to progress the way the Board involve CYP and listen to their voice. During the year participation activity has gone from strength to strength.
GSCB members have delivered a presentation to 5 secondary schools to inform students about the role of the safeguarding board and give young people an understanding of the structures and procedures in place to keep CYP in Gloucestershire safe from harm.

Feedback from the students in all 5 schools has been overwhelming positive. They have reported that their knowledge about safeguarding in Gloucestershire had improved as a result of the session and they demonstrated increased knowledge in where they could go for help. Roll out of the project to other schools is being considered by GSCB Participation Champions who will oversee the project.

Two Care Leavers have been working with the Participation Team on a voluntary basis since July 2012 to develop child friendly pages on GSCB website. They have consulted with groups of young people to find out what information would be useful and the style preferred by different age groups. They have also carried out extensive research on other websites to gain a better understanding of what works and what doesn't. The new pages are about to be finalised and will be launched when the GSCB new look website goes live.

The young people from Cleeve School were invited back during the year to meet with the Chair of the Board and the DCS in her role as a GSCB Participation Champion, to discuss the Business Plan that the Board produced, what the Board has done and what it plans to do next.
This year the Business Planning Day was attended by four young people who presented the safety views and concerns of vulnerable children and young people in the form of a DVD. The young people collated safety information from 4 groups of vulnerable children, they were, LAC, children subject to child protection, children known to Barnardo's Advocacy Project and children in receipt of CYPS services. The presentation helped shape the priorities going forward into the Business Plan for 2013-14.

Appendix 4:Training Activity during 2012/13

The GSCB provided the following courses, conferences and locality events between 1st April 2012 and 31st March 2013.

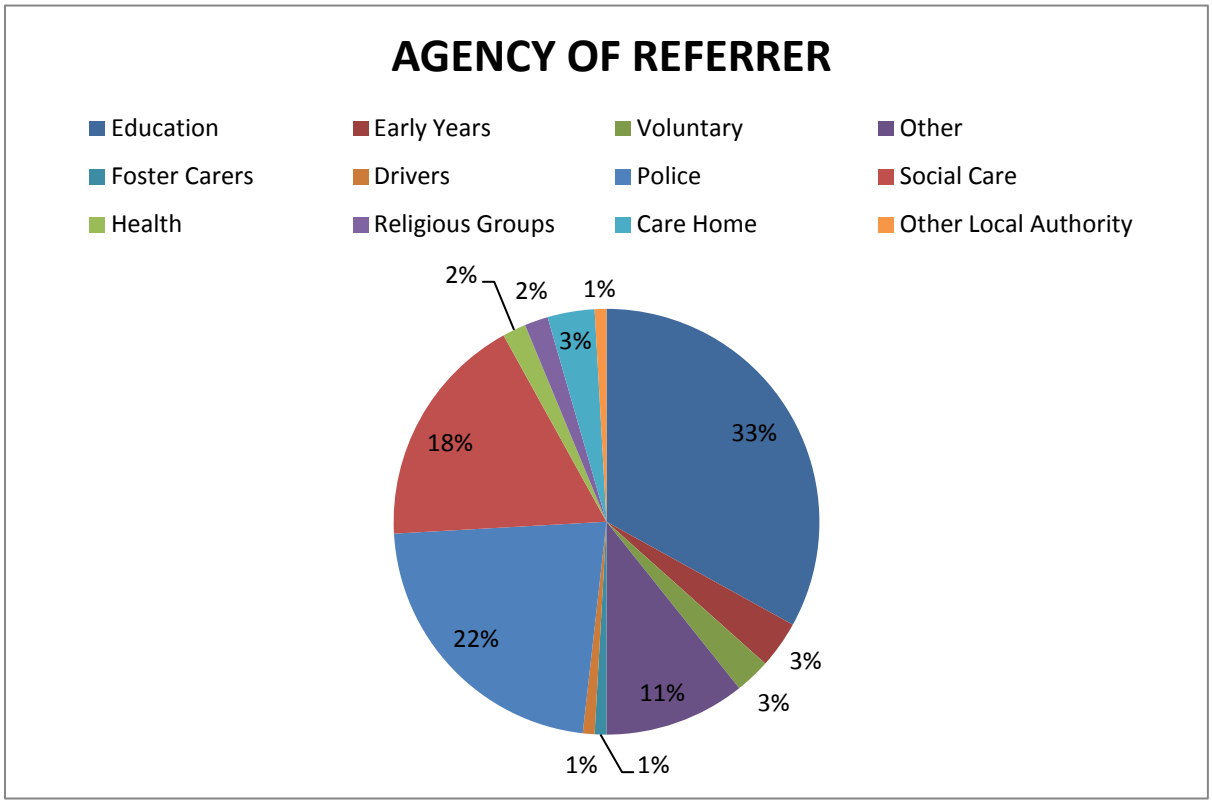
Training Course Name:	**No. of Courses:**	**No. of Delegates:**
Inter-Agency Child Protection *(Inc additional New – courses Sept 12)*	46	903
Revision and Update	26	532
Advanced Practitioner *(New - Sept 12)*	5	101
Child Sexual Exploitation *(New - Sept 12)*	7	150
Children and Young People with Disabilities	2	33
Parental Substance Misuse levels 1, 2, 3	14	231
Domestic Violence levels 1 & 2	16	175
Working Together in Child Protection Conference Groups	4	64
Inter-Agency workshops and Conferences	**No. of Courses:**	**No. of Delegates:**
C&YP – Substance Misuse Screening Tool Training *(New - Dec 12)*	15	238
Safeguarding QA Roadshows *(Nov 12)*	7	450
Child Sexual Exploitation Conference – Launch *(Nov 12)*	1	200
Trainers Information – *Summer 2012* Conference	1	59
Trainers Information – *Spring 2013* Conference	1	130
Neglect Workshops *(New – March 13)*	6	157
Total	**151**	**3423**

Appendix 5: Allegations Management 1 April 2012 – 31 Mar 2013

Who makes the referral?

Referrals to the LADO are recorded by the agency of referrer. The main referrers are shown in Graph A below.

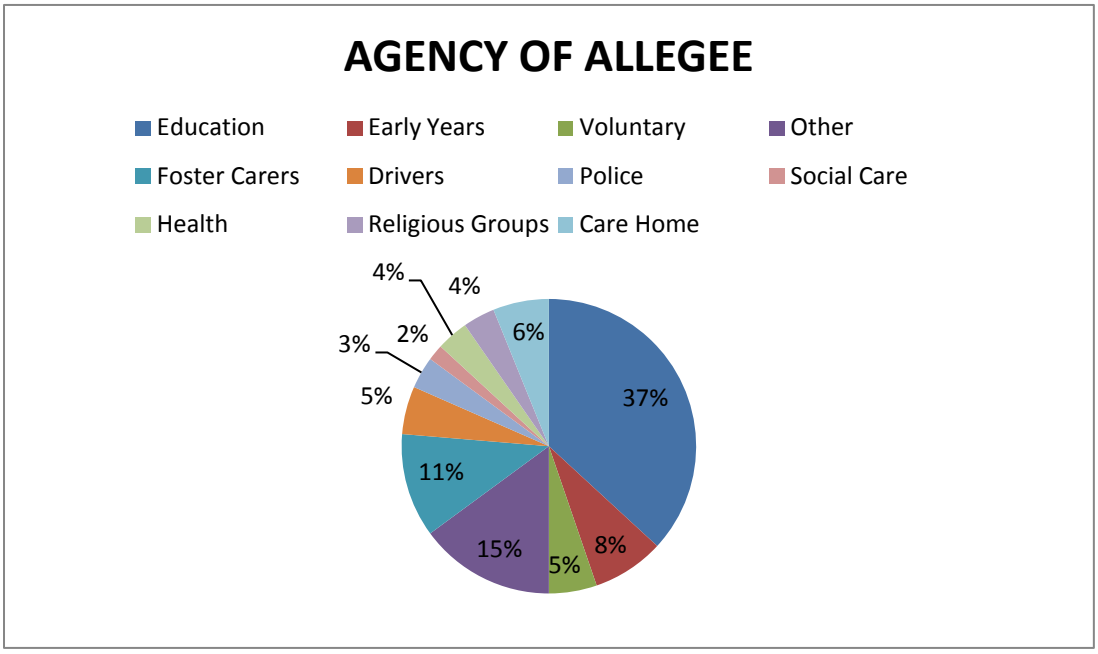
As last year, the majority of referrals come from education, social care and police. However, referrals are also received regularly from other agencies such as taxi and bus companies, religious groups (including non-Christian denominations) and the voluntary sector. Referrals from other local authorities have remained on a par with last year and the previously agreed arrangement within the South West LADO group on managing cross boundary allegations continues to work well. The 'other' category is made up of groups such as the NSPCC, Children's clubs and members of the public.



Which agency does the alleged perpetrator work for?

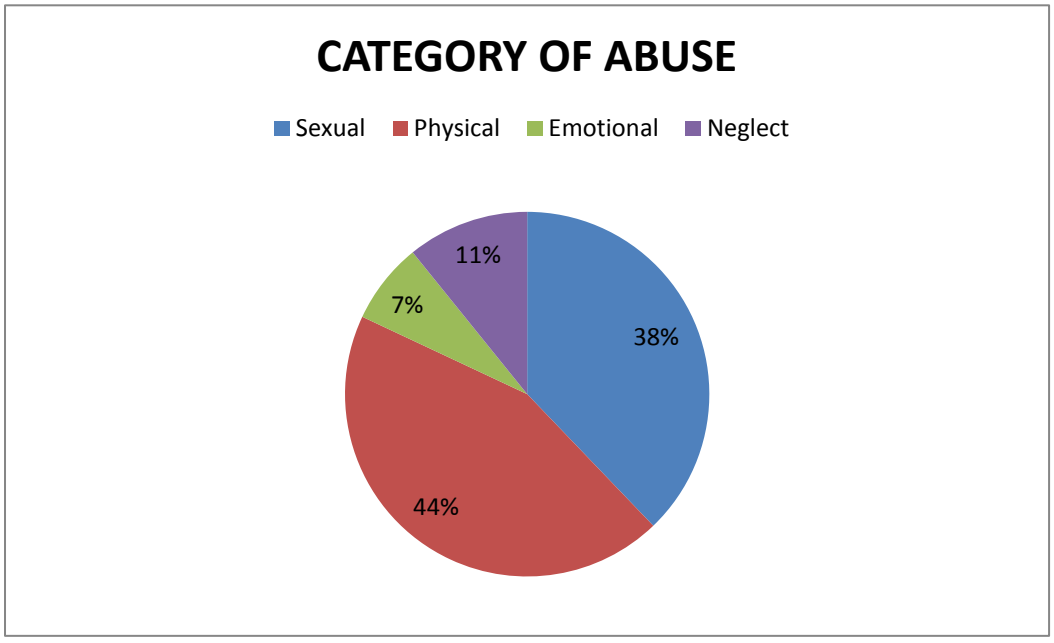
This graph shows the agency of the person the allegation is against. The majority of these continue to be eduation (as Nationally) and foster carers and are mainly physical and sexual abuse allegations. 'Other' agencies are made up of smaller agencies such as boating, riding, dancing and other sports clubs. There has been little increase in the number of allegations against police and health practitioners. The marked increase in allegations reported against staff driving children to and from school has remained at a similar number. The new definition of a

Regulated Activity introduced in September 2012 now includes people driving solely children and this has been welcomed by the LADO.



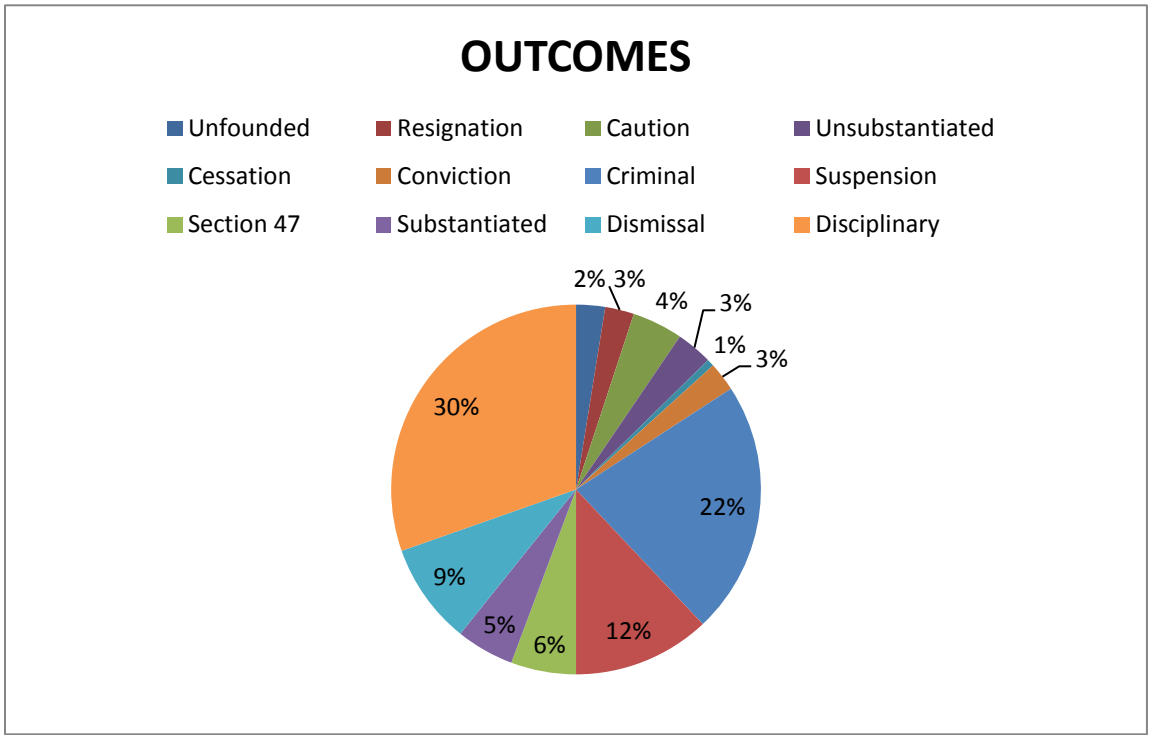
What sort of abuse is alleged?

The categories of abuse recorded are shown in the graph below. This graph shows only those cases that met the Allegations Management criteria (102 cases) the majority of which were physical abuse allegations which is a change from last year where the majority were sexual.



What happened next?

Outcomes for Allegations Management cases that reach the Government threshold are recorded by case. Figures recorded are higher than the actual number of allegations because each case is likely have more than one outcome as it progresses through investigation. For example, a case of sexual abuse may begin as a criminal investigation and suspension, moving through to a disciplinary investigation, dismissal and referral to the Independent Safeguarding Authority (ISA). All outcomes for this case are recorded. Of the 102 cases which met the threshold, 19 remain ongoing at the time of this report. 15 referral were made to the independent Safeguarding Authority because of concerns. The number of cases reaching the thresholds for Allegations Management remains around if not slightly lower than last year, but the complexity of these cases is increasing. This is suggestive a trend of lower numbers overall but of more concerning allegations and fewer low level concerns.



Appendix 6: Jargon Buster

CAIT- Child Abuse Investigation Team

CDOP - Child Death Overview Panel. This panel undertakes a review of all child deaths within the county (excluding still born babies and planned terminations) so that information about child deaths can be collected and learned from.

CEOP - Child Exploitation and Online Protection Centre

CWDC - The Children's Workforce Development Council is responsible for defining the training requirements and qualifications necessary for early years practitioners (Disbanded as of 1.4.12, most responsibilities now fall to the Department for Education).

GCC - Gloucestershire County Council.

GSAB – Gloucestershire Safeguarding Adults Board.

IRO - Independent Reviewing Officer.

LAC- Looked After Child.

LADO - Local Authority Designated Officer. The role of the LADO is to provide advice and guidance and to manage allegations against people who work with children.

LSCBs - Local Safeguarding Children Boards.

MAPPA - Multi-Agency Public Protection Arrangements. These arrangements are in place to manage the risks posed by sexual and violent offenders living in the community. MAPPA's role is to:

- Protect victims and potential victims
- Identify individuals who may pose a risk of harm
- Share relevant information about them
- Assess the nature and extent of that risk
- Find ways to manage that risk effectively

The Authority Responsible for MAPPA includes members of the Police, Probation and Prison Services.

MAQUA sub group – Multi-Agency Quality Assurance sub group. This sub group is responsible for revising and stream lining current policy and procedure to ensure quality and efficiency.

MARAC - Multi –Agency Risk Assessment Conference. The focus of this Conference is protection of high risk adult victims of Domestic Abuse and their children. It is a conference to share information and increase the safety of victims of Domestic Abuse and their families. MARAC looks at the highest risk domestic abuse cases and constructs risk management plans that provide professional support to those at risk, to reduce the risk and reduce repeat victimisation.

The Munro Report – Commissioned in 2010 this report sets out reform proposals intended to improve the ability of professionals to make best judgements with regard to children and safeguarding.

SCIE (Social Care Institute for Excellence) and Systems based learning. SCIE presents a "systems" model for undertaking Serious Case Reviews. This approach focuses on why actions or decisions, which later turn out to be mistaken, are made and appear to be rational and sensible at the time. This model hopes to generate new ideas of how to improve practice.

SCR - A Serious Case Review is conducted when a child dies or sustains a potentially life threatening injury (or serious impairment) as a result of suspected abuse or neglect. The purpose of the SCR is to ascertain whether any lessons can be learnt with regard to safeguarding children and interagency working. A SCR may also be conducted if a child has undergone serious sexual abuse or a parent has been murdered and a homicide review is undertaken.

Task and Finish Groups are established to report on, develop and drive forward particular areas of safeguarding which have been highlighted by GSCB.