

# annual report 2015-16



May 2016

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[safeguardingchildrenbarnsley.com](http://safeguardingchildrenbarnsley.com)

## Chair's foreword

I am pleased to introduce the Annual Report of the Barnsley Safeguarding Children Board (BSCB) for 2015/16.

Over the last financial year the board has continued to play a significant role in ensuring that improvements continue to be made to the arrangements for safeguarding children and young people in the Borough.

The board plays a significant role in monitoring the Continuous Service Improvement Plan that arose from the Ofsted Inspection in 2012 and is regularly reviewed to ensure it keeps pace with the changing environment. The plan features at every board meeting with members being encouraged to appropriately challenge, to identify new issues for the plan and to be satisfied that the intended action has been taken. The plan is a living document that has had many new actions added as the service and the board moves forward towards 'Good' and beyond. I have attended the Officer Improvement Group which drives the actions and I am satisfied that it is a robust process. I consider the Continuous Improvement Plan to be an area of good practice which BMBC and the public can take confidence in.

The board has had an impact in many other areas including:

- The creation of a task and finish group to explore the issues related to Female Genital Mutilation (FGM). This followed it being established that six patients in the Barnsley Hospital Maternity Unit had been found to have been the victims of FGM. The task and finish group developed a strategy and procedures. Subsequent audit of cases has found that the procedures had been followed in all cases.
- The board and Barnsley Metropolitan Borough Council submitted a joint letter to the Department for Education expressing our shared concerns at the current policies associated with Home Education. There has been a marked increase in the number of children being removed from mainstream schooling to be educated at home. Whilst the board fully appreciates that many of those will be receiving a full and planned education we are concerned that there are insufficient checks and balances to ensure that applies to all children and that they are being appropriately safeguarded.
- The board, and its members, signed up to a new county wide procedure dealing with the issue of children who go missing or absent. This gives much clearer instruction and guidance as to the action to be taken when reports are received.
- Child Sexual Exploitation (CSE) continues to be a priority for the board. During the year the CSE Strategy was revised and the action plan updated. More recently a new CSE Assessment Tool has been approved by the board.
- A Communications Strategy has been developed which will see much more information being proactively shared with the public, staff and other stakeholders. We believe that it is important that we continue to send out the message that Safeguarding is everyone's business.
- We continue to have a highly regarded training programme that delivers a wide range of training to individuals working with Children and Young People. The evaluation of courses is very positive.

- The board has continued to receive comprehensive performance data and has demonstrated that it is prepared to challenge when there are identified areas of concern. Many performance indicators have shown an improvement during the year.
- The board, and its partners, has signed up to changes in working practices at the front door of Children Social Care, the point where professionals and the public report any concerns. This has resulted in a significant reduction in the number of concerns being recorded which has allowed resources to be better targeted at those children, and families, that are in need of support. The number of children on Child Protection Plans has increased from 332 to 422 over the year which is seen as evidence that thresholds to access services are being applied more effectively.

During the year the board published three Serious Case Reviews; more details can be found on page 44 of this report. The cases were all published on the board's web site,

<https://www.safeguardingchildrenbarnsley.com/>

Last year, I expressed concern and disappointment at the reduced level of safeguarding self-assessments received from schools. I am pleased to be able to report a 100% return this year. The board recognises the hugely important role that schools play in the lives of children and young people including the vital role they have in safeguarding. It is therefore reassuring to get a full return.

Looking forward, we will see the establishment of a Multi-Agency Safeguarding Hub (MASH) during the

summer of 2016. This will see staff from a range of agencies including Police Officers, Social Workers and Health staff working in the same building. This will be to the benefit of children and case management as they will be able to better share information and make joint decisions on actions to be taken.

In conclusion, I am satisfied that the board and its member organisations consistently demonstrate their commitment to keeping children and young people safe.

Bob Dyson QPM,DL  
Independent Chair, Barnsley Safeguarding Children Board.

## Introduction and local safeguarding context

Barnsley Safeguarding Children Board comprises of representatives from a range of statutory partners, who are passionate about promoting the safeguarding and welfare of local children, young people and families in Barnsley.

Our vision is that:

*Every child and young person should be able to grow up safe from maltreatment, neglect, accidental injury/death, bullying and discrimination, crime and anti-social behaviour.*

*Children are entitled to a strong commitment from the BSCB and its constituent agencies to ensure that they are safeguarded. Where possible, this will be done in partnership with parents and carers, and by engaging the active support of the public. We will do as much as we can within the resources available to us and, with every agency providing services, we can maintain an inter-agency safeguarding system directed at safeguarding and promoting the welfare of all Barnsley's children.*

*We will endeavour to ensure that every child is safe, well cared for and thereby supported to fulfil their potential to make the transition from childhood to adulthood.*

The board's prime responsibilities are:

- To co-ordinate what is done by each person or body represented on the board for the purpose of safeguarding

and promoting the welfare of children in the area, and

- To ensure the effectiveness of what is done by each person or body for that purpose.

The board oversees work undertaken by partners to provide integrated services for children and families, with particular focus on safeguarding and promoting the welfare of children and young people.

This Annual Report provides:

- An outline of the main activities and achievements of the Barnsley Safeguarding Children Board during 2015 and 2016.
- An assessment of the effectiveness of safeguarding activity in Barnsley.
- An overview of how well children are safeguarded in Barnsley.
- Ambitions for future service developments and identification of key priorities.

## Early Help and Family Centres

The emphasis of the work undertaken by the board and partners continues to move towards effective early intervention and prevention. Early Help services in Barnsley form part of the continuum of help and support to respond to the different levels of need of children and families. The way practitioners work together, share information, put the child and family at the centre, move swiftly to provide effective support to help them solve their problems and find solutions at an early stage is at the heart of a strong Early Help approach.

It is recognised that Early Help is everyone's responsibility across the partnership. There is commitment at all levels to work more closely together to build upon what we do for and offer to children and families. The focus of the work over the last period has been to

strengthen understanding of the approach across the partnership ensuring that the shift to Early Help is embedded and is sustainable. Barnsley's whole family approach to working with families continues with the implementation of the Early Help Assessment.

Family Centres deliver integrated services for children pre-birth up to 19 years (or 25 years if the young person has a disability) offering a variety of provision according to the needs of local families. Family Centres bring together practitioners from a range of universal, targeted and specialist services in each local area including schools, police, social care, private and voluntary sector and some adult services. Services delivered will vary in each area depending on the needs of families and the wider community.

Early help services are co-ordinated and delivered through Family Centres and:

- Support children to be ready for school and thrive in school
- Support parents and carers to develop their parenting skills
- Support parents and carers to develop personal skills, access training and education and enhance their ability to access employment
- Support parents and carers to keep children safe
- Help children to achieve their full potential and reduce inequalities in their health and development
- Support the development of healthy lifestyles for children
- Support families to build their own resilience

Services for adults play an essential role in our early help approach as these can impact on adults parenting capacity and family life. Some adults have additional needs which can impact negatively on family life if not supported. Services which

predominantly work with either children and young people or adults need to adopt a 'think family' approach to secure better outcomes for children, young people and families with additional needs, through co-ordinating the support they provide.

### Local relationships

The board is strongly committed to further strengthening its relationship with other strategic partners, including the Children and Young People's Trust Board, the Health and Wellbeing Board and the local strategic partnership, 'One Barnsley'.

The One Barnsley Board, of the Local Strategic Partnership (LSP) is responsible for agreeing the overall strategic direction for achieving the economic and social wellbeing of the Borough, the vision and objectives are outlined in the following two strategies:

- Barnsley Health and Wellbeing Strategy (2013-16) - responsibility for delivery rests with the Barnsley Health and Wellbeing Board
- Barnsley Jobs and Business Growth Plan (2014-17) responsibility delivery with the Barnsley Economic Partnership

The role of the One Barnsley Board is to provide co-ordination and coherence across these two principal partnerships and to challenge partners in both partnerships, ensuring their performance contributes to the successful delivery of outcomes.

To affirm all these relationships, the board has approved a protocol covering governance arrangements and the degree to which they enable partners to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people. The board

also articulates clear improvement priorities in its Business Plan, with actions to accomplish improved outcomes.

A chart of the structural relationship between the BSCB and its strategic partners is shown on page 12.

To ensure effective safeguarding and child protection, the BSCB operates under an up-to-date information sharing agreement to which all partners are signed up, however this policy will need to be reviewed over the course of this year.

### **Local demographic context**

Barnsley is part of a broad South Yorkshire conurbation located around traditional community bases of former mining and market towns. The latest data from the Office for National Statistics (ONS) (2014) shows the population of those under 18 years is approximately 21% of the total population at 49,600 (ONS Mid-Year Estimates 2014) and is expected to increase by approximately 4% by 2020 to 51,700. The predicted population increase has implications for increased demands on all services, including those providing child and family support. The School Census (January 2016) shows that 8.4% of primary school pupils and 6.0% of secondary school pupils are from minority ethnic origins.

Growing Up in the UK report (2013) recognises a link between infant mortality and deprivation; those born to the most deprived parents have a higher infant mortality rate per 1,000 live births compared to babies born to the least deprived. The Public Health Outcomes Framework (2016) shows infant mortality rates at 3.4 deaths per 1,000 live births. This is lower than the regional and national averages of 4.3 and 4.0. The Index of Multiple Deprivation 2015 ranks

Barnsley as the 39th most deprived local authority in England.

Women living in deprived areas are more likely to smoke during pregnancy than their more affluent neighbours (Graham, 2003) with smoking in pregnancy being a major contributor to increased infant mortality in England (Public Health England, 2013). The rate of women smoking during pregnancy in Barnsley is 20.4% of the maternal population; this is higher than regional average of 15.6% and national average of 11.4% (Public Health Outcomes Framework 2016).

In Barnsley, unemployment is higher than national average for those aged 16-64 years; 6.0% compared to 5.1% nationally (Modelled Annual Population Survey, 2015) and the rate of children living in out-of-work benefit claimant households aged under 19 years is 21.5% (Department for Work and Pensions, May 2014 and 2014 Mid-Year Estimates). This is higher than the national rate of 17%. Child poverty in Barnsley is higher than the England average, with 23.8% of Barnsley's children under 16 years living in low income families according to the Children in Low-Income Families Measure (previously the Revised Local Child Poverty Measure or National Indicator) compared with an 18.6% national rate (HMRC, 2013).

The ONS's study into teenage conception rates in England found that rates were highest in the most deprived areas (ONS, 2014). The latest data shows Barnsley's teenage pregnancy rate is 36.3 per 1,000 of the population (ONS, 2014). This is higher than the national and regional averages of 22.8 and 26.4.

Nationally, individuals with a low level of educational attainment are almost five times more likely to live in poverty than those with high levels of education (Household Income and Expenditure



Analysis, ONS, 2014). Although educational attainment continues to improve in Barnsley, results at age 16 remain below the national average in relation to the proportion of children attaining 5 A\* to C grades at key stage 4, including English and Maths (49.6 % compared to 53.8%, Research & Business Intelligence Team, 2015).

Children from deprived backgrounds are more likely to have complicated health histories over the course of their lifetime, including a lower life expectancy; professionals live on average eight years longer than unskilled workers (ONS, 2011). In Barnsley, life expectancy is slightly lower than the national average, with an expectancy of 78.4 for males and 81.8 for females compared to 79.5 and 83.2 nationally (ONS 2012-2014). However, there is a significant inequality in life expectancy across the borough, with those living in the wards with the highest levels of deprivation dying on average 6 years sooner than those in the least deprived wards (Public Health England 2012-2014).

### **Coordinating local work to safeguard and promote the welfare of children**

#### **Governance and accountability**

The Board has six planned business meetings each year, together with additional sessions, to allow time for member development and reflection on specific issues. Special meetings are convened when required, for example to receive the findings from Serious Case Reviews or discuss key member financial contributions.

To promote optimum focus on priority issues, the board revised its sub-committee structure in 2012. These

arrangements were largely retained in 2013-14, 2014 -2015 and 2015 - 16 with the addition of two new sub-groups with direct reporting lines to the board in recognition of emerging priorities relating to child sexual exploitation/missing and services to children with disabilities and complex health needs. The current subcommittee structure will be maintained for 2016/2017. The terms of reference and the membership for each subcommittee will however be reviewed over the course of the year and task and finish groups will be established to help progress some subgroup priorities, for example; Female Genital Mutilation (FGM).

The current sub-committee structure, as depicted in Appendix 1, provides for focus on our priorities and promotes activities aligned to the board's statutory functions. The functions of the sub-committee and sub-groups, which all meet at least six times a year, are:

#### **Performance, Audit and Quality Assurance Sub-Committee (PAQA)**

- Provides oversight of performance management data, review of a rolling programme of audit activity and improvement to service quality

#### **Policy, Procedures and Practice Development Sub-Committee (PPPD)**

- Ensures that policy and procedures are current, implemented, embedded and reflective of practice

#### **Workforce Management and Development Sub-Committee (WMD)**

- Addresses all aspects of multi-agency safeguarding training including; evaluation of impact and reviews, aspects of workforce management



concerned with safer recruitment and supervision

#### **Serious Case Review Sub-Committee (SCR)**

- Oversees commissioning and management of SCRs, ensuring agencies are accountable for implementing recommendations and action plans and promotes strategic learning from local and national reviews, including Domestic Homicide Reviews. (A separate, independently chaired, Serious Case Review Panel is convened to review individual cases as required)

#### **Child Death Overview Panel (CDOP)**

- Examines the deaths of all Barnsley children, in accordance with statutory guidance and reports directly to the board

#### **The CSE Strategy Group**

- This group is responsible for the strategic development of Barnsley's response to CSE. This includes the newly refreshed CSE Action Plan and CSE Strategy. Progress is monitored by the group and scheduled audits in relation to CSE are conducted and submitted to the board.

The multiagency CSE team currently operate as a CSE Multi Agency Safeguarding Hub which considers and agrees the level of CSE risk in each referred case. In order to do this they utilise an agreed CSE risk assessment tool. Once the risk has been agreed then they jointly agree the actions required and monitor progress against the actions.

#### **Children with Disabilities and Complex Health Needs Sub-Group (CWDCHN)**

- Provides more robust oversight under the board's governance and support to the increased vulnerabilities of this group of children and young people ensuring continued provision and a multi-agency response

This structure provides the board with a mechanism for multi agency development and review of safeguarding practice ensuring existing and emerging priorities are identified and addressed. It also ensures a valued input from adult services in areas of mutual safeguarding concern such as domestic abuse, adult mental health and substance misuse.

Communication between the board and sub-committees is strengthened through the regular Sub-Committee Chairs Briefing held before each Board Meeting. During the briefing each of the subcommittees escalates any areas of concern to the BSCB Chair which are flagged to the board for action. It is evident that partners increasingly feel confident to use respectful challenge as a means of improving services to children and young people. Briefings provide beneficial support to the sub-committee chairs and reinforce their relationship with the board and their responsibilities as Subcommittee Chairs. This meeting also helps to retain a focus on key priorities as explained below.

#### **Focus on priorities**

Each year, the board reviews its current Business Plan to identify success in achieving objectives and identify new priorities for next year. The BSCB Chair and the Sub Committee Chairs meet regularly to review progress and ensure that workload is managed and

implemented effectively, in line with the Business Plan. These meetings also consider emerging issues of interest or concern in light of the board's priorities.

When testing effectiveness the BSCB draws on both performance data and quality assurance activity that examines in detail the quality and effectiveness of front line practice ensuring a 'line of sight' to practice at the front line. All board members and specialist advisors have a strategic safeguarding role in relation to their own agencies. Accountability to local communities is promoted through the two lay representatives.

The BSCB provides a forum to hold partners to account and test effectiveness of multi-agency working to safeguard children. The BSCB 'holds the ring' on challenging performance providing a forum for partners to challenge across the piece.

#### **Effective partnership working and relationships with strategic partners**

The board's functions and responsibilities complement those of the Children and Young People's Trust and provide for leadership and ownership of safeguarding at all levels in the council and partners.

The Children and Young People's Trust, chaired by the Executive Director for People, secures the cooperation of partners to strategically plan and align service commissioning to improve children's outcomes. These arrangements encompass all strategic partners, with a focus on working together to improve the wellbeing, life chances and outcomes of every local child.

The BSCB refers to the Children and Young People's Trust matters that have commissioning implications. The chair of

the BSCB escalates matters to the governance structures of partners and / or the Health and Well-Being Board where it is considered that agencies are failing to discharge responsibilities under 'Working Together' (2015).

Our high aspirations for children and young people, relating to their ability to secure optimum health, safety, educational attainment and contribution to their communities, recognises that families need support across the whole spectrum of services, including social care, education, health, police, voluntary organisations, safeguarding and other stakeholders.

Responsibility for establishing a secure continuous service improvement approach for children, young people and families rests with the Children and Young People's Trust and the BSCB.

The shared ambition of the Barnsley Children and Young People's Trust and BSCB is to go beyond Ofsted's judgement of 'requires improvement' and to deliver the best possible outcomes for local children, young people and families. This means collectively working together to deliver services which are judged to be at least good. In order to achieve this ambition services for children, young people and families will use the Continuous Service Improvement Framework.

The framework is made up of a number of dynamic elements. It is understood that it is the people (officers, elected members, non-executive officer, independent chairs) operating at different levels with different functions in their organisations who will make the children's system work effectively. This requires everyone operating within the system to discharge their responsibilities effectively and to be held to account. These elements include:

- The Children and Young People's Trust
- The Safeguarding Children Board
- Elected Member led challenge
- A Continuous Service Improvement Officers Group
- A Continuous Service Improvement Plan
- External Review and Challenge
- Culture of Respectful Challenge
- The Voice of the child
- Joint review of the framework.

At the annual joint meeting of the BSCB and the Children and Young People's Trust Executive Group (CYP TEG) held on 23 October 2015 key areas for discussion included: An understanding of the responsibility of both boards; the Continuous Service Improvement Plan; the combined risk register; further consideration of the ways in which both boards could work more effectively together in future to achieve improved outcomes, and enabled shared priorities. The group identified the following key areas for joint development and focus:

- Keeping the needs of children at the centre of all activities.
- Keeping children safe.
- Early Help
- Improving Education, Achievement and Employability
- Tackling Child Poverty and Improving Family Life
- Membership roles and responsibilities
- Supporting all children, young people and families to make healthy lifestyle choices
- Encouraging positive relationships and strengthening emotional health
- Improving staff skills to deliver quality services

The Children's Plan is currently being refreshed for 2016-19

The Children and Young People's Trust Children and Young People's Plan 2016 – 19 will continue to recognise the nature and value of its relationship with the BSCB through its three main safeguarding priorities:

- Improving the safety of children by developing the engagement and focus of all partners via the BSCB.
- Increasing confidence and understanding of referral processes and thresholds
- Developing data use, information and quality assurance.

During the year, these priorities were progressed as the BSCB continued to hold individual agencies to account in discharging their responsibilities to keep children safe.

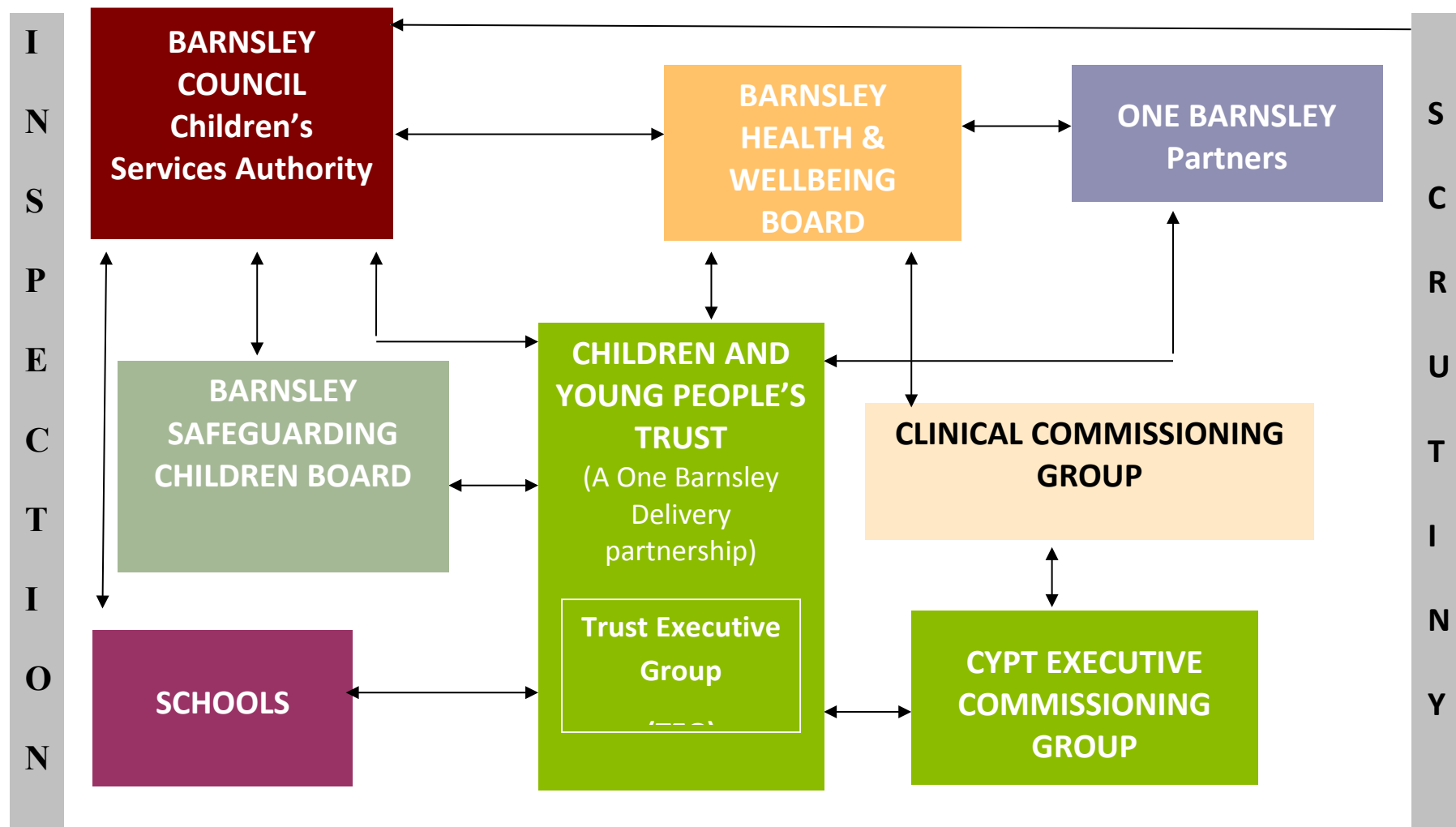
Through 2013-16, the Children and Young People's Trust and partners identified the following as continuing priorities:

- maintain oversight of and take forward actions from the Continuous Service Improvement Plan relevant to the BSCB
- To continue to improve performance management and quality assurance systems to ensure robust and continuous service improvement, supported by workforce development programmes to secure safe practice.
- Ensure that the board maintains a comprehensive overview of the work of partner agencies involved with safeguarding, including the voluntary sector.
- Ensure the implementation of actions within the Child Sexual Exploitation Strategy.
- Ensure all board members are up-to-date with changes in policies, guidance and practice to provide strategic direction and scrutiny of core

safeguarding and child protection processes and data, and provide effective challenge.

These were addressed as major priorities in the BSCB Business Plan 2014-15.

## WORKING TOGETHER Partnership Groups



### **Progress on key priorities and achievements in 2015-2016**

Last year's key priorities relating to the coordination of local safeguarding activity and promotion of children's welfare are set out below, with commentary on the extent to which they were achieved. More detail and examples of specific activities relating to each priority is contained in the sections of this report which outline the work of the subcommittees throughout the year.

### **Maintaining a strong commitment to continuous improvement and challenge through oversight and taking forward relevant actions from the Ofsted Improvement Programme and new governance structure**

The board has maintained oversight of activity under the Improvement Programme through regular updates, Section 11 interviews, individual reports on particular areas of concern, and evidence from specific audit activity. The board has sought to encourage more open challenge during debates in order to secure service improvement and embraces its new role in monitoring the Continuous Service Improvement Plan under the direction of the Executive Director for People.

### **Continue to develop and refine our Performance Management Framework**

The board is now able to secure systematic reporting of valid and useful KPIs, with sufficient contextual analysis to understand and identify improved performance across all partner organisations.

### **Address the increasingly high profile risk relating to Child Sexual Exploitation, (CSE) in conjunction with relevant partners**

We have seen a problem profile which supports the current position that there is little evidence of organised CSE criminality in Barnsley, this is not to say that we do not remain alert to the possibility and monitor trends and events. Trends continue to be monitored and managed through partnership working.

A new risk assessment tool has been introduced for CSE which focuses the minds of practitioners on the signs they should be looking out for that may indicate that a person is vulnerable or subject to CSE.

We have reviewed the CSE strategy and associated action plan.

The Terms of Reference for the multiagency CSE team have been reviewed and operational guidance developed to support the work of the team and ensure that practitioners are clear of expectations and responsibilities.

The multi agency team has been strengthened by establishing the role of a specialist nurse within the team to share information and provide links to the broader health community by way of liaison and awareness raising and to take a lead role in direct work with young people where health implications arise from risks of CSE, in line with broader multi-agency plans for intervention.

Multi Agency Meetings have been established in relation to CSE which review and assess cases of CSE utilising all the information available from partners involved with the child and family of either the victim or offender. This ensures robust and effective risk assessment, management plans and progress monitoring to reduce the risk to the child.



- Regular Deep Dive Audits are undertaken in relation to CSE investigations.
- Ongoing work continues to be undertaken with Local Businesses in relation to raising awareness of CSE.
- Ongoing training specific to CSE continues to be delivered.
- Increased funding has been accessed to improve therapeutic support to those who have been subject to CSE.
- A new structure has been put in place to manage return home interviews of children who are reported as missing from home, this supports ongoing interventions and support for the child and seeks to identify with partners where children may be at risk of CSE and any persons who present a risk to children.

#### **Going Forward:**

- Continue to work as a partnership to support victims reporting CSE and to pursue and prosecute offenders.
- Undertake gap analysis to identify any professionals who require further training or awareness raising.
- Introduce an offender management tool that will help identify any offenders who present a risk in relation to CSE in order that they can be appropriately managed. Links with local offender management teams will be further developed to support this.
- Undertake a review of the problem profile to ensure that the CSE picture is up to date to ensure appropriate response and allow for planned preventative work.
- Establish full children's MASH to bring together children's front door assessment, investigators and CSE team to improve information sharing and multiagency working.

- Continue to work with the private sector to raise awareness of CSE.
- Improve links with minority ethnic communities to raise awareness of CSE.
- Establish a service directory for CSE to ensure that those working with victims of CSE are aware of what support is available.

#### **Improve our learning from Serious Case Reviews**

The SCR Sub-Committee has continued to disseminate learning through multi-agency training activity and specific single agency learning events in relation to SCR action plans. Action plans are monitored by the committee to ensure implementation of actions and an evidence bank to illustrate the changes to practice has been established. This work will continue next year as additional case specific action plans are completed in relation to ongoing SCR's. A priority for 2016/17 will be to develop more robust commissioning arrangements in relation to the commissioning of SCR's.

#### **Continue to promote activities to mitigate the risks to children arising from domestic abuse, adult mental health, substance misuse and digital technology**

These areas of safeguarding are progressed by the PPPD Sub-Committee. Maintaining oversight of all these vital areas, together with other emerging areas such as bullying, and promoting activities to mitigate the risks, has been difficult and had limited success. More effort will be required next year to ensure sufficient resources are available and deployed to address these areas in a more systematic and consistent way.

### **Oversight of Children who are Missing from Home, Care and Education**

A weekly Multiagency meeting has been developed since the new CSE arrangements came into place to ensure there is scrutiny of all the episodes and circumstances where a child is reported as being missing to the police.

This is attended by the Police, Missing from Home Co-ordinator, Targeted Youth/Early Help and Youth Offending Team representative, Education Welfare Service, CSE Social Worker and LAC health colleague.

The purpose of the meeting is to ensure the effectiveness and robustness of response to any child who is reported as missing, to prevent any further missing episode and ensure that the South Yorkshire Missing Protocol and Safeguarding Procedures are being followed and to alert and escalate cases inappropriate.

The group track each case and will identify any emerging themes and feedback to the CSE Strategic Group, Corporate Parenting Panel and Children at high risk of Multiple Violence and Complex Abuse (MVCA) Panel

The development of the CSE team and Multiagency arrangements for CSE had led to the CSE forum being replaced by a broader monthly multiagency meeting to ensure oversight of any Young Person aged 10-18 years who may be at risk of Multiple Violence (including CSE) and complex abuse (which may include CSE). This meeting is chaired by the Head of Service to identify and track the most challenging Child Protection/LAC cases. This allows for the development of a central list and tracking process that can ensure a focus and effort into ensuring that the top 10 cases are identified and considered as part of the Empower and

Protect Innovation opportunities across South Yorkshire or to strengthen safeguarding arrangements for those children who are often placed from out of the area.

This group reports into the CSE Strategic Group, Corporate Parenting Panel and Senior Safeguarding leadership group.

### **Accelerate joint working arrangements with the Barnsley Safeguarding Adults Board where this could be mutually beneficial**

The Safeguarding Adults Board is represented on the BSCB and its sub-committees to facilitate joined up working around those issues that mainly affect adults, but also impact on their children. The focus on joint practice needs to be maintained in order to ensure a whole family approach to policy, practice and assessment.

### **A focus on and review of the 'Front Door'**

Over the course of 2014 the 'Front Door' has been through a period of development.

As a response to this review we have associated realignment of thresholds and supported by a re-launch of the BMBC threshold for intervention. This is to embed a shared understanding of threshold for intervention. An integral part of this approach has been to be more responsive to children living in neglectful situations and to address more chronic neglectful parenting which relates to parental substance misuse, and domestic abuse.

As the service has developed and the threshold realigned, the volume of work has continued to increase with more children accepted for tier 3 interventions and numbers of assessments increasing.

As pressure on capacity in the service has increased, strategies focusing on timely and good quality assessment and both social work and management capacity has increased to respond to this.

Data and feedback from service shows increase in children in need opened for referral and assessment and conversion rate from referral to assessment shows marked increase over the course of 2014 and into 2015.

There has been an appropriate rise in numbers of children subject to a child protection plan from 200 in December 2013 to circa 340 in March 2015. Significant increase in those categorised as 'neglect'. This increase in numbers per 10,000 brings us in line with national average and closer to statistical neighbours.

More agency partners now contact their own safeguarding lead to seek advice to divert low level contacts *however it* is important that all agency partners develop this practice to divert low level contacts and reduce growing pressures on the 'Front Door'. The board will ensure this continues to be a key priority throughout 2016/17.

#### **Workforce management and development**

The Workforce Management and Development Sub-Committee's remit includes oversight of partner agencies' workforce responsibilities with regard to agency compliance with Working Together to Safeguard Children and statutory guidance. This includes the planning design, delivery and evaluation of the multi-agency Safeguarding Children Training Strategy and Programme. Adult services and community representation maintain a strong link with adult workforce

training and promote a wider overview and input to safeguarding training.

During 2015-2016 there has been continued high demand for multi-agency training. An extensive programme of multi-agency training, lunchtime seminars and events were attended by a total of 2324 practitioners from across partner agencies. This is an excellent example of partnership working and learning together. There are strong links with the adult workforce training and we try to take a whole family approach to safeguarding training.

The training programme has been developed and delivered in response to statutory requirements, local and national Serious Case Reviews, local audits, current research and report findings.

The need to provide early help, remain alert to child sexual exploitation, neglect and the recognition of how the co-existence of key issues such as domestic abuse, parental mental illness and parental substance misuse can significantly contribute to the abuse and neglect of children have remained a priority for 2015-2016.

In addition to the variety of multi-agency courses and popular lunchtime seminars, further new topics have been added to the programme. These include:-

- Child Development
- Motivational Interviewing
- Human Trafficking
- Safeguarding Children with Disabilities
- Disguised Compliance
- Understanding Attachment
- The Mental Capacity Act and the Deprivation of Liberty Safeguards for Young People and Adults
- Adolescent to Parent Violence and Abuse

\*in addition to “classroom” taught sessions an extensive programme of E-learning is available.

### **Contribution from partner agencies**

Many of the courses benefit from partner agency colleagues co-delivering training with the Multi-Agency Trainer or sole delivery this and the use of free venues helps to gain maximum benefit from the training budget.

### **Key achievements**

Monitoring of the impact of training on staff and outcomes for children continues via the Section 11 Audit Challenge, Staff Professional Development Reviews and supervision. The feedback obtained from the above methodology is used to inform the future training programme.

The sub-group continues to engage with Faith Communities to ensure that they have up to date local information and resources to enable them to safeguarding children. Contact with Asylum seekers and Migrant Communities has continued to raise awareness of Female Genital Mutilation and ensure that clear messages are given that this is illegal in The United Kingdom and other countries across the World.

In these times of Austerity the Board requested that this subgroup look at ways of saving/generating income to maintain the excellent quality of our training programme. We have tightened up on charging for late cancellation of a place on a course this will ensure that the course administrator is notified in a timely manner and can ensure the number of course attendees is at capacity. The subgroup have developed a charging policy so that only the agencies that contribute

to the Board can access the Multi-agency training, other agencies can access training but they will be charged a very reasonable sum for such high quality training.

There have been improvements to the monitoring of the impact of training and feedback to inform the training programme.

The impact of training has been added to the Section 11 Challenge Visit that the Safeguarding Board Chair and Safeguarding Board Manager undertake with all Safeguarding Board member agencies.

Managers are expected to assess the impact of training during the member of staff's annual appraisal and during supervision.

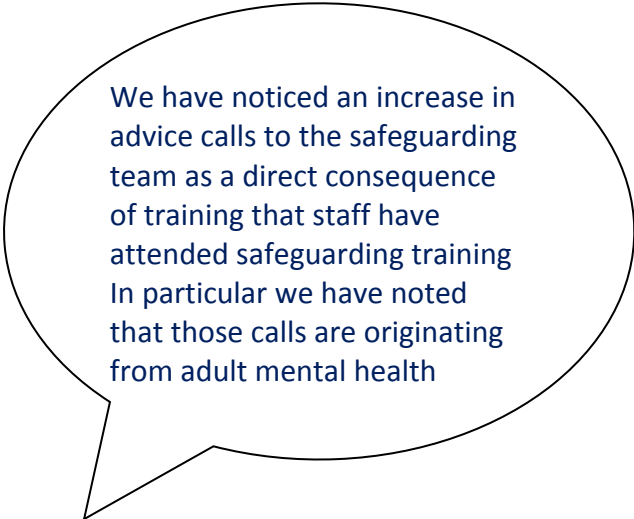
Ofsted Inspectors commented on the quality and variety of the multi-agency training programme.

This sub-group has continued to engage with Faith Communities to ensure that they are adequately safeguarding children. Links with travelers, asylum seekers and migrant communities have also been made.

A full day conference was held on neglect which was oversubscribed, and a conference on Domestic Violence ‘Behind Closed Doors’, held which received very positive evaluations.

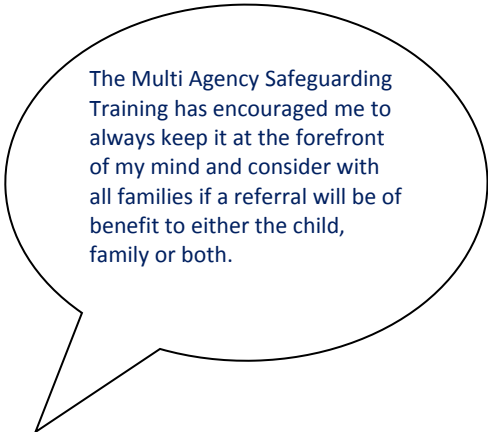
## Evaluation of multi-agency training

Training receives very positive feedback:



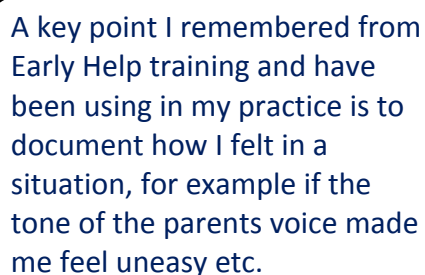
We have noticed an increase in advice calls to the safeguarding team as a direct consequence of training that staff have attended safeguarding training. In particular we have noted that those calls are originating from adult mental health.

**Named Nurse, health provider organisation.**



The Multi Agency Safeguarding Training has encouraged me to always keep it at the forefront of my mind and consider with all families if a referral will be of benefit to either the child, family or both.

**Member of staff working in an Acute Trust.**



A key point I remembered from Early Help training and have been using in my practice is to document how I felt in a situation, for example if the tone of the parents voice made me feel uneasy etc.

**Member of staff working in a Nursery**

## Future Plans

The sub group are planning a conference for later this year the theme will be the Toxic Trio and Neglect.

The conference is scheduled to take place on the 13<sup>th</sup> October 2016 at The Core in Barnsley.

The number and nature of multi-agency courses delivered in 2015-16 and agency attendance is set out in the table:

	Number of courses	BMBC - People Directorate (Children)	BMBC - People Directorate (Other)	Schools, Colleges and Academies	Berneslai Homes	BMBC - Other Directorates	Health, including BHNFT	Police	Probation	Voluntary, Community, Charitable and Independent Sector	Foster Carer	Other	TOTALS
Becoming Culturally Competent	2	11	0	2	2	0	3	0	0	8	8	2	36
Operation Klan - Child Internet Abuse Seminar	1	8	1	2	2	0	1	0	1	8	6	0	29
Raising Awareness of Child Sexual Exploitation	5	15	2	5	4	1	23	24	0	26	17	3	120
Forced Marriage, Honour Based Violence and Female Genital Mutilation	3	29	0	11	2	1	12	0	1	15	4	2	77
Understanding Thresholds - Continuum of Assessment	3	20	0	13	2	0	12	0	0	22	0	0	69
Multi-Agency Public Protection Arrangements	2	3	4	4	4	0	9	12	0	10	3	1	50
Working Together to Safeguard Children and Young People	8	25	4	4	7	4	43	35	1	66	6	1	196
Safeguarding Children Online	2	12	0	6	0	0	2	2	0	8	11	0	41
Helping You With Early Help	13	87	1	50	6	0	94	2	0	42	10	1	293
Managing Allegations Against Staff	1	3	0	2	0	0	1	0	0	8	2	0	16
Understanding Autistic Spectrum Disorders	1	1	0	5	1	0	3	0	0	11	2	1	24
Domestic Abuse and the Effects on Children and Adults	3	26	0	7	4	2	19	2	0	10	6	1	77
Sexual Exploitation of Children and Young People	3	18	1	14	1	1	10	4	2	11	1	1	64
Safeguarding Children and Adults	2	13	0	3	2	1	10	0	0	15	7	0	51
Parental Problematic Substance Misuse	2	9	0	8	2	0	16	0	0	15	1	0	51
Young People Affected by Intimate Partner Abuse	1	3	0	2	1	0	0	0	0	9	3	0	18
Signs of Safety' - Changes to Child Protection Conferences	4	28	0	6	7	0	35	5	0	16	9	1	107
The Role of the Substance Misuse Carer	1	4	0	1	3	0	0	0	0	2	2	1	13



Domestic Abuse, Risk Assessment & MARAC	3	14	2	4	2	1	17	11	1	17	3	2	74
Safeguarding Children through Safer Recruitment	2	6	0	14	1	0	7	0	0	20	0	0	48
Self Harm Awareness	2	10	0	7	1	1	9	0	0	9	1	0	38
Working with Parents with Mental Health Issues and Safeguarding Children	2	15	0	13	0	0	5	0	1	7	6	1	48
Working with Parents with Learning Disabilities and Safeguarding Children	1	9	0	3	0	0	0	0	0	4	2	0	18
Communicating Effectively with Children, including those with Special Needs	1	8	0	1	0	0	0	0	0	3	5	0	17
Working with Resistant Families	2	23	0	4	3	0	6	0	2	8	1	0	47
Learning Lessons from Serious Case Reviews	2	18	0	2	0	0	8	2	0	8	0	2	40
Fabricated and Induced Illness	1	7	0	0	0	0	9	0	0	8	5	1	30
Recognising and Responding to Children and Young People Who Display Concerning or Harmful Sexual Behaviour	1	6	0	3	0	0	5	0	0	9	4	0	27
Introduction to Child and Adolescent Mental Health Issues	1	4	0	1	0	0	2	0	0	9	0	0	16
Conferences and Core Groups	3	22	0	13	3	0	17	0	3	18	0	0	76
Working with Neglect	3	18	0	7	3	0	17	2	2	20	4	1	74
Pathways Role Within the Co-ordinated Community Response	1	7	0	8	0	0	5	0	0	2	0	0	22
Court Room Skills	2	10	0	6	0	0	11	1	0	12	0	2	42
Teenage Brain Development and Engaging Teens	2	9	0	6	0	0	7	0	0	11	10	2	45
Sleep: Issues and Impacts	1	1	0	2	1	0	3	0	0	5	8	0	20
Achieving Best Evidence Through Interviewing Skills	1	4	4	2	0	3	4	0	1	5	0	1	24
Information Sharing in Difficult Situations	1	5	0	3	0	0	2	0	0	6	8	0	24
Awareness of Female Genital Mutilation	1	12	2	6	0	0	6	1	1	6	3	0	37
Introduction to Safeguarding	2	4	0	6	2	1	16	1	0	14	7	0	51

Every Child Deserves the Best Start in Life	1	4	0	1	2	1	2	0	0	5	8	0	23
Workshop to Raise Awareness of PREVENT (WRAP)	1	2	0	28	0	1	0	1	0	6	0	0	38
Sexual Abuse: The Investigative Process	1	12	0	3	0	0	6	0	1	2	0	0	24
The Role of the Specialist Health Visitor for Migrant Health, Asylum Seekers and Roadside Gypsy Travellers	1	1	0	0	2	0	0	0	0	3	5	0	11
"We Don't Just Put Out Fires": Safeguarding and the Role of the Fire Service	1	3	0	2	0	1	3	0	0	3	7	0	19
Physical Abuse and the Role of the Paediatrician	1	9	0	5	0	0	3	3	0	3	0	1	24
When a Child Dies	1	11	1	11	3	0	3	2	0	3	1	0	35
	99	569	22	306	73	19	466	110	17	528	186	28	2324
	Number of courses	BMBC - People Directorate (Children)	BMBC - People Directorate (Other)	Schools, Colleges and Academies	Berneslai Homes	BMBC - Other Directorates	Health, including BHNFT	Police	Probation	Voluntary, Community, Charitable and Independent Sector	Foster Carer	Other	TOTALS

## Safeguarding vulnerable children and young people

### Children in Care

The Barnsley Safeguarding Children Board's oversight of children and young people in care is maintained through membership of the Care4Us Council and receipt of individual reports, including the Children in Care KPI Scorecard. The Care4Us Council, which comprises of young people in care, board members and relevant council officers, meets regularly to address issues which are important to this group. During 2016-17, the council, led and chaired by young people:

- A new Full time dedicated Participation Worker was employed on 1<sup>st</sup> April 2016 to drive the CICC forward and work with Care Leavers. This post will enable, develop and deliver a participation service. It will further the work of the children in care council to ensure it continues to impact on service design and delivery within the Local Authority, especially Corporate Parenting. It will also enable time to work directly with children, young people and care leavers to empower them to share their views and build resilience and to improve outcomes for these children more effectively.
- Children in Care took part in take over Challenge and were awarded 'silver' commendation from the Children's Commissioners Office. This was a great success and will be a yearly event.
- The Pledge has been revised through consultation and now used within the Review process by the IRO's. The Participation worker has sent a copy to all LAC placed out of the Local Authority and also taken

some out personally to meet the Young People. The Participation Worker will also take a copy of the Pledge out to Children who become Looked After when aged 10 or above when appropriate.

- 2 Care Leavers have attended The February Young People at Cabinet meeting to present the Pledge (which all members signed up to) and one of them presented a report regarding future 16+ accommodation including his own account of young people living in supported accommodation.
- Apprentices at Council have been very successful securing 2 young people's places to continue for a further period of time.
- CICC are attending the Yorkshire & Humber Children's Social Work Matters Conference. The conference aims to celebrate and promote good social work practice. Some of the Young People participated in some one minute film clip interviews to talk about their positive care experiences.
- One Care Leaver announced that she has just been offered a permanent Youth Coordinator post with Rotherham Council
- A Care Leaver will be attending a New Beginnings Dissemination Event in London. This is to raise engagement with Care Leavers, raising aspirations in employment, education and training. It also involves preparation for independence and health and well being.
- Celebration Event is an annual event due to its great success in 2015.
- LAC will be attending a Summer School at Sheffield University as part as the Go Further, Go Higher

campaign looking at LAW to raise aspirations to further their education and give them a different experience other than school.

- Care Leavers have produced a White Goods Catalogue to help with independence and provides information of where to go for the best priced essential items when moving into their own property and contact details of services they may need.

#### **Proposals for 2016-2017 include:**

Facebook for care leavers

Consultation on the review process and documentation (already started)

Consultation on the Welcome pack (again already started but name needs to change and it is not being used)

#### **Health of Children in Care**

Work is continuing to build on the substantial improvements already achieved in terms of performance and health outcomes for children in care. Data collection and audits of LAC health assessments show that 96.6% of review health assessments are completed within timescale and 100% of LAC have access to dental care. This is better than our statistical neighbours and the national average. 99.2% have up to date vaccination status which is excellent but at present there is no data available for comparison. The Timeliness of Initial health assessments has improved month on month since the appointment of a new Designated Doctor for Looked after Children in spring 2015. The delays are usually as a result of a delay in notification from an outside placing authority when a child is placed in by a Local Authority outside Barnsley. To improve notification quarterly meetings are held with

Private providers and this has improved notification of Children in Care placed in Barnsley by outside authorities. The Clinical Commissioning Group (CCG) has also written to every CCG in the country requesting that they encourage notification of children placed in Barnsley.

Children and young people in care in Barnsley receive consensual and holistic health assessments. Assessments are carried out at times and in venues that minimise disruption to the child and their education. All our children in care have excellent access to and use primary care to promote their health and development. Older children and young people are given the opportunity to be seen alone, this has recently been identified as key to empowering LAC to speak freely and honestly about their health and care.

There is a monthly meeting between the Designated Doctor and Service Managers for Children in Care to ensure actions related to the health of Children in Care are implemented. This includes the need to improve waiting times for the Children and Adolescent Mental Health Service (CAMHS) for Children in Care and that the improvement in timescales for health assessments and dental checks are maintained.

The Health and Wellbeing of Children in Care and Care Leavers Steering Group, reporting to the CCG Quality and Patient Safety meeting, meets every six weeks to identify service improvements to address the health needs of this group and to ensure ongoing improvement. In addition to this CQC made some recommendations that would improve practice and lessons were learned from a serious case review.

### **Together all these are or have:**

- Ensured that the completion and use of Strengths and Difficulties Questionnaires (SDQ) continue to be embedded into practice and inform a wider assessment of emotional health and wellbeing.
- Prompted the Designated and Named Nurse for LAC to provide revised training to health professionals undertaking health assessments to further increase awareness of the health needs of LAC and quality of health assessments.
- Developed a process for gaining consent from young people age 16 years and over to release GP summary records.
- Incorporated processes for ensuring GPs and CAMHS contribute to health assessments.
- Initiated the Named Nurse to undertake live audit of Review Health Assessments of children placed both in and out of Barnsley. This allows for timely challenge of assessments that don't meet the required standard, and feedback to health professionals to support continuous improvement.
- Instigated a process of follow up and monitoring of Barnsley LAC who are placed out of area to ensure their health needs are met by the receiving area.
- Ensured that the CCG have reviewed the Service Specification for Children in Care and Care Leavers, to ensure it remains appropriate in light of new statutory guidance. They have also liaised with Public health to ensure LAC provision is considered within the new commissioning arrangements

for 0-19 children's community services.

### **What difference have these made:**

- Better use of the SDQ both within individual health assessments and data collection to identify themes and trends.
- Health professionals that undertake LAC health assessments have received training to support competency requirements recommended in the Looked after Children: Knowledge, skills and competences of health care staff

### **(INTERCOLLEGIATE ROLE FRAMEWORK March 2015)**

- Young people's right to consent or dissent is supported and upheld.
- Information from a wider range of health provision is used to inform health assessments.
- There is closer timely monitoring of health assessments by provider agencies, and any problems are escalated including to the CCG when appropriate.
- Children and young people placed out of Barnsley are not disadvantaged in terms of their health needs.

### **Continuous Improvement**

There is a commitment to constantly challenge and improve practice and services to LAC. Areas of focus for the coming year are:

- Ensure that consideration of ethnicity, faith and identity is incorporated and documented in health assessments.
- Strengthen the voice of LAC and use

feedback to influence service improvement.

- Work with LAC to improve information for them regarding health assessments.
- Reinforce the use of existing health screening tools to support and enhance health assessments, particularly in terms of emerging issues such as child sexual exploitation, female genital mutilation and radicalisation.
- Continue to develop systems and processes to ensure significant health information is chronicled and follows the child.

#### **Arrangements for Private Fostering Support in Barnsley**

The Board oversees local arrangements to safeguard privately fostered children and young people and monitors the extent to which the local authority undertakes its responsibilities. A private fostering arrangement is one made without the involvement of a local authority for the care of a child under the age of 16 (under 18, if disabled) with someone other than a parent or close relative for 28 days or more. Anyone involved in, or knowing about, such an arrangement must notify the local authority at least six weeks before it begins and the fostering service takes active steps to advertise this responsibility through a range of measures:

- information disseminated via specific information sessions and training
- distribution of an updated Statement on Private Fostering to key stakeholders, including schools, school nurses, health visitors, GPs, children's social care teams,

housing and voluntary sector professionals, setting out notification requirements, the local authority's duties and the role of local professional agencies

- distribution of a private fostering flyer to the same stakeholders

Specific awareness raising activity, supported by the board, has continued throughout the year, including local advertising. Information leaflets are available for carers, parents, children and young people and professionals. Leaflets, posters and business cards are displayed in major public buildings and information is available on the board and council websites.

Parents, carers, children and young people can receive advice and support, including training opportunities, from the private fostering social worker.

The requirements on a local authority under private fostering span both child and carer focussed services. The service in Barnsley is currently based with the Fostering Service and the balance is more towards ensuring this is a suitable placement for the child. The needs of the child/young person remain very much to the fore while the suitability of the placement is assessed. However should the child need more support through services for children in need or children in need of protection the Private Fostering Worker will liaise with Assessment and Safeguarding Services.

Numbers of private fostering arrangements have continued to decrease in recent years and there is a need to maintain the focus on awareness-raising with other agencies. A twice yearly report is provided to the Board so progress can be monitored and to remind partnership agencies of



the need to maintain a focus on identification of private fostering arrangements within their own organisation.

The current Private Fostering Worker has been undertaking a programme of regular visits to agencies to raise the profile of private fostering across the Borough. This has particularly focussed on ALCs.

Colleagues within the CCG have worked specifically with GPs and publicity materials have been developed for schools and other agencies to raise awareness across the Borough.

The Board specifically funds this publicity as private fostering still remains a priority of the Board. Work to ensure assessments are child-focussed as well as addressing the carer's needs is taking place alongside a focus on involving birth parents more within the process.

Above all assessments need to be timely to ensure children do not drift in unsuitable home conditions or emotionally unsupportive environments. Improvements are being made but this is still work in progress and work will continue around all aspects of private fostering in 2016/17.

The table shows the figures for private fostering for the last four years.

		31.3.13	31.3.14	31.3.15	31.3.16
1	Number of children in private fostering arrangements as at 31 March	18	12	5	4
2	Number of new private fostering arrangements which commenced over the last 12 months	18	14	2	14
3	Number of private fostering arrangements that ended during the past 12 months	17	20	9	8
4	Number of arrangements that were visited within timescales	100%	100%	100%	100%
5	Number of arrangements initially assessed as suitable	12	14	2	Unavailable
6	Number of arrangements initially assessed as not suitable	0	0	0	Unavailable
7	Number of arrangements that ended following an assessment by the local authority that the arrangement was no longer suitable	0	0	0	Unavailable

### **Children with disabilities, complex needs and/or special educational needs**

The Children with Disabilities and Complex Health service has continued to work with a range of partner agencies, children, young people and the Barnsley Parents and Carers Forum to develop and improve services for children and young people with disabilities and complex health needs.

The key areas of work undertaken during 2015/16 have included:

- Continued review and development of services around short breaks and use of direct payments
- The continued development of Education, Health and Care Plans and the Local Offer outlining all local service.
- The development of a Disability Register
- The extension of person centered planning, transition planning the development of the Autism pathway and Strategy.

The Disabled Children Programme Board has met throughout the year and continues to steer and challenge progress of related sub groups and to ensure coordination of service delivery.

There has also been some very positive and productive work around awareness of Safeguarding of children with disabilities and complex health needs. This work has resulted in increases in children subject to child protection plans and the number who are looked after.

### **Children with Disabilities and Complex Health Needs Sub- Committee**

Work undertaken:

- Revised Terms of Reference
- Established multi agency themed audits around issues to do with children with disabilities and complex needs
- Considered learning from SCRs both internal and external to inform the groups action plan
- Review of the OFSTED thematic report into Safeguarding Disabled Children to strengthen safeguarding arrangements for this group. The Sub group regularly reviews the data from the Disabled Children's Team against the whole data for Children's Social Care and this has supported action to increase the number of section 47's and CP plans for this vulnerable group of children and young people.

### **Education Welfare Service (EWS)**

The Education Welfare Service works in partnership with schools to support and advice on attendance and safeguarding issues. School attendance is tracked, including vulnerable groups such as children in care, children subject to a child protection plan or child in need, those at risk of child sexual exploitation, children who have special educational needs (SEND) and children who are involved or at risk of criminal activity.

The EWS also oversees children missing education (CME) and those whose parents elect to provide education at home (EHE). Since 2014 a central record keeping system has been used which schools complete and return on a half termly basis to the LA. This identifies pupils who are

not in full time education provision with a focus on the most vulnerable groups. This became an Ofsted requirement following the publication of “Pupils missing out on education” published in November 2013. The service also contributes to a number of the board's sub-committees and related multi-agency safeguarding forums, including child sexual exploitation and missing forum.

### **The Education Welfare Service and the Early Help Offer**

The service will work with schools for earlier identification of pupils who display early signs of irregular attendance including nursery and non-statutory school age. Education Welfare Officers will play a key role in undertaking and supporting early help assessments.

Policies are updated annually by the EWS. These include promoting good school attendance, incorporating model school attendance policies for schools including nursery schools, and policies on Children Missing Education and Elective Home Education. Revised policies are taken to the Policy and procedures sub-group for approval before going out to schools for consideration at governors meetings. Updated policies form part of the annual head teachers safeguarding report and are located on the BSCB website.

The EWS delivers school designated safeguarding lead including, together with the schools S175/157 safeguarding training. The service audits case files to ensure minimum standards are met.

The service has taken part in a number of multi-agency audits including children who were identified at risk of child sexual exploitation and quality of early help assessments through the thresholds continuum of assessment group. The

service also completed its third year of work with vulnerable families over the summer holiday period which included:

As part of the Education Welfare Service on-going attendance strategies, the service continued to raise the importance of school attendance throughout the summer holiday period. A number of initiatives took place they included;

- Attendance sweeps to parents whose children's attendance was less than the schools attendance target,
- Home visits and contact with families who were open cased to the EWS, identified as vulnerable (needing additional support throughout the summer holidays) or whom required a safe and well visit.
- Year 6 to Year 7 transition
- Monitoring and tracking of children missing education
- Elective home education monitoring
- Visits for pupils without an identified school place in September for both primary and secondary schools
- Support with Springwell Special School summer school

A total of 178 home visits were made to pupils and families during this period. Each term time Education Welfare Officer (EWO's) were asked to refer their most vulnerable cases to the senior management team of the service, for allocation, this was based on the criteria that no other service would be making contact during the summer holiday period.

The service were also provided with a list of 83 pupils from admissions who had not registered for a school place in September, 75 were for nursery into primary school and 18 for Primary into secondary. We were able to identify school places for those who had not applied for September,

locate families that had moved out of the borough and follow up with admissions the parents application forms that had already been submitted. All but 4 of these cases have been resolved. These are now registered as children missing education and are being monitored and tracked through the Children Missing Education SEWO

There were 3 requests for elective home education that were followed up with parents.

There was joint working with the Police, School Health, Family Intervention Service, Child and Adolescent Mental Health Service, Youth Offending Team, Stronger Family's Team and Social Care. Education Welfare Officers attended core group meetings, case conferences, Child in Need meetings, Team around the child meetings, Multi-Agency Area Group forums, Fostering Panels, Case planning meetings, Looked after children reviews.

#### **Dealing with allegations against professionals**

The Ofsted Inspection Report published on 8 August, 2014, identified that:

*"There are very good arrangements in place to make sure that children are protected when allegations of abuse are made against professionals."*

This indicates that practice has remained consistently good from the previous inspection findings.

In the period April 2015 to March 2016 contact was made with the LADO in relation to 171 cases. This represents a significant reduction (27%) on the previous year. Since this reduction marks a departure from previous trends it will be

important to monitor this during the coming year and to ensure that the role of the LADO, in terms of both advice and formal action, continues to be highlighted at times of staff changes and induction.

Of the 171 cases discussed with the LADO 73 were deemed to meet the criteria of indicating a risk of harm to children, or a possible criminal offence committed against or related to a child.

The majority of behaviours reported were of a physical nature (44%) which is consistent with previous data for Barnsley and nationally. Sexual abuse allegations accounted for 24% of the total, a decrease of 4% on last year. Emotional abuse and neglect accounted for 9% and 5% of allegations respectively.

The referrals were made by a wide range of statutory and voluntary agencies. Education providers in the borough (Primary, Secondary, Special Schools and College) accounted for 41% of all referrals reflecting the frequency, duration and intensity of the direct work with children in the education sector.

Awareness raising activities have taken part during the year with training provided to a multi- agency audience and bespoke training to foster carers and taxi drivers and the designated safeguarding leads within schools.

Records evidence that referrals made to LADO received a timely and robust initial response which ensured that children and young people were protected. The majority of allegations were investigated by management investigations undertaken by the employers and in total 69% of the allegations had been concluded by the end of the year. Of these 24% were concluded as being substantiated in that there was sufficient evidence to prove the allegation.

A further 26% were concluded as unsubstantiated because there was insufficient evidence to prove or disprove the allegation. The remainder were concluded as unfounded or false, with only one case considered to have been malicious during the year. The Board will continue to monitor the level of referrals to encourage all partners to refer to the LADO appropriately.

### **Equality, diversity and participation**

The board is strongly committed to promoting equality of opportunity and ensuring that all safeguarding activities take account of the diverse needs of all children and young people in the borough.

The council's Equality Scheme 2012-15 reaffirmed this commitment, to be achieved through development and provision of relevant, appropriate and accessible services.

Equality objectives for children and young people include:

- providing support to schools and settings to meet their public sector equality duty
- helping schools and settings identify, record and deal with bullying and harassment in schools
- narrowing the gap between different sections of the community, including where different levels of achievement are related to disability, gender, ethnicity or economic background
- challenging the barriers faced by looked after young people
- fulfilling the 'Pledge' to children in care.
- meeting the needs of children and young people with special educational needs, learning difficulties, disability and complex health needs

- implementing/reviewing the One Path One Door strategy
- continuing to reduce the number of young people not in education, employment or training and address the needs of specific groups
- undertaking work to improve transition of vulnerable groups, particularly those with learning difficulties

All newly developed strategies, policies and procedures are subject to an equality impact assessment. Active steps taken to facilitate inclusion include the provision of appropriate support for families to enable them to participate fully in child protection conferences and representation of young people's views at the board's sub-committees. Where necessary, specialist support, for example, interpretation and translation services are engaged to support families.

Key points of development within the Continuous Service Improvement Plan for the BSCB are:

- The needs arising out of ethnicity, faith and identity should be consistently considered and reflected within assessments.
- The introduction of systematic use of cultural competence tool (completed July 2014)
- Review BSCB training to ensure ethnicity, faith and identity are included in all relevant training.
- Monitor impact and outcomes through multi and single agency case file auditing and S11 audit process



Current Position and the Improvement Journey		
EFFECTIVENESS		
What we need to do	How are we doing and what difference did it make?	How do we plan to improve?
Overall: 'good' characteristics are widespread and 'common practice'	"Good" characteristics are not yet consistently embedded in daily practice.	Actions are ongoing to improve performance and embed good practice through our continuous service improvement programme.
Overall: How effectively LSCB evaluates and monitors the quality and effectiveness of partners	Multi agency performance data was provided but the Board was not satisfied that it routinely reported the right measures. Special meetings in February and March 2014 identified the KPIs to be routinely monitored by the Board and PAQA Sub-Committee. From April onwards appropriate data collection has taken place and is routinely reported to the Board and PAQA where it is explored to ascertain areas of progress and areas for development/further exploration. The Section 11 audit challenge process evaluates and monitors the quality of partners' effectiveness. Further supporting information has been requested from partners this year to ensure actions/impact is able to be demonstrated.	<p>The PAQA Sub-Committee will continue to refine its suite of KPIs and monitor audit outcomes from the single and multi-agency audit schedule. Work has been undertaken to develop the schedule of audits and audit reporting during 2014/15. This work has been further developed during 2015/16 and assisted by increased resource identified to support quality assurance activities.</p> <p>A programme of multi-agency audits will continue to be undertaken to examine priority areas of concern and identify key actions which will be monitored by PAQA through the development of specific action plans. Audit finding will be disseminated by PAQA into the relevant services.</p>
Complies with its statutory responsibilities in accordance with the Children Act 2004	The Board was established on 1 April 2006 and CDOP on 1 April 2008 in accordance with legislation. The Annual Report and Business Plan are produced and published each year.	The Board will undertake more rigorous and systematic review of its Business Plan objectives to ensure continuing relevance and evidence of achievement.
Complies with the Local Safeguarding Children Board Regulations 2006.	Enshrined in Constitution. Board and CDOP established in accordance with legislation. SCRs are commissioned when criteria are met and findings published.	Where criteria for holding SCRs are not met the Board will undertake alternative learning events in compliance with its Learning and Improvement Framework to promote and disseminate learning.
Able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area	<p>Section 11 self assessments to demonstrate compliance and impact.</p> <p>Multi-agency training programme</p> <p>The Board produces multi-agency policies, procedures and</p>	Section 11 challenge process to be more rigorous. Interviews take place and evidence bank introduced however further review work throughout the year could be introduced which would focus on key areas for

	<p>strategies.</p> <p>A multi-agency Sub-Committee structure is operational</p> <p>Action plans are created and monitored for SCRs, Learning Lesson events and specific strategies/policies/pathways are developed as a result.</p>	<p>development and support reporting against actions within the Continuous Improvement Plan.</p> <p>The Board needs to review its policies and procedures more systematically to ensure they are all up to date and relevant.</p> <p>Action Plans from SCRs, other learning events and strategies need to be SMART and implementation of actions and impact clearly able to be demonstrated.</p>
There are mechanisms in place to monitor the effectiveness of those local arrangements	<p>Section 11 challenge process</p> <p>Multi-agency training evaluation process</p> <p>Action plans monitored</p> <p>Multi agency audit programme in place and findings reviewed by PAQA Committee.</p>	<p>A more systematic review of multi and single agency audit activity.</p> <p>Improve evaluation process for multi-agency training to evidence impact of training more effectively.</p> <p>Improvement in this area has been made during 2014/15 with agencies demonstrating how they are recording and monitoring the impact of training. These improvements can be used to drive further development during 2014/15.</p>
Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice.	<p>Comprehensive programme of multi-agency training provided.</p> <p>Evaluation process in place with plans to develop this further to evidence improved outcomes for children.</p> <p>Guidance published to encourage management support in ensuring that messages from training are embedded in practice.</p> <p>Regular monitoring of evaluations by the WMD Sub-Committee</p>	<p>Training will continue to be monitored and developed to address emerging priorities.</p> <p>Evaluation of impact will continue to be improved.</p>
LSCB checks that policies and procedures in respect of thresholds for intervention are understood and operate	<p>New thresholds document was approved and disseminated in February 2014. Staff summary leaflet developed.</p> <p>Multi-agency training provided on thresholds.</p> <p>Multi agency thresholds group working to further develop</p>	<p>There is clear evidence to suggest that the Escalation Policy is being used but further work was undertaken during 2015/16 to review the current policy and improve the process for formally recording and collating</p>

effectively and identifies where there are areas for improvement	and embed understanding of thresholds across all agencies. Development and endorsement of the Barnsley Assessment Framework January 2015 which is consistent with Early Help development. Safeguarding leads encouraged to use escalation policy re thresholds.	escalations which will increase reliability of data and allow for themes and trends to be identified. This will continue into 2016/17.  Further work required to raise partner agency understanding of thresholds, increase the use of agency safeguarding leads and 'hold the ring' on early help.  Multi-agency audit on thresholds and work to collate data in relation to the pressures on the front door.
Challenge of practice between partners rigorous and leads to improvement	Section 11 challenge Encourage challenge on debate at Board and Sub-Committee meetings Log of challenges and outcome is developing. Use of Escalation policy is encouraged and monitored	Maintain and strengthen challenge relating to attendance and representation at the Board and Sub-Committees. Continue to monitor challenges made to identify themes, trends and response/outcome.
Casework auditing is rigorous and used to identify where improvements can be made in front-line performance and management oversight	Substantial audit work undertaken however quality of audits undertaken need to be improved.	The programme of single and multi agency audits reported to PAQA Sub-Committee needs refining and more systematic scrutiny.  The Board will undertake an agreed programme of multi-agency audits.
Serious case reviews, management reviews and reviews of child deaths are used by the local authority and partners as opportunities for learning and feedback that drive improvement.	SCRs undertaken when criteria met - where not met learning lessons reviews commissioned if appropriate. Action plans monitored by SCR Sub-Committee. Multi agency training provided on SCR's Individual reviews disseminated through relevant forums e.g. Head teachers meeting	The Board will continue to disseminate lessons derived from SCR's and similar reviews and develop specific multi-agency training to address identified need.
The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and	Performance management system still developing. Safeguarding Board's set of key indicators identified for regular review at each meeting. Wider set also identified for the PAQA Sub-Committee to review and escalate issues	Further strengthen the role and function of the BSCB through building on current work to improve performance management, including: Coordination of the process to evaluate the impact of

delivery of high-quality services.	<p>of concern to the Board.</p> <p>Supplementary audit programme to evidence practice improvements.</p> <p>Much improved data for LAC.</p> <p>Areas of poor performance identified for action as part of the Continuous Improvement Plan monitored by the BSCB.</p>	<p>multi-agency training.</p> <p>Performance data and audit activity integrating child protection and IRO activities to provide learning from quality assurance.</p>
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#### WHAT GOOD LOOKS LIKE

What we need to do	How are we doing and what difference did it make?	How do we plan to improve?
The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.	<p>Clear relationship articulated between SCB and Children's Trust (TEG report November 2013)</p> <p>Common members on all 3 bodies i.e. SCB/TEG/HWB provides opportunity for mutual reporting</p> <p>Protocol agreed to articulate relationship between SCB, TEG and HWB.</p>	Embed the developing performance management process to clarify and understand how well statutory responsibilities are fulfilled.
The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a delivery plan to improve outcomes.	<p>Priorities are set out in Board's Business Plan and Annual Report.</p> <p>New priorities identified as local issues arise and action taken.</p> <p>Sub-Committees review their Business Plan priorities regularly for achievement and relevance.</p> <p>Reports to the BSCB are required to show the link between the subject of the report and the board priorities.</p>	<p>The Board needs to monitor its own priorities more systematically and develop a clear delivery plan. This should feed directly into the Continuous Development Plan monitoring Process.</p> <p>More formal evidence of Board and Sub-Committee achievement required to ensure continuing validity of the purpose, values and vision. This should include specific developments in relation to identified vulnerable groups and key areas of development priority.</p> <p>The Board will improve its oversight of the extent of neglect as a local feature and the processes in place to monitor the efficacy of interventions to ensure that all partner agencies are addressing neglect robustly and without compromise.</p>

		The Board aims to improve oversight of missing children and continue to develop its strategic approach to CSE which includes Female Genital Mutilation in line with local and national developments.
Regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children identifies where improvement is required in the quality of practice and services that children, young people and families receive. This includes monitoring the effectiveness of early help.	Regular audits. Performance reporting with escalation from PAQA Sub-Committee.	Regular reports on effectiveness and monitoring of Early Help to the Board.
Partners hold each other to account for their contribution to the safety and protection of children and young people (including children and young people living in the area away from their home authority), facilitated by the chair.	Board Chair encourages open debate at Board meetings and culture where respectful challenge is encouraged.  Performance information provides transparency to rate partners' performance.	More clarity and systematic reporting needed on children placed out of district.  A report to the Board to highlight recent work undertaken by key partners facilitated by PAQA.
Safeguarding is a priority for all of the statutory LSCB members and this is demonstrable, such as through effective section 11 audits. All LSCB partners make a proportionate financial and resource contribution to the main LSCB and the audit and scrutiny activity of any sub-groups.	Revised more rigorous Section 11 self assessment. LSCB partner contributions have been reviewed during 2015/16 to try to increase levels of funding to the Board in order to maintain its current programme of work including facilitation of SCRs. Sub-Committees have multi-agency representation. Multi-agency audits undertaken. Additional contributions in kind considered e.g. the provision of training venues and meeting rooms.	Feedback to be provided by school representatives to all schools through the weekly bulletin following key meetings (BSCB, Schools Forum, SEE, Improvement Board, Trust Executive Group, Challenge Board, Children and Families Act Project). Sub-Committee attendance will continue to require proactive oversight and action to address unsatisfactory attendance The Board will need to meet challenges posed by partner

		agency reorganization and impact on attendance. Further work to address resourcing issues in relation the Board to be addressed.
The LSCB has a local learning and improvement framework with statutory partners. Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. Serious case reviews are published.	Learning and Improvement Framework approved and published on the SCB website. Learning lessons opportunities undertaken with frontline practitioners and resulting action plans monitored through SCR Sub-Committee. SCRs initiated where criteria are met and are published Learning from SCRs and learning events disseminated by partner agencies and through multi-agency training.	Learning from SCRs and learning events will continue to be disseminated to partner agencies and through multi-agency training.
The LSCB ensures that high-quality policies and procedures are in place (as required by <i>Working Together to safeguard children</i> ) and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. The LSCB monitors and understands the local application of thresholds.	Policies and procedures in place and accessible via website.  Continued focus of the Board in relation to thresholds.  Work to improve the monitoring and reporting of escalations through the Continuous Improvement Plan.	Undertake more regular and systematic review of the Board's Policies and Procedures to ensure they are comprehensive, up to date and relevant.  Need better evidence of the effectiveness and impact of policies and procedures and when they are revised following review.  Application of thresholds needs to be more consistent and better understood by partner agencies which can be demonstrated via appropriate data and regular progress reporting to the Board. This should include input from partner agencies.
The LSCB understands the nature and extent of the local issues in relation to children missing and children at risk of sexual	SCB received reports on children missing and at risk of CSE in January 2014. Local CSE Strategy and Action Plan in place. Strategic CSE Group maintains coordinated oversight and monitors CSE Strategy Action Plan. CSEM Forum monitors	The Strategic CSE Group will monitor and periodically report on achievement of the CSE Strategy Action Plan.  Regular audits in relation to CSE undertaken and

exploitation and oversees effective information sharing and a local strategy and action plan.	individual cases. Review of CSEM Forum TORs and practice. The Board is represented on the South Yorkshire Police and Crime Commissioner's county wide forum and is participating in the county wide CSE campaign lead by the PCC. In March 2014 the Board agreed a county wide addendum to the information sharing Protocol re CSE.	reported.
The LSCB uses case file audits including joint case audits to identify priorities that will improve multi-agency professional practice with children and families. The Chair raises challenges and works with the local authority and other LSCB partners where there are concerns that improvements are not effective.	Case file audits undertaken including multi-agency audits to identify priorities for improvement.  Log of challenges developing to evidence challenge from Chair and Board to partners, including the local authority.  Board minutes evidence challenge by partners to improve effectiveness of services e.g. health service DNA polices.	Findings from the multi - agency and case file audits will be incorporated into Action Plans where appropriate for monitoring by the PAQA Sub-Committee and report back to the Board.  In overseeing partner effectiveness the Board will provide challenge in respect of any areas of concern
Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. Experiences of children and young people are used as a measure of improvement.	Practice audits undertaken by managers.  Developments ongoing to capture voice of young person e.g. in cp conference reports.	More development is needed to capture and use the experiences of children and young people as a measure of improvement and to inform service delivery
The LSCB is an active and influential participant in informing and planning services for children, young people and families in the area and draws on its assessments of the effectiveness	The LSCB has influenced service delivery e.g. continued concerns on thresholds has led to additional work. The report on private providers of Children's homes led to new meetings and additional work to ensure compliance. DNA concerns led to additional work to ensure effectiveness. The SCB contributes to the C&YP plan.	The Board will continue to influence the planning of services for children in areas of identified need e.g. next neglect, appropriate resources to support young people who have been victims of CSE.  Ensure the Board clearly communicates commissioning



of multi-agency practice. It uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board.	<p>The Chair has influenced the Health and Well Being Section of the C &amp; YP Plan to ensure that CSE was captured under the Sexual Health section in response to a consultation on the draft plan.</p> <p>The Board had approved a Protocol to clarify relationships between the SCB, TEG and HWB</p>	priorities to the Children's Executive Trust.
The LSCB ensures that sufficient, high-quality multi-agency training is available and evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people, families and carers. All LSCB members support access to the training opportunities in their agencies.	<p>The Board provides a comprehensive programme of high quality multi-agency training which is flexible and adapted to meet newly identified needs e.g. response to CSE.</p> <p>Effectiveness and impact on frontline practice evaluated through new evaluation process.</p> <p>Multi-agency membership of Sub-Committee promotes take up of training plus wide promotion through website, flyers etc.</p> <p>Managers are encouraged to ascertain impact on practice through guidance approved by Sub-Committee and published on website</p>	<p>Better evidence of the impact of multi-agency training is required and should be reported with supporting evidence within Section 11 Audits.</p> <p>Sustainability of the MA Training Programme should be explored and issues around access by private providers considered and addressed via commissioning and contract arrangements.</p>
The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.	<p>LSCB's Annual Report provides assessment of performance and effectiveness of local services, including areas of weakness and future priorities for action.</p> <p>Annual Report includes information from SCRs, lessons learned reviews and child deaths.</p>	Consideration should be given to the develop of a monitoring timetable for activities of the board and sub committees which could be used to develop the report and ensure that board priorities are being met and are consistent with the priorities outlined in the annual report and business plan.

### **Monitoring the effectiveness of local work to safeguard and promote the welfare of children**

The work of the Board is progressed largely through its sub-committees and sub-groups who have undertaken the following work over the last year:

#### **Performance, audit and quality assurance sub-committee**

This is the key forum through which the Board examines and verifies the quality of individual agency safeguarding practice. It oversees performance management, scrutinises a developing suite of key performance indicators (KPIs) and secures quality assurance through findings from single and multi-agency audit activity.

#### **Performance management and quality assurance framework**

##### **Remit**

- Implement an effective strategy to monitor quality & effectiveness through analysis of relevant safeguarding performance information from partner agencies including, where appropriate, service users' views.
- Develop and oversee a planned programme of single and multi-agency audit review and quality assurance in relation to safeguarding activities.
- Secure quality assurance and performance management through receipt of reported audit activity arising from agencies and Sub-Committees.
- Co-ordinate Section 11 self-assessment audits and analysis, monitoring agency action plans by reviewing summary data and determining response in respect of non-compliance
- Oversee the Section 175 and 157 audit process relating to schools and outcomes
- Undertake reviewing activity and performance data analysis, providing regular updates/recommendations to the BSCB to mitigate risk, highlight trends, areas of concern and recommendations for further activity / monitoring designed to improve quality and promote good practice.
- Commission specific audits, thematic reviews or case management reviews at the request of the Safeguarding Children Board.
- Ensure that findings from case audits and other enquiries are communicated effectively to frontline staff and managers
- Ensure that messages from inspection, case reviews, audit and quality assurance are acted upon to address inspectorate recommendations and improve practice, through regular learning events.
- Embed performance issues into other Sub-Committees to evaluate and monitor the work of single agencies and reflect the Sub-Committee's role as an external quality check.
- Highlight and disseminate required improvements and areas of good practice through the Policy, Procedures and Practice Developments and Workforce Management and Development Sub-Committees

A Quality Assurance and Performance Management Framework is in place and has been endorsed by the Board. This confirms the need for continuous service improvement and delivery to be driven through quality standards, monitoring of improvement targets and focus on a suite of selected KPIs.

The Board and sub-committee have held development sessions to determine the data to be received by the Board and sub-committee. Respective scorecards of multi-agency KPIs have been identified for regular

reporting. The sub-committee will escalate any issues of concern to the Board. The Board has developed a more effective performance management culture through increasing focus on performance and quality assurance. More valid data with contextual information will enable constructive challenge and provide proper reassurance about safeguarding from partner agencies.

The Board's own set of KPIs, framed around the child's journey from early intervention through to Tier 4 and looked after status includes:

### Early Intervention

1. Number of Early Help assessments

### Contacts, Referrals and Assessments

2. Number of contacts received
3. % of contacts to referral
4. Numbers of referrals
5. % of referrals to assessment under S17 and S47
6. % of Section 47 Investigations converting to initial child protection conference
7. % of assessments completed within 20 days
8. % of assessments completed within 45 days and those out of timescale

### Child Protection

9. % of children becoming the subject of a CP Plan for the second or subsequent time within 2 years
10. % of open CP Plans lasting 2 years or more

### Children in Care

11. Looked after children missing from care incidents (episodes)

12. Police Data. In May 2015 new police measures and safeguarding performance data was provided by South Yorkshire Police (SYP) across a range of categories

13. During 2015/16 the numbers of unallocated assessments to Children's Social Care have been reported.

### Assurance from audit activity

The sub-committee promotes practice improvement through review of audit outcomes, drawn from an evolving programme of planned single and multi-agency audits. For 2015 – 16 the sub-committee considered the following findings from partner and multi-agency audits:

- PAQA Scorecard of Indicators (at every meeting)
- Monthly Social Care Scorecard (at every meeting)
- Education Data Performance Reports (children missing, excluded, elected home educated)
- Youth Offending Data Performance Report
- Multi Agency Deep Dive into S47s
- Health Assessment of LAC placed outside the Borough
- Quarterly Multi Agency CSE audits
- Private Fostering; arrangements and performance
- Education Welfare Assessment Audit
- Audit Report relating to children being subject to a child protection plan lasting for two years or more.
- Audit of children on a CP Plan for the second or subsequent time
- Record Keeping - Special Care Baby Unit Audit
- The quality of agency reports to Child Protection Case Conferences

## Overview of vulnerable groups:

In fulfilling its objective to review the welfare of vulnerable groups of children, the sub-committee questioned information on the following during the year:

- **Children Missing Education (CME):** This relates to children of compulsory school age, not on school roll or educated otherwise, who have been out of any educational provision for at least four weeks. The sub-committee sought information on local numbers and how the children were monitored to ensure they receive suitable education and are safeguarded. Although potential complications relate to school transfer and relocation to another area, the EWS request a safe and well visit to ensure a child's welfare as soon as relocation is known. The service has revised its CME policy and procedure guidance during the year in response to a national consultation. Ofsted has commended our procedures as robust.  
The sub-group have also looked at performance information and safeguarding arrangements for children who are excluded from school and children who are home educated.
- **Looked After Children (LAC):** The sub-committee continue to closely review performance indicator data relating to looked after children.
- **Child Sexual Exploitation (CSE):** Quarterly multi agency audits are undertaken by the CSE Strategic Group and reported in to PAQA. Audits are showing an improvement in joined up responses to young people.

## Priorities for 2016-2017

- Improve a systematic reporting of single and multi-agency practice in terms of identifying key themes for learning and improvement, informing priority areas and promoting multi-agency contribution
- Develop an analysis of Police data to better understand and inform priority areas for multi-agency contribution
- Continue to undertake quarterly multi agency audits:
  - Q1 Children and young people who are cared for by parent/s who misuse substances;
  - Q2 Children and young people who are missing from home, education, school
  - Q3 Children and young people who present risky behaviours
  - Q4 Children who are neglected

## Policy, procedures and practice developments sub-committee

Ensures that policy and procedures are current, implemented, embedded and reflective of practice

This sub-committee oversees a range of areas of safeguarding practice. In acknowledgment that many safeguarding issues relevant to children and young people are derived from adult behaviours, membership of the sub-committee contains representation from adult services. These clear links to adult mental health and substance misuse provide for more cohesive working in these areas of safeguarding concern and forge stronger alliances with relevant partner agencies. The sub-committee has found this

extensive remit to be a challenge in terms of addressing all issues thoroughly, and has therefore established periodic time-limited task groups to address particular pieces of work. Last year, it built on this approach in its considerations to:

- Develop and consult on new multi-agency protocols, policies and procedures on specific safeguarding issues or in response to Serious Case Review findings
- Ensure relevant communications to frontline staff
- Identify any gaps in safeguarding practice that need to be addressed through development of new safeguarding policies/procedures
- Respond to national and local policy changes and advise the Board of the implications of relevant publications and safeguarding developments
- Work with the Serious Case Review Sub-Committee to undertake 'lessons learnt' reviews, and identify required amendments to policy and procedure
- Ensure development of a holistic approach to the safe use of digital technology and ensure that e-safety safeguards are audited and evaluated within the Board's Performance Management Framework
- Provide advice and support on digital technology safeguarding requirements
- Maintain oversight of interagency arrangements to protect young people who are vulnerable/exposed to risk of harm through sexual exploitation and/or running away from home and/or substance misuse. Receive reports from the Sexual Exploitation and Young Missing Forum. Report on specific areas of unmet need to advise the Board of potential and necessary resources/services to meet these needs
- Ensure multi-agency training on the impact of adult mental health on parenting children and promote

shadowing opportunities for relevant staff in partner agencies

- Strengthen engagement of young people with the Board through maintenance of links with relevant forums, such as the Youth Council, to secure the voice of the young person
- Promote better awareness of the impact of adult mental health, learning difficulties, substance misuse and domestic abuse.
- Ensure that work relating to anti bullying policies and strategies reflects a zero tolerance approach.

### **Development of new policies and procedures**

The Board's web enabled policies and procedures were revised and updated in September 2015 and March 2016. In response to identified needs or recommendations from SCRs/learning events, the Board approved the following new policies and procedures, developed with multi-agency consultation:

- Missing from Home or Care and Runaways - Multi-agency protocol - April 2015
- Barnsley CSE Strategy 2015-2017
- Revised Missing Children Procedures
- Revised CSE Joint Investigation Team Protocol
- The Assessment Framework
- Anti Bullying Policy
- Person Posing Risk Policy
- FGM Policy

### Serious case review sub-committee

The information and findings from SCRs and learning events are used to ensure that we continue to improve practice in Barnsley to safeguard children and young people.

During the last 12 months the sub-committee has taken a more robust approach to evidencing that actions arising from reports have been completed and that there is an audit trail to show the work completed.

### Serious Case Review Panel

During the last 12 months the serious case review panel met on 3 occasions to consider if individual cases met the criteria for a serious case review to be commissioned. The criteria for a serious case review (SCR) is set out in chapter 4 of Working Together 2015 and includes individual cases where a child or young person has died or suffered significant harm, where abuse or neglect is suspected and where there may be concerns about partnership working to safeguard the child. Where an SCR is commissioned an independent author is appointed who has no connections to any of the agencies involved; this ensure that there is an independent review. The purpose of an SCR is not to apportion blame but to identify lessons that will help to safeguard other children.

During 2015/16 three Barnsley Serious Case Reviews (SCRS) were published. They can be found in full on the Barnsley Safeguarding Children Board web site: <https://www.safeguardingchildrenbarnsley.com/professionals-and-partners/serious-case-reviews.aspx>

Brief details of those individual cases are as follows:

**Child M:** this SCR relates to a 14 week old baby that was found to have a number of significant non accidental injuries including fractured ribs and four fractures to its leg bones. A police investigation was undertaken to attempt to identify who was responsible for inflicting the injuries. A number of adults who had caring responsibilities for the baby were questioned but the investigation did not result in a criminal prosecution due to a lack of evidence. The baby was taken into the care of the Local Authority to ensure its future safety.

**Child N:** This SCR was commissioned following the tragic death of a 14 year old boy who was in the care of Barnsley Local Authority and died in a private care home in Rochdale having taken an overdose of methadone which he is believed to have acquired during a visit to family and friends in Barnsley. There was a police investigation into his death. At the Coroner's inquest the Coroner made a finding of death by misadventure. It is worthy of note that both in the Coroner's findings and the SCR that there are positive comments regarding the support provided to Child N by his Barnsley Social Worker.

**Children P:** This SCR relates to the sad death of two young brothers who died as a consequence of a deliberate house fire started by their father who also died in the incident. A police investigation took place into the circumstances of their deaths. The Coroner's inquest resulted in a finding of unlawful killing. Both the Coroner's inquest and the SCR found that no agency had fundamentally failed the family.

In each of the SCRs recommendations were made by the independent authors. Those recommendations were incorporated into



action plans which were robustly monitored by the members of the SCR sub committee. The action plans for each of the SCRs described above have been now shown as complete with the supporting evidence having been scrutinised by the committee; the completed action plans have then been tabled at the main safeguarding board for their oversight and agreement.

Where appropriate the lessons learned from SCRs have been incorporated into training programmes.

### What have we learnt?

Examples of lessons learnt from reviews that have been completed and actioned are:

- Ensuring that agencies policies and procedures for following up where children Do Not Attend (DNA) for medical appointments are fit for purpose and are being complied with. This includes the auditing of cases to ensure effective practice.
- Actions around the training of staff in relation to Common Assessment Frameworks (now revised to become Early Help Assessments)
- The review and development of the multi agency process for their collective response to critical incidents involving children. The process and policy is in place and was the subject of a half day dedicated training event attended by staff from a range of agencies.
- Improving the transitional arrangements for children moving from primary schools to secondary schools. Transitional arrangements are in place for all secondary schools.
- Ensuring professionals are inquisitive about significant others involved with families and that they share information on any concerns.

- Ensuring that birth visits are conducted by health visitors within 10 to 14 days of a baby's birth even if the baby is still in hospital
- Ensuring that the record keeping on the Special Care Baby Unit meets national recording standards
- Ensuring the correct action is taken to complete risk assessments around domestic violence and notifications to other agencies
- Ensuring a co-ordinated approach to effective bereavement follow up.

The board will assess how well this learning is embedded in practice through evidence from quality assurance and audit findings.

### Child Death Overview Panel

#### 1. Introduction

Following the death of Victoria Climbié in 2000, national guidance was produced in the form of Working Together to Safeguard Children. This Guidance states that all agencies who have a responsibility towards children should work together to look at ways to keep children safe. This led to the formation of Child Death Overview Panels (CDOPs) who are accountable to the Local Safeguarding Children Boards.

The child death review process is not about apportioning blame but aims to learn lessons in order to improve the health, safety and wellbeing of children and to seek to reduce the number of deaths.

Compared to national data, Barnsley has relatively few child deaths. However, the circumstances surrounding the death of each child are considered on an individual basis in order that any modifiable factors identified may form the basis of recommendations to the Barnsley Safeguarding Children Board (BSCB). Consideration is given to how local services



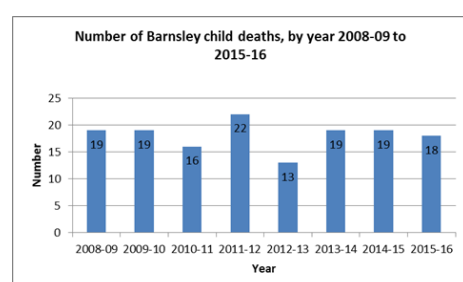
can work together to mitigate future harm to children and young people. The findings from all child deaths inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children and young people in Barnsley.

Barnsley CDOP is a multi-agency panel responsible for reviewing information on all children and young people under 18 years who reside in Barnsley. The CDOP meet quarterly and by exception. The Terms of Reference, including membership, are available to download from the BSCB website.

## 2. Number of child deaths notified

From 1 April 2015 to 31 March 2016 there were 18 deaths notified to Barnsley CDOP. Figure 1 shows the number of Barnsley child deaths by year, 2008-09 to 2015-16 and Figure 2 shows the number of these that were expected and unexpected. Figure 3 illustrates the number of deaths by month.

**Figure 1**



Source: Barnsley CDOP Database

**Figure 2**

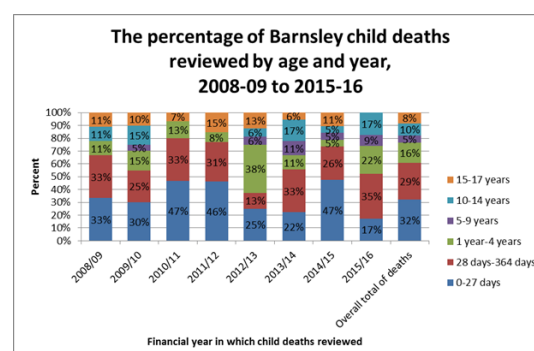
	Expected	Unexpected	Total
2008/09	13	6	19
2009/10	11	8	19
2010/11	7	9	16
2011/12	12	10	22
2012/13	8	5	13
2013/14	13	6	19
2014/15	13	6	19
2015/16	9	9	18
Totals	86	59	145

## 3. Cases Reviewed

The panel met 5 times (quarterly plus an additional panel was convened specifically to review neonatal deaths) and 24 reviews were completed during the April 2015 - March 2016 reporting period. Due to the small numbers of deaths that occur each year in Barnsley, identifying trends and patterns is difficult. An analysis has been undertaken of the child death information held on the CDOP database over the period 2008/09 to 2015/16 to provide a picture of what is happening over a longer time period.

Figure 3 shows the breakdown of child deaths reviewed by CDOP by age over the period 2008-09 to 2015-16 (total 133).

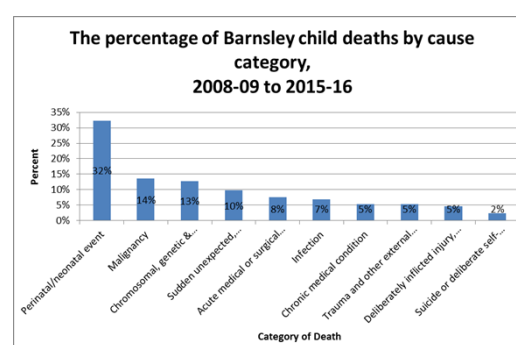
**Figure 3**



Source: Barnsley CDOP Database

Figure 4 shows the percentage of child deaths reviewed by cause category over the period 2008-09 to 2015-16.

**Figure 4**



Source: Barnsley CDOP Database

The findings show that the pattern of child deaths seen locally reflect those identified in national findings with approximately a third of deaths being associated with premature birth.

#### **4. Progress against 2015-16 recommendations**

In accordance with the previous year's proposed service developments, the following have been successfully completed:

- An audit has been undertaken of the governance and administrative processes.
- In light of the review and revision of Working Together to Safeguard Children Guidance, initial rapid response multi-agency meetings are being piloted for unexpected and unexplained deaths
- The leaflet for parents/carers explaining the child death review process and the role of the Child Death Overview Panel has been revised.
- Multi-agency training has been jointly delivered by the BMBC Multi-Agency Trainer and Public Health Specialist Technical Officer (CDOP Administrator).

In addition to the above:

- A training session relating to the CDOP procedures was delivered specifically to School Nurses and Health Visitors in June 2015 which provided an understanding of the CDOP and what is expected in completion of Agency Report Form B.
- Links have been strengthened with the Histopathology secretaries at Sheffield Children's Hospital for inviting the Consultant Paediatric Pathologists to multi-agency case review meetings for unexpected child deaths to present findings from their medical

examinations and all post mortem reports are provided to CDOP.

#### **5. Recommendations for 2016-17**

The Panel has discussed and agreed participation with South Yorkshire CDOPs in a peer audit review around decision making for modifiable factors.

#### **6. Further references**

Barnsley Joint Strategic Needs Assessment:  
<https://www.barnsley.gov.uk/services/public-health/joint-strategic-needs-assessment-jsna>

Working Together to Safeguard Children, 2015:  
<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

#### **Partner agency contributions to safeguarding**

The Board values the contributions of all partner agencies in promoting and monitoring the effectiveness of safeguarding in the area. An effective Board requires all partner agencies to participate fully, engage in the Board's business and transfer the safeguarding ideology into their own sphere of activity.

#### **Barnsley Hospital NHS Foundation Trust (BHNFT)**

BHNFT continues to meet the requirements of an ever challenging safeguarding agenda. The safeguarding children team fulfils regular commitments to training, supervision, advice, support, audit, supporting the child death process and representing the Trust at various Board sub-committees.

The team is promoting awareness of the Thresholds for Intervention to ensure early initiation of offers of help and support. Staff are encouraged to seek advice where required to ensure that cases do not become 'stuck' and also to provide challenge where there might be a professional disagreement.

BHNFT undertakes regular audits of records, child protection reports and court reports to ensure they meet minimum quality standards and identify improved actions, planning and decision making.

The Safeguarding Children Training Strategy states staff who have significant involvement with children must be knowledgeable and access training in relation to domestic abuse, sexual exploitation and the WRAP prevent agenda. We also continue to raise awareness and knowledge through single agency training, multi-agency training and learning events.

The hospital's 'Did Not Attend' policy has been revised and updated to ensure that, when a child misses a hospital appointment, a safeguarding review is undertaken to assess risk. Cancelled appointments are also reviewed to assess issues of veiled compliance to ensure improved health outcomes for children and addressing of neglect.

To improve their experience, the team actively seeks the views of children and families through an evaluation questionnaire, the findings from which are reviewed. The ongoing audit programme seeks to ensure effective high quality practice.

BHNFT has updated its Safeguarding Supervision Policy to ensure that community midwives and community nurses receive individual and group supervision to enhance their knowledge

and ensure they are supported in their work.

Additionally BHNFT have developed good working relationships with substance misuse services and staff follow procedures in relation to this and refer young people into services. Feedback from Commissioners is that they feel this sets BHNFT above the national average for this. Additionally feedback from this demonstrates we are having a beneficial impact on these young people. The safeguarding department have a comprehensive audit schedule to provide assurance that standards outlined in policy and guidance are being met. Moreover, any breaches in policy are investigated under Datix, Serious Incident or SCR procedures.

#### **NHS Barnsley Clinical Commissioning Group**

In addition to safeguarding requirements incorporated into closely monitored contracts with health care providers, the Designated Nurse for Safeguarding Children, the Designated Nurse for Adults and the Named Doctor have developed a Safeguarding Vulnerable People Section 11 Audit to inform the forth coming 'safeguarding stock take' of primary care.

The issue of children failing to attend health appointments has featured in national and local child deaths and remains of concern to the Safeguarding Board. Steps have been taken to address this issue and the Board has received assurance that health providers are monitoring failure to attend medical appointments and poor engagement with services more effectively to assess risk to children.

We have a Commissioning Strategy which includes meeting the needs of children and young people in Barnsley and reflects our

vision and values which are fair and equitable access to reduce known inequalities. Furthermore as part of the Executive Commissioning Group for the Children and Young People Trust we are committed to partnership working to achieve the Trust's aims e.g. we are leading on developing the offer for emotional wellbeing

#### **South West Yorkshire Partnership Foundation Trust (SWYPFT)**

South West Yorkshire Partnership Foundation Trust covers four local authorities and Safeguarding Boards across the region. The strength of that spread is that learning experience and confidence can be shared across the service for the direct benefit of children, young people and their carers.

Services provided for children include health visiting, school nursing, family nurse partnership, therapy services, child and adolescent mental health services and early intervention in psychosis for young people from 14.

The service also promotes the think family agenda and offers services across health and wellbeing and mental health.

#### **Key achievements last year have been:**

- The service has met the section 11 challenge and continues to strive towards demonstrating improved outcomes for children and young people who have contact with SWYPFT services
- Excellent attendance by staff at Initial and review child protection conferences
- A proactive response which seeks to offer an extensive programme of training for all staff groups as identified within the Intercollegiate Document 2014

SWYPFT provides the following messages to it's staff in relation to safeguarding:

- Assessments should be thorough and utilise all information available; systematic risk assessment should look at all aspects of the child's journey and all adults involved in the delivery of care. The wishes and feelings of the child need to be heard throughout our assessments
- To be aware of the importance of Early Help Assessments and the instrumental role for health within this arena
- The rule of optimism should be understood by all staff and objective assessment of the facts should take place taking account of all the interrelated dynamics, always ask is this child safe and healthy? Is this the whole picture?
- Compliance with supervision supports staff to develop professional resilience and is instrumental in improving outcomes for children and young people
- non-attendance at appointments should always be assertively challenged and risk assessed.
- children should not be invisible, all children – grandchildren, partners children.
- be observant and ask key questions.
- share information – understand the NHS code of confidentiality and when it is important to share information.
- good record keeping is essential to facilitate high quality care.
- families can be vulnerable, vulnerable adults can be perpetrators – Think Family.

#### **South Yorkshire Police**

Protecting Vulnerable People is a priority within the Police and Crime Plan 2013/2017. The Barnsley located Police Public Protection Units fall under the

central control of Specialist Crime Services, reporting to an Assistant Chief Constable who holds responsibility for all areas of Protecting Vulnerable People. However, the provision of services in terms of safeguarding children is locally delivered, with strong ties to the Barnsley district command who has responsibility for local children's safeguarding.

In recognition of the importance of effective, locally based partnership working, the force is disbanding the Central Referral Unit and introducing Multi-Agency Safeguarding Hubs. The Barnsley M.A.S.H. is based within Barnsley District and incorporates partners from Police, Social Care and Health, working together to safeguard children. This means that all child protection referrals will be received and actioned by a dedicated team of professionals within the M.A.S.H., who are also able to progress joint investigations and ensure services required by children and families are signposted to the relevant partner agency without delay.

Over the last year, Barnsley PPU has gradually increased in size as a result of increased funding provision from the Police and Crime Commissioner. The team now has additional staff across all areas, with increased capacity available for child abuse and child sexual exploitation investigations. In Barnsley there is also a new team dedicated to vulnerable adult investigations, which includes all high-risk domestic abuse cases. It is acknowledged that the impact on children living in families where domestic abuse features can be immense and negative affect a child's quality of life. This team has strong links to child protection colleagues and partners within the M.A.S.H., which means that the risk to any children is identified and managed at the earliest opportunity.

This strengthened approach to partnership working in Barnsley will enable a more timely and effective response to safeguarding which will provide greater reassurance to victims and families.

### **Berneslai Homes**

Berneslai Homes' primary contribution to Safeguarding is via its established Vulnerability Strategy: 'Something Doesn't Look Right'. Through this approach, they provide practical support and interventions to address identified issues to prevent progression to other services for example social care or the police. Their strategy aims to ensure the early intervention of risks during routine visits to thousands of homes within the Borough, at the start of tenancies and at various times throughout them. For example, they are able to provide practical support, make referrals to other appropriate support providers and carry out housing application assessments as part of their response to the early identification and intervention with tenants in need.

Berneslai Homes continues to undertake proactive visits to Council properties specifically to identify any support or vulnerability issues early.

During the last year they carried out over 4,500 support visits, with nearly 2,500 resulting in supportive interventions. This included a number of cases where there were safeguarding concerns around the safety of children and adults. During the year we have also continued to visit vulnerable individuals affected through Universal Credit although this is still to be fully rolled out across the borough and we continue to support those affected by welfare reform.

Berneslai Homes Family Intervention Service (FIS) provides cross tenure family support and interventions to families across



the Borough, often with multiple and complex needs. The FIS continues to make significant progress in achieving positive outcomes for families under the Troubled Families Programme; supporting over 270 families ranging from those requiring early intervention to those requiring intensive support during the last year.

The primary aim of this work is to secure and sustain clear behavioural change, thus reducing the effect of a family on the surrounding community. Positive changes are evidenced through reduced antisocial behaviour and criminality, addressing worklessness and improving progress to work, and improved opportunities for children through better school attendance. Families are allocated dedicated keyworkers, delivering an evidence based approach of early intervention/prevention, non-negotiable support and enforcement in order to provide families with a positive incentive to change.

### **Barnsley College**

Barnsley College is committed to safeguarding the total college community, including learners, staff and visitors. In 2015 - 16, the College continued to embed safeguarding across all College activity by:

1) having a robust safeguarding structure led by the Assistant Principal (Access to Learning), operationally led by the Head of ALS, Counselling & Safeguarding. The College continues to provide dedicated frontline support through the work of the Safeguarding Team Leader, Safeguarding Officer, Safeguarding Advisors and Departmental Safeguarding Representatives. These staff provide a range of advice, guidance and safeguarding support to learners, staff and visitors;

2) Linking up with secondary schools and other key agencies to support the transition of learners into College;

4) Continuing professional development for staff to improve skills and knowledge and excellent partnership working arrangements, so the workforce is able to safeguard the college community. College delivers safeguarding awareness training in-house so that the training can be tailored towards how best to safeguard the College community.

5) The college will continue with its approach to embedding safeguarding throughout College activity in 2016 - 17, with a particular focus on:

- further CPD for staff, in particular in key safeguarding roles, leading to a recognised safeguarding qualification
- reviewing and refreshing the College's safeguarding policy to ensure that it reflects recent legislative and statutory guidance updates
- ensuring that the Prevent agenda is fully embedded into College policies and procedures and that staff are suitably trained to meet their statutory duties.

### **Voluntary and community sector**

Over the past year, a lot has been achieved in the voluntary and community sector in relation to safeguarding children, young people and vulnerable adults.

The consortium has voluntary and community sector representatives on the Safeguarding Board, the Serious Case Review Sub Committee, the Think Family Board.

As a consortium, safeguarding is vitally important and should be evidenced as such. However, due to the diverse nature of the voluntary and community sector, Section 11

requirements may be covered in a different way that meets the individual needs of that service and, for some groups, completing the Section 11 is not always appropriate.

#### **Integrated working with partners**

Integrated and partnership working is a particular local strength and all the individual partner agency contributions to safeguarding are valued. The Board maintains links with partners and contributes to local initiatives on a variety of safeguarding themes, through representation on a range of multi-agency working groups.

#### **Planned future developments and key priorities for 2016 - 17**

Barnsley Safeguarding Board's strong commitment to continuous service improvement and addressing the needs of the most vulnerable children and young people is evidenced through the objectives in our 2015 -16 Business Plan. Future aims and priorities are identified in the context of significant change, nationally and locally, particularly in the light of continuing budgetary pressures. The continuing effectiveness of the Board's work will continue to be subject to close scrutiny. The synergy obtained from strong partnership working remains an essential element of effective safeguarding. The objectives of the Board and sub-committees/groups for the coming year have been determined with multi-agency input and will be subject to regular review throughout the year to measure their achievement and impact.

#### **Oversight and progress of actions from the Continuous Improvement Programme**

The Board will assume responsibility for driving forward and monitoring practice to secure mainstreamed continuous

improvement. It will assimilate learning from the Improvement Programme and use it to inform future safeguarding developments through partner agency participation. The Board will also require regularly updated reports of specific case file thematic audit and general audit activity.

#### **Encourage challenge**

The Board will seek to strengthen and evidence its own effectiveness through rigorous challenge, participation and engagement. This will include challenge sessions for each refresh of the Section 11 self assessment, encouraging challenge at Board debates, monitoring use of the escalation policy and promoting participation and engagement of stakeholders wherever possible. The Section 11 challenge will also seek evidence that current austerity measures and budget reductions are not having an adverse effect on the ability of partner agencies to fulfil their responsibilities.

#### **Child Sexual Exploitation**

Although the Board has an approved strategic approach in relation to CSE there is a need for continuous focus which will include a strategy refresh and procedure update. The development of the Multi-Agency Safeguarding Hub (MASH) will support the early identification and intervention for children at risk of CSE.

#### **Promote understanding on thresholds and monitor pressures on the front door**

Continued work to ensure that the thresholds are understood and correctly applied by partner agency staff and that effective use is made of the escalation process in cases where there are concerns about the decision making.



To encourage agencies to ensure that non urgent referrals and contacts into social care are quality assured and discussed with agency safeguarding leads prior to children's social care.

That developments in relation to Early Help are supported and monitored.

### **Strengthening work with partners**

The Board will seek to improve its overview of the work of partner agencies involved with safeguarding children, including the voluntary and community sector and local faith groups through issues reported and escalated by the sub-committees. It will actively seek to strengthen existing links with the VCS and associated groups and continue to explore the benefits of closer co-operation through multi-agency working, building on establishment of the Joint Investigation Team and the development of the MASH.

### **Performance management and quality assurance**

Development of the Board's Performance Management Framework and routine reporting of key indicators has continued to be refined during the year. The Board is now able to scrutinise performance in a more informed and systematic way and challenge areas where it appears that improvements are required. This approach will continue to evolve to ensure the Board receives the necessary information to be assured about the safety and quality of frontline services. Responsibility for regular mainstream scrutiny rests with the PAQA Sub-Committee, who will escalate areas of concern to the Board through exception reporting.

Through oversight of a comprehensive audit programme, the PAQA Sub-Committee will continue to scrutinise findings from

commissioned single and multi-agency audits to ensure actions are embedded through practice changes. The Board has also agreed to receive themed presentations on performance from partners for challenge at Board meetings. The Board are keen to retain a key focus in relation to CAMHS and monitor improvements within this service.

### **Developing stronger means of engaging with young people and their families to be clear about how they feel safe in the borough**

Securing the voice of children and young people to inform strategic and service planning is underdeveloped and an area for further work. There are examples of engagement with young people for specific activities and the Board maintains participative links to the views of young people through membership of the Care4Us Council and the Youth Council which is represented on the Policy, Procedures and Practice Developments Sub-Committee. Although the Board is addressing this through plans to hold meetings in schools, and enter a dialogue with young people about their priorities/ views on safeguarding, more systematic engagement is required.

### **Learning from serious case and other reviews to inform practice**

Continue to assimilate and act on the learning and improvements derived from Serious Case Reviews, the CDOP, and other learning events in order to improve practice and service delivery. The SCR Sub-Committee will continue to inform local practice through examining findings from SCRs held elsewhere to identify lessons with local resonance for dissemination to agency practitioners.

## **Board Attendance**

Board membership represents all key local partner agencies. Last year saw a limited number of membership changes. The majority of changes were in relation to school membership and the replacement of interim staff with permanent staff members.

## **Member attendance at Safeguarding Children Board meetings in 2015 - 16**

From March 2015 until March 2016 there were six ordinary meetings and a joint meeting with the Children's Trust Executive Group (TEG).

The Board maintains regular oversight of attendance to promote regular and consistent participation. Analysis shows that attendance and participation is

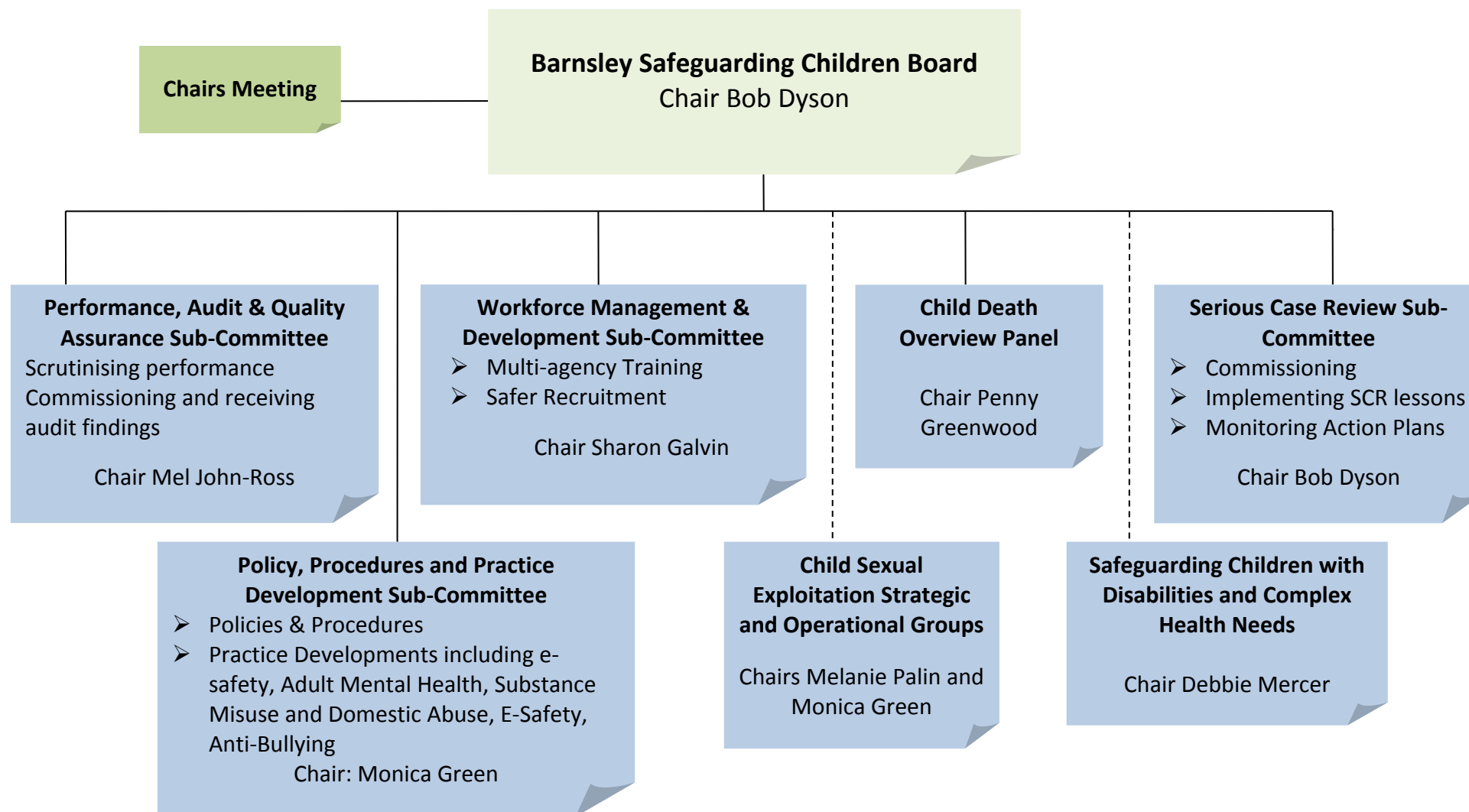
generally very good, especially by key stakeholder representatives from the local authority, health services, secondary schools, Barnsley College, the police and the voluntary and community sector.

## **The BSCB Budget 2015 - 16**

The Board is funded by contributions from partner agencies, in accordance with a locally agreed formula. The budget breakdown and contributions made by member organisations for the 2015 - 16 year are shown in appendix 3.

There was a pressure on the budget last year due to the increased level of Serious Case Review Work which resulted in the budget being overspent.

## BARNSELY SAFEGUARDING CHILDREN BOARD GOVERNANCE STRUCTURE



**MEMBERSHIP AND ATTENDANCE**

The list of members and advisors to the Barnsley Safeguarding Children Board, as at 3 May 2016, is set out below.

<b>Members</b>	<b>Representative Agency</b>
Bob Dyson	Independent Chair
Susan Barnett	Barnardos/Voluntary and Community Sector representative
Tim Breedon	Director of Nursing, South West Yorkshire Partnership NHS Foundation Trust
Tim Innes	Temporary Chief Superintendent
Rachel Dickinson	Executive Director People, BMBC
Ben Finley	Service Manager Barnsley Youth Offending Team,
Jo Nolan	Secondary Head Teachers' Association
Max Lanfranchi &	Director of Probation , Barnsley
Heather McNair	Chief Nurse Barnsley Hospital NHS Foundation Trust
Brigid Reid	Chief Nurse, NHS Barnsley Clinical Commissioning Group
Pat Sokell	Lay Member
Steven Szocs	Lay Member
Sue Symcox	Service Manager, CAFCASS
Phil Briscoe	Assistant Principle, Barnsley College
Judith Wild	Quality & Patient Safety Manager, NHS England SY and Bassetlaw
<b>Advisors</b>	<b>Representative Agency</b>
Philip Shire	Service Manager, Safeguarding Adults, BMBC
Steve Eccleston	Assistant Director, Legal Services, Sheffield MBC
Sharon Galvin	Designated Nurse Safeguarding Children, Barnsley CCG
Pete Horner	Head of Public Protection Unit South Yorkshire Police
Mel John-Ross	Assistant Executive Director of Children's Services, Safeguarding, Health and Social Care, BMBC
Dr Saqib Iqbal	Designated Doctor, Barnsley Hospital NHS Foundation Trust
Dave Fullen	Director of Housing Management Berneslai Homes
Kathryn Padgett	Assistant Director of Children's Health Improvements, SWYPFT
Dawn Peet	Safeguarding Officer South Yorkshire Fire & Rescue
Nigel Leeder	Safeguarding Children Board Manager
Penny Greenwood	Assistant Director of Public Health
Cllr Margaret Bruff	Cabinet Spokesperson
Monica Green	Head of Service for Safeguarding

Barnsley Safeguarding Children Board Budget 2015/16			
Income £		Expenditure £	
Partner Contributions			
Barnsley MBC	£94,788	Staffing	£107,007
NHS Barnsley CCG	£49,175	Multi-agency Training	£17,456
Probation	£1,157	Professional Fees including SCR	£27,203
South Yorkshire Police	£12,024	Service Developments	£0
Cafcass	£2,500	Running Costs	£7,978
Connexions	£0	Training Income	£0
TOTAL	£159,644	TOTAL	£159,644